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

NOVEMBER 6, 2025
2:00 P.M.

505 CITY PARKWAY WEST, SUITE 108
ORANGE, CALIFORNIA 92868

BOARD OF DIRECTORS

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

CHIEF EXECUTIVE OFFICER
Michael Hunn

OUTSIDE GENERAL COUNSEL
James Novello
Kennaday Leavitt

CLERK OF THE BOARD
Sharon Dwiers

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

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

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

Members of the public may attend the meeting in person. Members of the public also have the option of participating in the meeting via Zoom Webinar (see below).
Participate via Zoom Webinar at:**https://us02web.zoom.us/webinar/register/WN_xbLe0isoQGqUbLpvrjDi5g**
Join the Meeting.
Webinar ID: **880 9081 6369**
Passcode: **391254** -- Webinar instructions are provided below.

CALL TO ORDER
Pledge of Allegiance
Establish Quorum

PRESENTATIONS/INTRODUCTIONS
1. Digital Member Communications: Texting Program Overview

MANAGEMENT REPORTS
2. Chief Executive Officer Report

3. Chief Financial Officer Report

ADVISORY COMMITTEE UPDATES
4. Member Advisory Committee and Provider Advisory Committee Updates

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
5. Minutes
   a. Approve Minutes of the October 2, 2025 Regular Meeting of the CalOptima Health Board of Directors
   b. Approve Minutes of the October 16, 2025 Special Meeting of the CalOptima Health Board of Directors
   c. Receive and File Minutes of the June 18, 2025 Special Meeting of the CalOptima Health Board of Directors' Quality Assurance Committee

6. Approve Modifications to CalOptima Health Quality Improvement Policies

7. Approve CalOptima Health's Calendar Year 2026 Member Health Rewards

8. Ratify Amendments to CalOptima Health's Primary Agreement and Secondary Agreement with the California Department of Health Care Services

9. Authorize Amendments to the CalOptima Health Contracts with Edifecs Inc. for Covered California Related Services and Enterprise Data Management Software and the Consolidation of the Contracts

10. Approve new CalOptima Health Policy CC.1502: Coverage for Rape and Sexual Assault Treatment Services

11. Approve Actions Related to Covered California Administrative Services Agreement for Transportation

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

REPORTS/DISCUSSION ITEMS

13. Approve Actions Related to Federal Shutdown Response Supplemental Food Support for CalOptima Health Members

14. Adopt Resolution No. 25-1106-01 Approving the Revised 2026 CalOptima Health Compliance Plan, 2026 CalOptima Health Code of Conduct, 2026 CalOptima Health Anti-Fraud, Waste and Abuse (FWA) Plan, 2026 CalOptima Health HIPAA Privacy and Security Program, and Revised CalOptima Health Office of Compliance Policies and Procedures

15. Authorize Amendments to the CalOptima Health Behavioral Health Professional Services Contracts for the Medi-Cal Program

16. Consider a Request to Support a Proposed Amendment to CalOptima Health's Governing Ordinance

CLOSED SESSION

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

CS-2. CONFERENCE WITH LEGAL COUNSEL – Anticipated Litigation, pursuant to Government Code Section 54956.9 (d)(2), (e)(1): 2 cases

CS-3. CONFERENCE WITH LEGAL COUNSEL—ANTICIPATED LITIGATION: Significant exposure to litigation pursuant to Government Code section 54956.9(d)(2) and (e)(1): up to 2 potential cases

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

ADJOURNMENT

TO REGISTER AND JOIN THE MEETING

Please register for the Regular Meeting of the CalOptima Health Board of Directors on November 6, 2025 at 2:00 p.m. (PST)

To **Register** in advance for this webinar:
https://us02web.zoom.us/webinar/register/WN_xbLe0isoQGqUbLpvrjDi5g

To **Join** this webinar:
https://us02web.zoom.us/s/88090816369?pwd=z32fX86cpKP9bUFvniQkVi7AeC8lLx.1

Phone one-tap:
+16699009128,,88090816369#,,,,*391254# US (San Jose)
+16694449171,,88090816369#,,,,*391254# US

Join via audio:
+1 669 900 9128 US (San Jose)
+1 669 444 9171 US
+1 719 359 4580 US
+1 253 205 0468 US
+1 253 215 8782 US (Tacoma)
+1 346 248 7799 US (Houston)
+1 386 347 5053 US
+1 507 473 4847 US
+1 564 217 2000 US
+1 646 558 8656 US (New York)
+1 646 931 3860 US
+1 689 278 1000 US
+1 301 715 8592 US (Washington DC)
+1 305 224 1968 US
+1 309 205 3325 US
+1 312 626 6799 US (Chicago)
+1 360 209 5623 US

Webinar ID: 880 9081 6369
Passcode: 391254
International numbers available: **https://us02web.zoom.us/u/koDQTILT4**

Digital Member Communications: Texting Program Overview

Board of Directors Meeting
November 6, 2025

Deanne Thompson, Executive Director, Marketing and Communications

Our Mission

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

Our Vision

Provide all members with access to care and supports to achieve optimal health and well-being through an equitable and high-quality health care system.

Overview

- Texting is integral to CalOptima Health's member outreach strategy

Reaches more than 388,000 members in English, Spanish, Vietnamese, Korean, Farsi, Arabic, Chinese or Russian

Keeps members informed, connected to care and engaged with their health

Includes informational and interactive messages

Supports key health priorities and improves quality measures

Drives attendance at CalOptima Health's community events

CalOptima Health

Member Selection

- Each campaign reaches the right members, in the right language, at the right time

Sourcing Data

- Eligibility, claims and quality measure data used to create member lists
- Focus on clinical and quality initiatives, such as medication adherence and blood lead screenings

Targeting

- Member cohorts further refined by need and location, such as distance from a community event
- Messages approved by regulators and translated into threshold languages

Message Delivery

- Personalized, multilingual texts sent at optimal times
- Campaign performance analyzed to improve targeting

CalOptima Health

Texting Campaigns and Member Reach

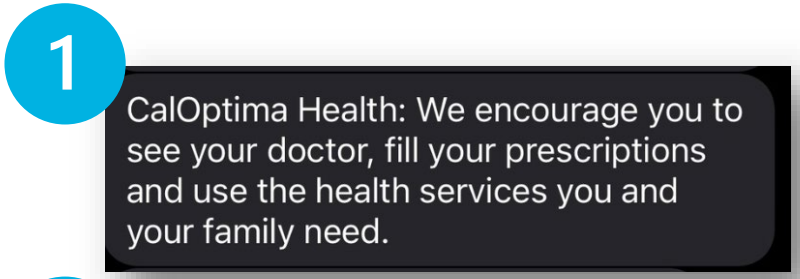
- Members reachable through text based on:
  - Phone numbers on file (including multiple members in the same household)
  - Members who have opted out of getting text messages

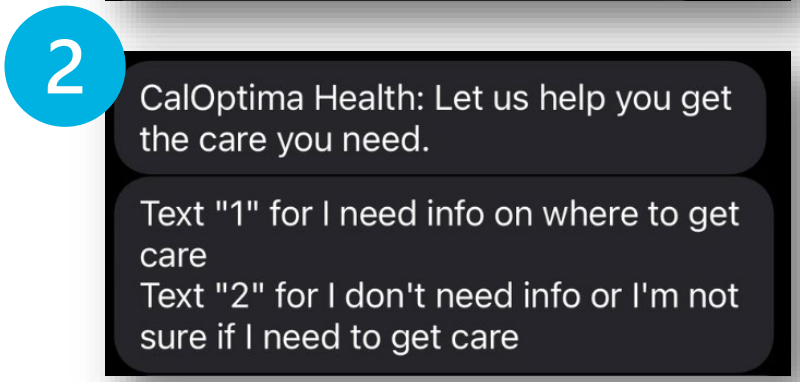
Total active text campaigns (*weekly, monthly or yearly*): **27** *(One-Way: 10 and Two-Way: 17)*	Total targetable members (*with valid numbers and excluding opt outs*): **~388,000**	Text message delivery rate: **~81%** (*Industry benchmark: 86%*)	Total reachable members (*factoring in average delivery rate*): **~318,000**

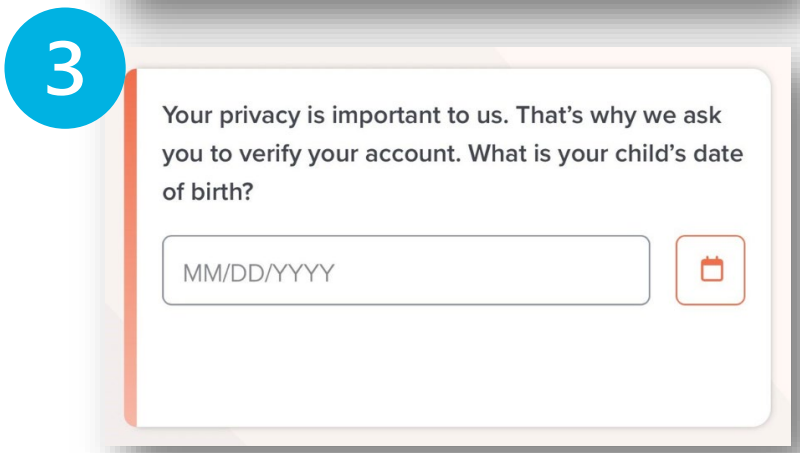
CalOptima Health

Message Types

- CalOptima Health sends:
  1. One-Way SMS
     - Text, email or robocall only; no direct member engagement
  2. Two-Way SMS
     - Members engage directly by texting back replies
  3. Two-Way Invisible App
     - Members engage directly via encrypted web portal







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General Campaigns

Coverage and Benefits
- Medi-Cal Renewal Reminder
- OneCare Eligibility Marketing

Member Engagement
- Discontinued Medi-Cal Members
- OneCare Health Rewards

Two-Way (Interactive)

One-Way (Informational)

Member Information
- Update Preferred Language
- Update Mailing Address

Resources
- Promotion of Health Fairs and Community Events

CalOptima Health

Quality Improvement Campaigns

Health Care Access
- Access to Care and Resources
- Health Risk Assessment

Behavioral Health
- Behavioral and Mental Health Quality Measures and Follow-Up

One-Way (Informational)

Condition Management
- Medication Adherence for Cholesterol, Diabetes, etc.

Transitions of Care
- Post-Hospital Admission and Transitional Care Services

CalOptima Health

Quality Improvement Campaigns (cont.)

🔬 Condition-Based Care
- Diabetes Screening and Tests
- Dental, Vision, Hearing Support

💗 Health Coaching
- Promotion for Health Coach Services and Health Classes

Two-Way (Interactive)

⭐ Member Feedback
- Member Experience Surveys
- Listening Posts on Touchpoints

🥼 Care Coordination
- Health Network, PCP Selection
- Medication Review and Survey

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Health Network Collaboration

- CalOptima Health is supporting health networks by offering coordination to:

Provide our approved campaign scripts to health networks to repurpose or adapt

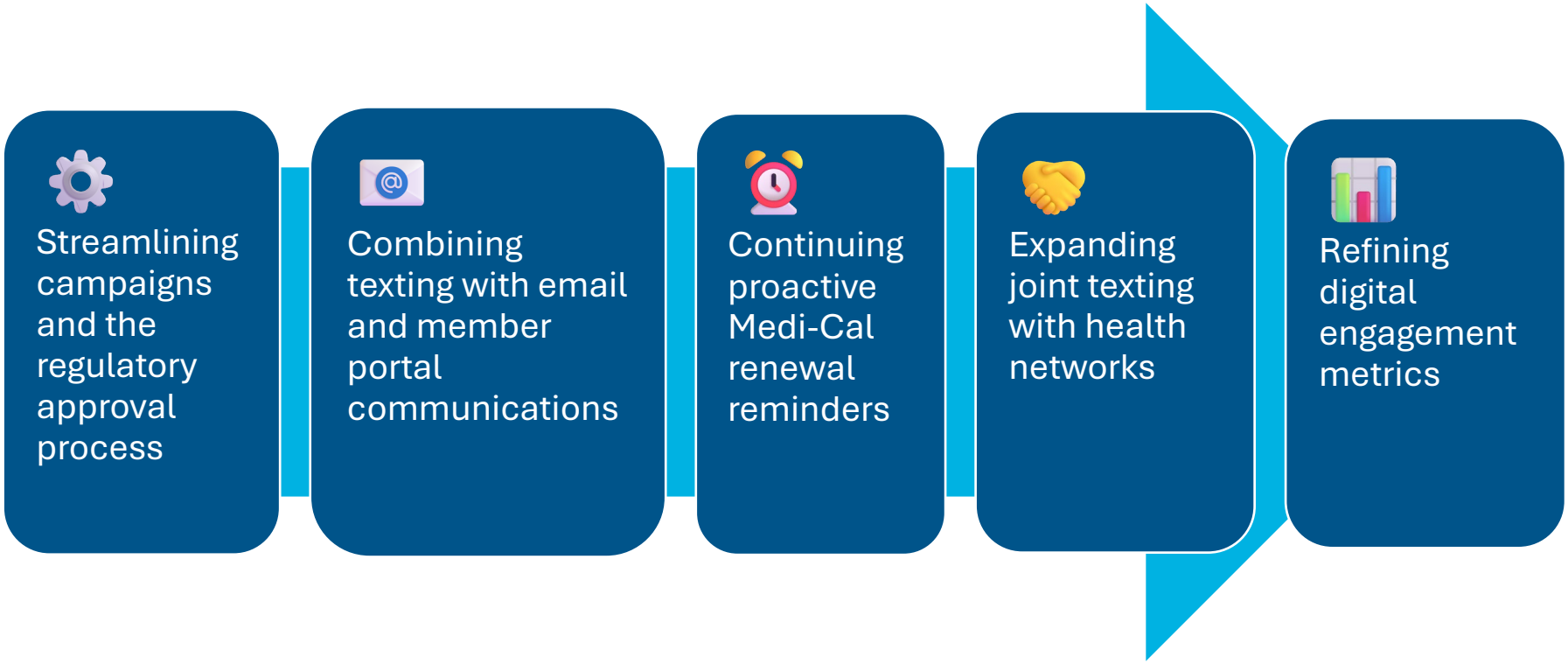
Update our scripts with health networks' custom phone numbers or URLs

Segment campaign lists by health network

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Expanding Member Engagement

- CalOptima Health is working to improve our texting program by:



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MEMORANDUM

DATE:	October 31, 2025
TO:	CalOptima Health Board of Directors
FROM:	Michael Hunn, Chief Executive Officer
SUBJECT:	CEO Report — November 6, 2025, Board of Directors Meeting
COPY:	Sharon Dwiers, Clerk of the Board; Member Advisory Committee; Provider Advisory Committee; and Whole-Child Model Family Advisory Committee

A. Member and Population Health Needs Assessment Member Survey Launches

CalOptima Health's Member and Population Health Needs Assessment (MPHNA) member survey officially launched on October 23. This online survey is a key part of our strategy to better understand the health needs, lived experiences and priorities of our members. Insights and results will shape future planning, program development and community investments, ensuring our commitment to improving health care access and outcomes. A sample of 25,000 CalOptima Health members will receive communications via mail from the Social Science Research Center (SSRC) at Cal State Fullerton on behalf of CalOptima Health. Additionally, 1,000 member survey postcards will be distributed through our community events and our Street Medicine program. Members will have the option to receive a gift card to thank them for participating. Our MPHNA project also included a provider survey that was conducted in the summer. We received 301 responses, which exceeded the previous engagement.

B. Federal Government Shutdown Continues

On October 1, the federal government halted most non-essential operations when Fiscal Year (FY) 2025 federal funding, as well as several health program authorizations, expired on September 30, 2025. The action came after the U.S. Congress was unable to reach a bipartisan agreement to pass either new FY 2026 appropriations bills or a Continuing Resolution (CR) to fund the federal government at existing levels. As the federal shutdown now reaches its one-month mark, both Republican and Democratic leaders in Congress are standing firm in their respective stances. While the Republican-led U.S. House of Representatives has passed a CR through November 21, the U.S. Senate has repeatedly failed to pass the CR as Senate Democrats continue to demand that any federal funding legislation include an extension of the enhanced Advanced Premium Tax Credits (eAPTCs), which are used to purchase coverage on a health insurance marketplace — such as Covered California — and are set to expire on December 31. However, there have been and will continue to be additional stressors that may prompt Congressional action. Many federal employees have now missed their first full paycheck, and it is unclear how long the actions by the Trump Administration to keep the military paid through this point will continue. The U.S. Department of Agriculture has also said it does not believe it has the legal authority to use emergency funding for Supplemental Nutrition Assistance Program (SNAP) benefits, known as CalFresh in California. This means SNAP funding will run out if action is not taken by November 1. (See Item B. below.) These situations put pressure on Congress to reach an agreement or,

at the very least, pass piecemeal legislation to ensure federal paychecks go out and SNAP funding does not dry up.

At this time, CalOptima Health has not experienced any direct operational impacts. Generally, federal shutdowns only affect discretionary programs that are funded through the annual appropriations process and not mandatory programs that are automatically funded, such as Medicaid, Medicare and Social Security. However, the California Department of Health Care Services (DHCS) recently updated its public-facing website to note a potential disruption in Medi-Cal if the shutdown extends beyond December 31. Although unlikely, in the event of a prolonged shutdown, there is a risk of delayed Medicaid payments to states. While Medicaid is a mandatory program, it is funded on an advanced appropriation basis, which Congress had previously approved through the first quarter of federal FY 2026. In addition, despite the lapse in Medicare telehealth flexibilities and several other health program authorizations, the telehealth changes only mandatorily impact Original/Fee-For-Service Medicare payments. Medicare Advantage plans, such as OneCare, may choose to continue covering and reimbursing for telehealth services. OneCare is NOT implementing any temporary claim holds during the shutdown.

C. November CalFresh Benefits Are Delayed

Due to the ongoing federal government shutdown, Orange County is bracing for a delay in November's CalFresh benefits, which more than 310,000 low-income residents use to buy food. To keep our community informed, CalOptima Health shared the news on our website and social media, sent an email alert to providers and community stakeholders, and provided talking points to staff. CalFresh recipients with questions are encouraged to call 2-1-1 or visit 211oc.org to be connected to food, housing and utility resources. November benefits are anticipated to be retroactively issued when the shutdown is resolved. In a press release distributed by the County of Orange Social Services Agency, Director An Tran said: "The Social Services Agency issues, on average, $62 million a month in CalFresh benefits. This will not only have an impact on the families and individuals receiving benefits, but also on the local economy. For every dollar of benefit spent at local retailers accepting EBT, up to $1.50 is generated."

D. U.S. Centers for Medicare & Medicaid Services (CMS) Releases Star Ratings

CMS uses a five-star rating system to evaluate the quality of Medicare health plans. Each year, CMS calculates an overall, Part C and Part D Star Rating for each Medicare Advantage health plan. Star Ratings combine clinical quality, member experience, prescription drug and health plan administrative measures. On October 9, CMS released the Star Ratings for the 2026 display year (2024 calendar year). OneCare's overall Star Rating improved to 3.0 Stars; Part D performance was steady at 3.0 Stars; and Part C performance dropped from 3.0 Stars in 2025 to 2.5 Stars in 2026. CalOptima Health has launched a series of targeted quality improvement initiatives aimed at enhancing Star Ratings performance. These efforts focus on closing care gaps in key preventive and chronic care areas, including Annual Wellness Visits, breast and colorectal cancer screenings, diabetes management, and influenza vaccinations. To further support these goals and improve access to care, CalOptima Health is also implementing in-home service programs. These programs enable members to receive Annual Wellness Visits, health assessments and select laboratory tests in the comfort of their own homes.

E. CalOptima Health Completes National Committee for Quality Assurance (NCQA) Health Equity Accreditation Initial Survey

CalOptima Health successfully completed the document submission portion of our NCQA Health Equity Accreditation Initial Survey on October 6, 2025. The submission included more than 70 documents, such as policies, desktops, reports and materials, for the lookback period from April 7–

October 7, 2025. This submission officially initiates the review portion of the survey, which involves the off-site review of documentation provided by CalOptima Health against the accreditation standards. On October 29, CalOptima Health received an initial issues list from NCQA, and we will have until November 7, 2025, to submit final responses addressing these issues. Please note that there is no file review component for the Health Equity Accreditation Survey.

F. Covered California Monthly Update

CalOptima Health continues to prepare for the launch of a Covered California line of business, effective January 1, 2027. Following the Board's approval on June 5, staff submitted an initial filing on June 16 to the California Department of Managed Health Care (DMHC) to expand the scope of CalOptima Health's current Knox-Keene Act license, which is required to offer a commercial insurance product. Since then, we have engaged with DMHC on two rounds of comments and are submitting our second filing, including provider network rosters, on October 31. Staff continue to collaborate with our provider network and execute amendments with several existing vendors to include Covered California in their scopes of service. In addition, operational workstreams are actively addressing program solutions to achieve operational readiness during the next year. Our teams are also currently reviewing and developing strategies to respond to the 2027 Qualified Health Plan application in April 2026 (pending Board approval) and have engaged with Covered California's Plan Management Advisory Group to maintain alignment. Finally, staff are actively monitoring regulatory and policy impacts on the Marketplace landscape in California as a result of H.R. 1 to best understand risks to CalOptima Health's members as well as projected enrollment in 2027.

G. OneCare Annual Enrollment Period Opens

The annual enrollment period (AEP) for CalOptima Health OneCare (HMO D-SNP), a Medicare Medi-Cal Plan, opened on October 15 and will run through December 7. To be eligible for OneCare, a member must be:

- Age 21 and older
- Living in Orange County
- Enrolled in Medicare Parts A and B
- Receiving Medi-Cal benefits

In 2026, the OneCare Flex Plus plan will be consolidated into the OneCare Complete plan due to changes in the federal Medicare program. All existing OneCare Flex Plus members will be transitioned into OneCare Complete.

- CalOptima Health OneCare Complete — Our original plan offers $0 copays on medical and hospital services and generic prescription drugs. It includes many extras, such as a fitness benefit, comprehensive dental, more vision care, a flex card for over-the-counter (OTC) items and, for those who qualify, food and produce.

Our 2026 OneCare advertising effort extends the success of last year's "Built Around You" campaign by using focus group feedback to refine and refresh the creative elements. In addition, we introduced a dedicated caregiver campaign, emphasizing the crucial role caregivers play in health care decisions for their loved ones. The campaign includes print, outdoor, television, streaming audio, online display, social media and paid search ads.

H. Provider Workforce Development OC Collaborative

CalOptima Health released RFP #25-057 on July 23, 2025, as part of its $50 million Provider Workforce Development Fund. The RFP seeks a convener to lead the Orange County Workforce Development Collaborative, a five-year initiative to address critical health care workforce shortages. The selected convener will be responsible for coordinating cross-sector stakeholders and developing a

strategic plan that strengthens the Medi-Cal-serving workforce. The Orange County Department of Education was selected, and the contracting process is underway with a target implementation to begin mid-November. This initiative represents a major step toward building a sustainable, community-driven workforce pipeline.

I. Series of October Press Releases Build Awareness of Key CalOptima Health News

- On October 8, CalOptima Health distributed a press release about the Board-approved $19.8 million investment to expand outreach efforts during the upcoming period of significant Medi-Cal changes. The funds will drive a multifaceted campaign to raise awareness about the changes to Medi-Cal and CalFresh eligibility requirements through December 31, 2028. On October 27, the Orange County Register ran a front-page article highlighting this effort to help members keep their coverage.
- On October 23, CalOptima Health and Wellness & Prevention Center issued a joint release about the grand opening of allcove San Juan Capistrano, an innovative center providing mental health and wellness services for youth ages 12–25. CalOptima Health contributed $2.7 million to support allcove's opening and operations.
- On October 29, CalOptima Health distributed a press release announcing Providence as our 10th health network. Effective November 1, the partnership will provide enhanced care coordination and comprehensive health and wellness services for more than 13,000 Medi-Cal members as they move into the new network.

CalOptima Health

Fast Facts
November 2025

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

Membership Data* (as of September 30, 2025)

Total CalOptima Health Membership

885,314

Program	Members
Medi-Cal	866,543
OneCare (HMO D-SNP)	18,242
Program of All-Inclusive Care for the Elderly (PACE)	529

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

Key Financial Indicators (for the month ended September 30, 2025)

	Dashboard	YTD Actual	Actual vs. Budget ($)	Actual vs. Budget (%)
Operating Income/(Loss)	●	$58.5M	$43.2M	282.9%
Non-Operating Income/(Loss)	●	$30.0M	$5.4M	22.0%
Covered California Start-up Expenses	●	($1.4M)	$1.0M	42.6%
Bottom Line (Change in Net Assets)	●	$87.1M	$49.7M	132.7%
Medical Loss Ratio (MLR) *(Percent of every dollar spent on member care)*	●	91.5%	---	(1.1%)
Administrative Loss Ratio (ALR) *(Percent of every dollar spent on overhead costs)*	●	4.5%	---	1.8%

Notes:
- For additional financial details, refer to the financial packages included in the Board of Directors meeting materials.
- Adjusted MLR (without the estimated provider rate increases funded by reserves) is 87.8%.

Reserve Summary (as of September 30, 2025)

	Amount (in millions)
Board Designated Reserves*	$1,604.7
Statutory Designated Reserves	$134.1
Capital Assets (Net of depreciation)	$102.8
Unspent Balance of Allocated Resources	$389.9
Unspent Balance of Board Approved Provider Rate Increase**	$263.1
Unallocated Resources*	$393.0
Total Net Assets	$2,887.7

* Total of Board-designated reserves and unallocated resources can support approximately 180 days of CalOptima Health's current operations.

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

Total Annual Budgeted Revenue **$4.7 Billion**

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

CalOptima Health Fast Facts

November 2025

Personnel Summary (as of October 18, 2025, pay period)

	Filled	Open	Vacancy % Medical	Vacancy % Administrative	Vacancy % Combined
Staff	1,348.25	85	36.19%	63.81%	5.93%
Supervisor	83	4	25%	75%	4.6%
Manager	113	14	21.43%	78.57%	11.02%
Director	79	8.5	17.65%	82.5%	9.71%
Executive	21	1	---%	100%	4.55%
Total FTE Count	1,644.25	112.5	20.05%	79.95%	6.4%

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

Provider Network Data (as of October 24, 2025)

	Number of Providers
Primary Care Providers	1,288
Specialists	7,728
Pharmacies	496
Acute and Rehab Hospitals	42
Community Health Centers	71
Long-Term Care Facilities	227

Treatment Authorizations (as of August 31, 2025)

	Mandated	Average Time to Decision
Inpatient Concurrent Urgent	72 hours	36.16 hours
Prior Authorization – Urgent	72 hours	8.86 hours
Prior Authorization – Routine	5 days	1.66 days

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

Member Demographics (as of September 30, 2025)

Member Age	
0 to 5	8%
6 to 18	22%
19 to 44	34%
45 to 64	20%
65 +	16%

Language Preference	
English	56%
Spanish	30%
Vietnamese	9%
Other	2%
Korean	1%
Farsi	1%
Chinese	<1%
Arabic	<1%
Russian	<1%

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

CalOptima Health

Provider Network Trend

November 2025

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

CHCN and Health Networks

Total Providers [1]

Provider Type	2024 – Q3	2024 – Q4	2025 – Q1	2025 – Q2	2025 – Q3	YOY Net Δ
PCP [2]	1,308	1,313	1,312	1,301	1,281	-27
Specialist (Physicians)	7,056	7,017	7,070	7,479	7,685	629
Hospitals [3]	41	41	41	41	43	2
Community Health Centers [4]	65	65	65	68	68	3
Long Term Care	206	206	207	207	225	19
Behavioral Health [5]	2,256	2,273	2,529	2,579	2,791	535
ECM	32	32	31	32	34	2
Community Support	102	103	102	103	107	5

Medi-Cal

Provider Type	2024 – Q3	2024 – Q4	2025 – Q1	2025 – Q2	2025 – Q3	YOY Net Δ
PCP [2]	1,084	1,087	1,087	1,076	1,057	-27
Specialist (Physicians)	6,435	6,420	6,464	7,173	7,394	959
Hospitals [3]	37	37	37	37	40	3
Community Health Centers [4]	63	63	63	66	66	3
Long Term Care	202	202	203	203	221	19
Behavioral Health [5]	2,176	2,177	2,436	2,495	2,695	519
ECM	32	32	31	32	34	2
Community Support	102	103	102	103	107	5

OneCare

Provider Type	2024 – Q3	2024 – Q4	2025 – Q1	2025 – Q2	2025 – Q3	YOY Net Δ
PCP [2]	1,098	1,099	1,096	1082	1074	-24
Specialist (Physicians)	5,407	5,437	5,488	5,844	6,047	640
Hospitals [3]	36	36	36	36	40	4
Community Health Centers [4]	58	58	58	62	62	4
Long Term Care	206	206	203	207	224	18
Behavioral Health [5]	613	649	668	713	851	238

PACE

Provider Type	2024 – Q3	2024 – Q4	2025 – Q1	2025 – Q2	2025 – Q3	YOY Net Δ
PCP [2]	5	3	3	4	3	-2
Specialist (Physicians)	3,405	3,457	3,549	4,033	4,256	851
Hospitals [3]	29	29	29	29	31	2
Community Health Centers [4]	0	0	0	0	0	0
Long Term Care	65	66	67	69	76	11
Behavioral Health [5]	96	103	106	116	119	23

Provider Network Trend

November 2025

CHCN Only

Total Providers [1]

Provider Type	2024 – Q3	2024 – Q4	2025 – Q1	2025 – Q2	2025 – Q3	YOY Net Δ
PCP [2]	680	678	677	671	671	-9
Specialist (Physicians)	6,418	6,335	6,384	6,841	7,058	640
Hospitals [3]	37	37	37	37	40	3
Community Health Centers [4]	56	56	56	58	58	2
Long Term Care	202	202	203	203	221	19
Behavioral Health [5]	2,234	2,247	2,500	2,541	2,767	533
ECM	32	32	31	32	34	2
Community Support	102	103	102	103	107	5

Medi-Cal

Provider Type	2024 – Q3	2024 – Q4	2025 – Q1	2025 – Q2	2025 – Q2	YOY Net Δ
PCP [2]	657	656	653	650	650	-7
Specialist (Physicians)	6,041	5,988	6,026	6,791	7,000	959
Hospitals [3]	34	34	34	34	38	4
Community Health Centers [4]	56	56	56	58	58	2
Long Term Care	202	202	203	203	221	19
Behavioral Health [5]	2,157	2,155	2,411	2,471	2,673	516
ECM	32	32	31	32	34	2
Community Support	102	103	102	103	107	5

OneCare

Provider Type	2024 – Q3	2024 – Q4	2025 – Q1	2025 – Q2	2025 – Q2	YOY Net Δ
PCP [2]	572	569	571	565	567	-5
Specialist (Physicians)	4,691	4,706	4,746	5,136	5,359	668
Hospitals [3]	31	31	31	31	33	2
Community Health Centers [4]	46	46	46	48	48	2
Long Term Care	202	202	203	203	220	18
Behavioral Health [5]	598	634	652	699	836	238

PACE

Provider Type	2024 – Q3	2024 – Q4	2025 – Q1	2025 – Q2	2025 – Q3	YOY Net Δ
PCP [2]	5	3	3	4	3	-2
Specialist (Physicians)	3,405	3,457	3,549	4,033	4,256	851
Hospitals [3]	29	29	29	29	31	2
Community Health Centers [4]	0	0	0	0	0	0
Long Term Care	65	66	67	69	76	11
Behavioral Health [5]	96	103	106	116	119	23

Footnotes:

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

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

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

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

[5] Includes Practitioners and Behavioral Health Groups

Chief Financial Officer Report

Board of Directors Meeting

November 6, 2025

Nancy Huang, Chief Financial Officer

Our Mission

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

Our Vision

Provide all members with access to care and supports to achieve optimal health and well-being through an equitable and high-quality health care system.

Financial Highlights Notes: September 2025

- Notable events/items in September 2025
  - $212.1 million of Hospital Directed Payments (DP) were received and paid out in September 2025 for Calendar Year (CY) 2023
  - $9.1 million of Quality Incentive Pool Program (QIP) received and paid out in September 2025 for CY 2024

CalOptima Health

Financial Highlights
September 2025

September 2025					July - September 205			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
885,314	898,765	(13,451)	(1.5%)	Member Months	2,681,404	2,708,085	(26,681)	(1.0%)
631,490,594	395,456,178	236,034,416	59.7%	Revenues	1,420,510,565	1,192,100,988	228,409,577	19.2%
581,778,696	363,134,399	(218,644,297)	(60.2%)	Medical Expenses	1,299,525,490	1,103,665,172	(195,860,318)	(17.7%)
22,219,615	25,294,095	3,074,480	12.2%	Administrative Expenses	63,850,891	75,571,593	11,720,702	15.5%
27,492,283	**7,027,684**	**20,464,599**	**291.2%**	**Operating Margin**	**57,134,184**	**12,864,223**	**44,269,961**	**344.1%**
				Non-Operating Income (Loss)				
14,217,389	8,333,340	5,884,049	70.6%	Net Investment Income/Expense	46,524,912	25,000,020	21,524,892	86.1%
(457,546)	-	(457,546)	(100.0%)	Grant Expense	(457,546)	-	(457,546)	(100.0%)
(5,274,430)	-	(5,274,430)	(100.0%)	Community Reinvestment	(15,724,510)	-	(15,724,510)	(100.0%)
(176,029)	(138,610)	(37,419)	(27.0%)	Other Income/Expense	(338,377)	(415,830)	77,453	18.6%
8,309,384	**8,194,730**	**114,654**	**1.4%**	**Total Non-Operating Income (Loss)**	**30,004,478**	**24,584,190**	**5,420,288**	**22.0%**
35,801,667	**15,222,414**	**20,579,253**	**135.2%**	**Change in Net Assets**	**87,138,662**	**37,448,413**	**49,690,249**	**132.7%**
92.1%	*91.8%*	*0.3%*		*Medical Loss Ratio*	*91.5%*	*92.6%*	*(1.1%)*	
3.5%	*6.4%*	*2.9%*		*Administrative Loss Ratio*	*4.5%*	*6.3%*	*1.8%*	
4.4%	*1.8%*	*2.6%*		*Operating Margin Ratio*	*4.0%*	*1.1%*	*2.9%*	
100.0%	*100.0%*			*Total Operating*	*100.0%*	*100.0%*		
83.6%	*87.4%*	*(3.8%)*		**Adjusted MLR*	*85.5%*	*88.2%*	*(2.7%)*	
5.4%	*6.4%*	*1.0%*		**Adjusted ALR*	*5.3%*	*6.3%*	*1.0%*	

*Adjusted MLR/ALR excludes estimated Board-approved Provider Rate increases and Directed Payments, but includes costs associated with CalOptima Health's Digital Transformation Strategy (DTS) budget

CalOptima Health

Enrollment Summary: September 2025

September 2025					July - September 2025			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
152,063	147,660	4,403	3.0%	SPD	456,467	442,241	14,226	3.2%
252,438	258,905	(6,467)	(2.5%)	TANF Child	764,218	778,580	(14,362)	(1.8%)
125,087	129,020	(3,933)	(3.0%)	TANF Adult	380,333	389,206	(8,873)	(2.3%)
3,016	2,512	504	20.1%	LTC	8,380	7,537	843	11.2%
324,901	333,259	(8,358)	(2.5%)	MCE	989,167	1,008,393	(19,226)	(1.9%)
9,038	9,098	(60)	(0.7%)	WCM	27,167	27,325	(158)	(0.6%)
866,543	**880,454**	**(13,911)**	**(1.6%)**	**Medi-Cal Total**	**2,625,732**	**2,653,282**	**(27,550)**	**(1.0%)**
18,242	**17,774**	**468**	**2.6%**	**OneCare**	**54,086**	**53,204**	**882**	**1.7%**
529	**537**	**(8)**	**(1.5%)**	**PACE**	**1,586**	**1,599**	**(13)**	**(0.8%)**
556	**558**	**(2)**	**(0.4%)**	**MSSP***	**1,660**	**1,674**	**(14)**	**(0.8%)**
885,314	**898,765**	**(13,451)**	**(1.5%)**	**CalOptima Health Total**	**2,681,404**	**2,708,085**	**(26,681)**	**(1.0%)**

*MSSP enrollment is included in Medi-Cal total

Balance Sheet: As of September 2025

ASSETS		LIABILITIES & NET POSITION	
Current Assets		**Current Liabilities**	
Operating Cash	$529,228,976	Accounts Payable	$102,805,275
Short-term Investments	1,438,154,754	Medical Claims Liability	1,052,501,127
Capitation Receivable	455,576,184	Accrued Payroll Liabilities	27,598,083
Receivables - Other	86,563,533	Deferred Revenue	14,728,656
Prepaid Expenses	24,490,152	Other Current Liabilities	-
Total Current Assets	**2,534,013,599**	Capitation and Withholds	168,197,198
		Total Current Liabilities	**1,365,830,338**
Capital Assets		**Other Liabilities**	
Capital Assets	192,362,882	GASB 96 Subscription Liabilities	19,540,147
Less Accumulated Depreciation	(89,531,288)	Community Reinvestment	103,822,622
Capital Assets, Net of Depreciation	**102,831,594**	Capital Lease Payable	233,561
		Postemployment Health Care Plan	17,312,195
Other Assets		Net Pension Liabilities	5,840,992
Restricted Deposits	300,000	**Total Other Liabilities**	**146,749,516**
Board Designated Reserves	1,604,696,215		
Statutory Designated Reserves	134,144,257	**TOTAL LIABILITIES**	**1,512,579,855**
Total Other Assets	**1,739,140,472**		
TOTAL ASSETS	**4,375,985,665**	**Deferred Inflows**	**4,309,519**
Deferred Outflows	**28,626,072**	**Net Position**	
		Required TNE	131,812,377
		Funds in Excess of TNE	2,755,909,986
		TOTAL NET POSITION	**2,887,722,363**
TOTAL ASSETS & DEFERRED OUTFLOWS	**4,404,611,737**	**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION**	**4,404,611,737**

CalOptima Health

Board Designated Reserve and TNE Analysis: As of September 2025

Board Designated Reserves

Investment Account Name	Market Value	CalOptima Policy Compliance Level		Variance	
		Low	High	Mkt - Low	Mkt - High
Payden & Rygel Tier One	802,340,607				
MetLife Tier One	802,355,608				
Board Designated Reserves	1,604,696,215	1,082,540,573	1,732,064,917	522,155,642	(127,368,702)
Current Reserve Level (X months of average monthly revenue) [1]	*3.71*	*2.50*	*4.00*		

Statutory Designated Reserves

Investment Account Name	Market Value	CalOptima Policy Compliance Level		Variance	
		Low	High	Mkt - Low	Mkt - High
Payden & Rygel Tier Two	67,192,404				
MetLife Tier Two	66,951,852				
Statutory Designated Reserves	134,144,257	131,812,377	144,993,614	2,331,880	(10,849,358)
Current Reserve Level (X min. TNE) [1]	*1.02*	*1.00*	*1.10*		

[1] *See CalOptima Health Policy GA.3001: Statutory and Board-Designated Reserve Funds for more information.*

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Board of Directors Meeting
November 6, 2025

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

Report to the Board

The Member Advisory Committee (MAC), and the Provider Advisory Committee (PAC) held a regular joint meeting on October 9, 2025.

The PAC welcomed Jonathan (Tom) Megerian, MD, Ph.D. FAAP to the committee.

Zeinab Dabbah, MD, JD, MPH, FACP, Deputy Chief Medical Officer, provided an update on the Advisory Committee on Immunization Practices (ACIP) and noted that ACIP now recommends COVID-19 vaccination for everyone aged 6 months and older, using a shared clinical decision-making approach. While those over 65 are prioritized, clinicians should assess risk for younger individuals. The vaccine remains covered under Vaccines For Children (VFC), Children's Health Insurance Program (CHIP), Medicaid, Medicare, private insurance, and Affordable Care Act (ACA) plans. ACIP also recommends universal Hepatitis B testing during pregnancy to reduce mother-to-child transmission. This testing is covered by all major insurance programs. For children under 23 months, ACIP advises using separate Measles, Mumps and Rubella (MMR) and varicella vaccines instead of the combined MMRV vaccine, due to increased risk of febrile seizures. Both vaccines remain available and covered under the VFC program.

Dr. Dabbah also provided an update on California Assembly Bill (AB) 144, signed on September 17, 2025, which expanded vaccine access and mandates insurance coverage for all California Department of Public Health (CDPH) recommended vaccines without cost-sharing. The law allows CDPH to issue independent vaccine guidance, even if it differs from federal recommendations, ensuring continued access to vaccines like COVID-19, influenza, and RSV. It also provides liability protection for providers following CDPH guidance. Additionally, the VFC program continues to cover key vaccines, including COVID-19, Hepatitis B, MMR, and varicella, with updated guidance allowing separate ordering of MMR and varicella.

Michaell Silva-Rose, DrPH, LCSW, Chief Health Equity Officer, provided an update on the Member and Population Health Needs Assessment and thanked the committees for their support with provider surveys, which saw 301 responses which was more than double the previous round. Member surveys are currently being translated, with a large email campaign and postcard distribution planned for later this month. Postcards will include unique identifiers to ensure one response per person. Focus groups are expected to begin next month, facilitated by Community Action Partnership of Orange County (CAP OC). Additional locations and participants are still being sought.

Dr. Rose also spoke briefly on the Health Equity Asset Mapping process which identifies and documents a community's existing strengths and resources, noting that it was still in its early stages. She noted that the Equity and Community Health teams are collaborating closely with Strategic Development on these initiatives and said that updates will be shared with the committees as progress continues.

Dr. Rose also provided a Community Reinvestment update which was originally introduced in April 2025. She noted that managed care plans with positive net income are required by the Department of Health Care Services (DHCS) to reinvest in their communities. Reinvestment activities must align with five broad categories: neighborhoods and built environment, healthcare, workforce, well-being for priority populations, and improved health. These activities must also align with Orange County's Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP), which identified six priority areas: mental health, substance use, diabetes/obesity, housing/homelessness, care navigation, and economic disparities. A third alignment layer includes Orange County Behavioral Health's transformation efforts, with findings from their needs assessment expected soon.

She noted that CalOptima Health has formed a joint internal-external workgroup, including public health and behavioral health leaders, to develop a community reinvestment plan that is due in Q3 2026. The plan must align with DHCS guidelines, Orange County's CHA/CHIP priorities, and Behavioral Health Transformation findings. Funding obligations will be confirmed in Q2 2026, with spending to begin once approved. Prior 2024 investments may count toward the first-year requirement.

Dr. Rose noted that the proposed strategy includes three funding streams, (1) Access to Health and Well-Being supporting insurance retention, outreach, and access to public benefits; (2) Behavioral Health addressing quality measure deficiencies and (3) Improvement in Health Outcomes and Equity which addresses prevention and upstream causes of poor health. Regular updates and stakeholder input will continue as the plan develops as the plan must align with multiple layers: DHCS reinvestment categories, Orange County's CHA/CHIP priorities, and Behavioral Health Transformation findings. Non-permissible uses include administrative costs, member incentives, and duplicative spending. The team will continue engaging stakeholders and will return to this group regularly for feedback and co-design. Dr. Rose asked the members to use the QR code noted in their materials to provide feedback.

Cheryl Meronk, Director, Medicare Programs, presented a OneCare update and noted that in 2026, the Centers for Medicare & Medicaid Services (CMS) would be ending the Value-Based Insurance Design (VBID) model, which previously allowed Medicare Advantage plans to offer flexible benefits addressing members' social needs like food, housing, and transportation. As a result, the plan lineup is changing: the 2025 plans, OneCare Complete and OneCare Flex Plus will be consolidate into a single OneCare Complete plan in 2026. She noted that despite the loss of VBID flexibility, most supplemental benefits will be enhanced. The popular flex card benefit will continue, offering $167 per quarter (no rollover), usable for over-the-counter items. However, food and produce will no longer be a standard benefit. Members may still qualify for this through the Special Supplemental Benefits for the Chronically Ill (SSBCI), based on claims data and health conditions.

She also noted that drug coverage will also change and that while $0 copays for generics remain, brand-name medications will now have copays based on members' Extra Help status which is also known as the Low-Income Subsidy (LIS) that provides prescription drug costs assistance to members with limited income and resources. These copays will range from $4.25 to $12.65 and a new mail-order pharmacy

service will be launched in 2026. Additional benefits include continued transportation for non-medical needs, such as unlimited gym trips within 10 miles. Vision benefits will offer $500 every two years for eyewear, and hearing benefits will include a $500 OneCare allowance plus up to $2,010 in total when combined with medical coverage.

Ms. Meronk also noted that in 2026, healthy food and produce benefits will remain available only to members who qualify for the Special Supplemental Benefits for the Chronically Ill (SSBCI) program. Members who are not pre-qualified can still become eligible by submitting a provider-completed form indicating their chronic condition. Additional 2026 benefits include up to 90 hours of in-home support and companionship, continued access to Silver & Fit gym memberships and fitness resources, one annual physical exam, and expanded comprehensive dental services beyond Medi-Cal dental. OneCare Complete will also cover $0 copays for generic drugs, buy down Part D premiums, and introduce brand-name drug copays ($4.90 or $12.65). Prior authorization will no longer be required for podiatry and certain dental diagnostic/preventive services, though it will still apply to prosthodontics and some general dental services. For clarity on dental coordination between Medi-Cal and supplemental plans. Nancy Martinez, Manager, OneCare Customer Service provided further explanation about dental benefits and how customer services helps members coordinate these services.

Donovan Higbee, Director, Public Policy, provided a state and federal legislative update for the committees. He noted that at the October 2, 2025, Board of Directors' meeting, the Board approved an updated public policy priorities document, which expands the former legislative platform to include both legislative and regulatory advocacy for the current 2026 fiscal year. He discussed how many priorities remain from last year and that new items were added, particularly around access to care in response to federal legislation (H.R. 1) and the enacted state budget. The priorities also now authorize advocacy on Covered California, especially regarding the upcoming expiration of the Enhanced Advanced Premium Tax Credits (eAPTCs), which could raise premiums if not extended beyond December 31, 2025. The legislative matrix in your packet includes analyses of H.R. 1 and the state budget, and, although the legislature had already adjourned for the year, the governor was still reviewing bills through October 12.

Mr. Higbee also provided an update on the federal government shutdown, noting that core programs like Medicaid and Medicare remained unaffected, while some discretionary health programs may see impacts that indirectly affect members and providers. Medicare telehealth flexibilities enacted during the COVID-19 pandemic lapsed on September 30, 2025, but only affect fee-for-service Medicare, not OneCare members.

Mr. Higbee also discussed the Covered California implementation and noted that CalOptima Health is progressing through the Department of Managed Health Care (DMHC) licensing process and preparing to apply directly to Covered California. Operational planning is underway with Deloitte's roadmap, and workgroups are being formed. Lastly, CalOptima Health celebrated its 30th anniversary with recognitions from state and local officials.

Nancy Huang, Chief Financial Officer, presented a brief overview of CalOptima Health's financials. She provided a brief finance update covering member demographics, enrollment trends, and CalOptima Health's financial position as of August 31, 2025. She also provided a demographics report noting that CalOptima Health's membership skews slightly female (53%) with an average age of 36, and the largest age group is 15–19, indicating a need for pediatric, behavioral health, and digital engagement strategies. She noted that language access remained critical, with top threshold languages including English,

Spanish, Vietnamese, Korean, Farsi, Arabic, Mandarin Chinese, and newly added Russian. Geographically, 45% of members reside in the Santa Ana, Anaheim, and Garden Grove areas, guiding resource planning and outreach.

Ms. Huang noted that CalOptima Health's membership trends over the past decade have been shaped by policy changes, economic conditions, and public health events and that membership grew significantly after the Affordable Care Act, rising from around 470,000 in 2013 to nearly 1 million by mid-2023, driven by Medi-Cal expansion and the COVID-19 public health emergency. She also noted that since redeterminations resumed in mid-2023, enrollment has declined, with recent net losses of 9,000 to 10,000 members monthly and that future enrollment will be impacted by the 2026 reinstatement of Medi-Cal asset tests for Seniors and Persons with Disabilities and Long-Term Care members. She also discussed a freeze on new undocumented adult enrollments, and anticipated 2027 changes such as work requirements and monthly premiums. Ms. Huang noted that financially, CalOptima Health remains stable with strong reserves and ongoing coordination with state partners to ensure future Medi-Cal funding.

The next MAC/PAC joint meeting is scheduled for December 11, 2025. The members of the MAC and PAC appreciate the opportunity to update the Board on their current activities.

REGULAR MEETING
OF THE
CALOPTIMA HEALTH BOARD OF DIRECTORS

October 2, 2025

A Regular Meeting of the CalOptima Health Board of Directors (Board) was held on October 2, 2025, at CalOptima Health, 505 City Parkway West, Orange, California. The meeting was held in person and via Zoom webinar, as allowed for under Assembly Bill 2449, which took effect after Governor Newsom ended the COVID-19 state of emergency on February 28, 2023. The meeting recording is available on CalOptima Health's website under View Past Meeting Materials. Chair Isabel Becerra called the meeting to order at 2:08 p.m., and Director Maura Byron led the Pledge of Allegiance.

ROLL CALL

Members Present: Isabel Becerra, Chair; Supervisor Vicente Sarmiento, Vice Chair (left meeting at 5:48 p.m.); Maura Byron; Supervisor Doug Chaffee; Blair Contratto; Norma García Guillén; Catherine Green, R.N.; Brian Helleland; Veronica Kelley (non-voting); Jose Mayorga, M.D.

(All Board members participated in person except Director Kelley, who participated remotely under Just Cause using her first of two uses for calendar year 2025)

Members Absent: None.

Others Present: Michael Hunn, Chief Executive Officer; Yunkyung Kim, Chief Operating Officer; James Novello, Outside General Counsel, Kennaday Leavitt; Nancy Huang, Chief Financial Officer; Zeinab Dabbah, M.D., JD, MPH, FACP, Deputy Chief Medical Officer; John Tanner, Chief Compliance Officer; Sharon Dwiers, Clerk of the Board

The Clerk noted for the record that since Director Kelley is a non-voting member and all other Board members are participating in person, the Board will not need to take roll call votes.

In addition, the Clerk noted for the record that staff would like to continue Agenda Item 8 to a future Board meeting.

PRESENTATIONS/INTRODUCTIONS

1. CalOptima Health 30th Anniversary Recognition

Michael Hunn, Chief Executive Officer (CEO), kicked off CalOptima Health's 30th Anniversary celebration by providing a brief overview of its accomplishments since its inception. Mr. Hunn outlined the speakers and events in celebration of this important milestone, which included comments from Senator Tom Umberg, Assemblymember Sharon Quirk-Silva, Chairman of the Orange County Board of Supervisors and CalOptima Health Board Member, Doug Chaffee, Orange County Supervisor and CalOptima Health Vice Chair Vicente Sarmiento, as well as group photos. CalOptima Health presented a video with comments from some of its 30-year tenured staff and handed out certificates to staff in attendance to celebrate their 30-year commitment to CalOptima Health and the members they serve. Mr. Hunn invited Senator Tom Umberg to say a few words.

Back to Agenda

Senator Tom Umberg thanked the Board and staff for the opportunity to spend a little time with CalOptima Health today. Senator Umberg noted that he was reminiscing about 1995 with former Assemblymember Tom Bailey. What stood out from that time was that less than a year before CalOptima was founded, Orange County faced a major financial crisis. Despite those challenges, the organization was born out of adversity, a testament to the vision and resilience of its founders.

Over the past 30 years, Senator Umberg added that he has had a front row seat to CalOptima Health's growth. Senator Umberg noted that his career has taken him in and out of the legislature, but he has been consistently inspired by how the organization has evolved. CalOptima Health has become a holistic provider, addressing not only health care but also food insecurity, homelessness, and other critical needs. CalOptima Health's work has truly improved the quality of life for so many in Orange County.

Senator Umberg asked Mr. Hunn to join him at the podium, and on behalf of the California State Senate and all who signed the senate resolution for CalOptima Health's 30-year anniversary, Senator Umberg thanked Mr. Hunn for CalOptima Health's outstanding service to the people of Orange County. Mr. Hunn thanked Senator Umberg and invited Assemblymember Sharon Quirk-Silva to say a few words.

Assemblymember Sharon Quirk-Silva noted that it is a privilege to join the Board and staff in celebrating CalOptima Health's 30th anniversary. She commented that as Senator Umberg noted, many have had the opportunity to collaborate with CalOptima Health over the years. Assemblymember Quirk-Silva added that she has worked alongside Board member, Supervisor Chaffee, during her time on the Sanitation Board, and even earlier –as an elementary school teacher to his sons. She noted that she has partnered with many of the individuals in the room on critical issues ranging from health to homelessness.

Assemblymember Quirk-Silva commented that CalOptima Health stands out not only for its mission but for the legacy it continues to build. The dedication of the CalOptima Health team is evident, having nine members remain with the organization for three decades speaks volumes about CalOptima Health's culture of loyalty and purpose. Most importantly, CalOptima Health's work directly impacts the most vulnerable residents in Orange County. Since 1995, CalOptima Health's membership has grown from 180,000 to over 900,000. While that growth reflects CalOptima Health's reach, it is also a reminder of the growing need, because qualifying for these services often means someone is struggling.

Assemblymember Quirk-Silva added that what she deeply values about CalOptima Health's model is its holistic, integrated approach. Too often, sectors like healthcare, education, and housing operate in silos. CalOptima Health, especially through the CalAIM program, bridges those gaps. CalOptima Health's support for nonprofits providing housing assistance – such as the $5,000 grants for first and last month's rent – demonstrates that housing is healthcare. Stabilizing a family with safe housing leads to better health outcomes. Conversely, those living on the streets face significantly higher health risks and mortality.

Assemblymember Quirk-Silva further added that CalOptima Health's expansion of the Program of All-Inclusive Care for the Elderly (PACE) is another example of innovation in care. By bringing seniors out of isolation and into community-based settings, CalOptima Health is not just improving their health, it is enriching their lives. These daily interactions are vital, and they reflect the heart of CalOptima Health's mission.

Assemblymember Quirk-Silva recognized CEO Michael Hunn's presence at community events, from resource fairs to local coffee gatherings, noting that it shows a hands-on commitment that inspires trust

and connection. On behalf of the California State Assembly, and with full bipartisan support from the Orange County delegation, Assemblymember Quirk-Silva stated that she was honored to present CalOptima Health with a state assembly resolution for its 30-year anniversary. She congratulated CalOptima Health for building and sustaining this impactful organization. Mr. Hunn thanked Assemblymember Quirk-Silva and invited Supervisor Chaffee to say a few words.

Supervisors Chaffee congratulated CalOptima Health on its 30th Anniversary and started by noting some of the recent events the Fourth District has hosted where CEO Hunn was in attendance along with other staff informing attendees of the benefits of CalOptima Health. Supervisor Chaffee expressed his gratitude and the importance of CEO Hunn's attendance at these events. He added that there are so many pilots and programs that CalOptima Health has implemented to serve its members, including the Street Medicine Program, which has been launched in Garden Grove, Costa Mesa, Anaheim, and Santa Ana, and serves the unhoused population where they are on the street. Supervisor Chaffee also mentioned CalOptima Health's work with Cal State Fullerton and its School of Nursing in providing scholarship grants for social workers and nurses, who in turn agree to stay in Orange County for two years and serve the most vulnerable individuals in Orange County.

Supervisor Chaffee and Supervisor and Vice Chair Sarmiento presented CEO Hunn with a resolution on behalf of the Orange County Board of Supervisors commending CalOptima Health for 30 years of health care for Orange County's most vulnerable residents.

Supervisor and Vice Chair Sarmiento thanked Assemblymember Quirk-Silva for her comments and noted it is a privilege to recognize not only the dedicated employees and staff of CalOptima Health, but also the evolving needs and faces of the members it serves. Supervisor and Vice Chair Sarmiento said, as Mr. Hunn noted, the growth from 120,000 to over 900,000 members reflects not just numbers, but the changing demographics and challenges of the Orange County community. Many of these individuals face language, mobility, and other barriers, and yet, CalOptima Health has consistently delivered care with dignity and respect.

Supervisor and Vice Chair Sarmiento noted that what makes CalOptima Health's model so unique is that, despite not having a county hospital, Orange County has built a strong network of healthcare providers that works. This success is a testament to the leadership of the board and the commitment to keeping services member-centric. CalOptima Health has ensured that families, children, and individuals receive the care they need in a way that honors their humanity.

Supervisor and Vice Chair Sarmiento further commented that CalOptima Health's 30 years of service milestone underscores the critical need that exists in Orange County, although often seen as affluent, the reality is that many of Orange County's neighbors live in fragile circumstances. CalOptima Health's work brings that truth to light and addresses it with compassion and effectiveness.

On behalf of the Orange County Board of Supervisors, and especially the Second District, where 41% of residents are CalOptima members, Supervisor and Vice Chair Sarmiento thanked the Board, CEO Michael Hunn, and all staff for their unwavering commitment to treating people with respect and dignity. He noted that it is an honor to present this recognition to Chair Isabel Becerra today.

Chair Isabel Becerra thanked the Board of Supervisors for this unexpected recognition and noted that she was not planning on speaking today. However, Chair Becerra added that the comments about the fact that Orange County does not have a public health system made her reflect on the vital role that the

community health system plays in the county. It truly is the safety net backbone of the county. The Coalition of Orange County Community Health Centers just celebrated its 50th anniversary, and it was honored to have Senator Umberg and Supervisors Chaffee and Sarmiento in attendance for that milestone. Chair Becerra noted that it is important to recognize that community health centers have been serving this county for over 50 years. Many of its members have been part of this work for more than 30 years. They were here from the very beginning. Chair Becerra acknowledged the strong partnership between community health centers and CalOptima Health and the joint efforts that continue to address the needs of the Orange County communities.

Chair Becerra added that now more than ever, with the dedicated Board of Directors in place here at CalOptima Health, both staff and leadership are committed to fulfilling the mission that CalOptima Health set out to achieve. Chair Becerra noted that she is proud to be part of this group. She congratulated CalOptima Health, especially to those staff members who have been with the organization since the early days. She ended by noting that she truly applauded their dedication.

The Board of Directors and members of the public watched a brief video of some of the 30-year employees sharing what makes CalOptima Health special and their reasons for staying with the organization for so many years. Mr. Hunn thanked the employees for their comments and noted that CalOptima Health Board Director Veronica Kelley was online today and wanted to make a few comments.

Director Veronica Kelley commented that most marriages do not last 30 years, so the fact that Orange County's CalOptima Health is celebrating this milestone is truly remarkable. It speaks volumes about the strength of the collaboration and partnership that the County, community partners, and CalOptima Health built over these three decades. For 30 years, CalOptima Health has been providing health care, working side by side in service to Orange County's community.

Director Kelley noted that the community that has not just grown, it has also faced significant disparities in health access and outcomes. These are challenges the Orange County community has worked on together, with shared purpose and commitment. Director Kelley added that she is familiar with the work of many managed care plans across California and their efforts with local communities and counties. But here in Orange County, things are done differently, collaboratively, and the community partners do it all together. Director Kelley thanked CEO Hunn for his leadership and the entire team at CalOptima Health. She also expressed her deep appreciation of the CalOptima Health Board of Directors who serve Orange County communities with dedication and heart. This achievement belongs to all. Mr. Hunn thanked Director Kelley for her comments and introduced Yunkyung Kim, Chief Operating Officer.

Ms. Kim noted that she was honored to be recognizing CalOptima Health's 30-year employees attending today's Board meeting with a certificate and read a little background on each employee provided by their supervisors. Employees also received a resolution from the Orange County Board of Supervisors to commemorate 30 years of service at CalOptima Health.

MANAGEMENT REPORTS

2. Chief Executive Officer (CEO) Report

Michael Hunn, CEO, presented his report and started by welcoming everyone, including those individuals listening to the meeting remotely.

Mr. Hunn reviewed the latest Fast Facts, noting that CalOptima Health shows a strong financial position,

with all indicators in the green, thanks to the finance team. However, there was a month-over-month drop of approximately 14,000 members. As CalOptima Health moves through October, it expects to better understand enrollment trends in collaboration with the Social Services Agency, monitoring whether the decline is due to incomplete or unreturned renewal packets and anticipate clearer insights by mid-October regarding November 1 enrollments.

Mr. Hunn reported that CalOptima Health is actively working to keep communication open with trusted community partners, including clinics, outreach groups, and the County of Orange. A Board action today supports continued investment in outreach to help members navigate tightened renewal deadlines. The key message remains that when members receive their renewal packets, they should complete and return them immediately to avoid gaps in care.

Mr. Hunn also reported that despite the recent federal government shutdown, there is no impact to CalOptima Health's ability to fund member care. He added that CalOptima Health has 120 days of cash reserves to cover any delays in state reimbursements and if needed, it will seek Board approval to use reserves to ensure uninterrupted care. Members are encouraged to continue accessing services, including doctor visits, medications, and essential screenings for children.

Mr. Hunn announced that CalOptima Health will host its 30th Anniversary Member Wellness Fair on Saturday, October 18, 2025, from 9:00 a.m. to 1:00 p.m. at CalOptima Health's office located at 505 City Parkway West in Orange, California. The event will offer dental and vision screenings, flu vaccines, food, diaper distribution, and enrollment assistance for Medi-Cal and CalFresh programs.

Mr. Hunn reported that this month marks the 12th anniversary of CalOptima Health PACE. He thanked the dedicated team in Garden Grove, led by Monica Macias-Garcia and Dr. Donna Frisch, for serving over 525 individuals. Mr. Hunn noted that PACE helps eligible seniors avoid institutional care by providing comprehensive services in the community.

Lastly, Mr. Hunn noted that as the member renewal processes and work requirements grow more complex, CalOptima Health remains committed to supporting its members and will continue to collaborate with the county and its community partners to ensure that members are well-informed and supported through these changes.

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

PUBLIC COMMENTS

- Georgina Maldonado, Community Health Initiative of Orange County: Oral report regarding Agenda Item 19.
- Susan Parmelee, Wellness and Prevention Center: Oral report regarding Agenda Item 20.
- Jeremy Elkins, Camino Health Center: Oral report regarding Agenda Item 20.
- Madelynn Hirneise, Families Forward: Oral report regarding Agenda Item 21.

CONSENT CALENDAR

3. Minutes

a. Approve Minutes of the September 4, 2025 Regular Meeting of the CalOptima Health Board of Directors
b. Receive and File Minutes of the May 22, 2025 Regular Meeting of the CalOptima Health Board of

Directors' Finance and Audit Committee

4. Approve Reappointment to the CalOptima Health Board of Directors' Investment Advisory Committee

5. Approve New CalOptima Health Pharmacy Policies in Accordance with Covered California Regulatory Requirements for Department of Managed Health Care Filing

6. Approve New CalOptima Health Enrollment Policy in Accordance with Covered California Regulatory Requirements for Department of Managed Health Care Filing

7. Approve CalOptima Health's Fiscal Year 2025–26 Public Policy Priorities and Authorize Related Advocacy Efforts

8. Adopt Board Resolution No. 25-1002-02, Ensuring Orange County Residents Who Are Entitled to Medi-Cal Coverage Have Access to Health Care
This item was continued to a future meeting.

9. Authorize the Chief Executive Officer to Execute a Contract Amendment with Cornerstone onDemand Inc. for Continued Use of Systems and Services

10. Authorize the Chief Executive Officer to Execute a Contract Amendment with SilkRoad Technology Inc. for Continued Use of Systems and Services

11. Authorize the Chief Executive Officer to Execute a Contract Amendment with Computer Technology Corp for Continued Use of Credentialing Systems and Services

12. Authorize the Chief Executive Officer to Execute a Contract Amendment with Ceridian for Continued Use of Ceridian Human Resources Systems and Services

13. Authorize the Chief Executive Officer to Execute a Contract Amendment with Change Healthcare Solutions, LLC for Continued Use of Print/Fulfillment, Electronic Data Interchange Clearinghouse, Remittance Advice, and Check Printing Systems and Services

14. Adopt Resolution No. 25-1002-01 to Add Three Seats and Rename Three Existing Seats on the CalOptima Health Board of Directors' Member Advisory Committee

15. Increase Stipend Amount for Members or Authorized Family Members on the CalOptima Health Whole-Child Model Family Advisory Committee

16. Receive and File:
a. August 2025 Financial Summary

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b. Compliance Report
c. Government Affairs Reports
d. CalOptima Health Community Outreach and Program Summary

Vice Chair Sarmiento thanked staff for work done on Agenda Item 7.

Vice Chair Sarmiento had questions on Agenda Items 9 through 13 regarding why CalOptima Health was not going out to bid on those items.

Vice Chair Sarmiento made a motion to approve the balance of the Consent Calendar.

Action: ***On motion of Vice Chair Sarmiento, seconded and carried, the Board of Directors approved the Consent Calendar Agenda Items 3 through 16, minus Agenda Items 7, 8, and Agenda Items 9 through 13, as presented. (Motion carried 9-0-0)***

Ms. Kim, Chief Operating Officer, responded to Vice Chair Sarmiento's questions noting that three of the items are related to CalOptima Health's HR system. Over time, CalOptima Health added capabilities to its current system, but are now exploring end-to-end HR management solutions. While evaluating options and preparing for implementation and transition, staff is requesting a contract extension to allow staff sufficient time to complete the work thoroughly and accommodate potential delays – whether in selecting a solution or due to shifting organizational priorities.

Another item concerns CalOptima Health's provider credentialing system. Ms. Kim noted that staff had initially pursued a comprehensive provider lifecycle solution, but the project became too complex. Staff is now breaking it into smaller, manageable phases. In the meantime, staff recommend extending the current credentialing contract, as it houses all provider data and remains essential until a replacement is in place.

The final item involves CalOptima Health's check-cutting, print fulfillment, and remittance advice vendor. This procurement is currently active, and staff is requesting an extension to allow time for vendor selection, implementation, and a smooth transition of data and workflows.

For all these systems, staff is requesting standard contract terms of three years, with two optional one-year extensions. CalOptima Health retains the right to terminate early without penalty if a replacement solution is ready sooner.

Vice Chair Sarmiento thanked Ms. Kim for her responses and amended his motion to include all the Consent Calendar, Agenda Items 3 through 16, minus Agenda Item 8.

Action: ***On motion of Vice Chair Sarmiento, seconded and carried, the Board of Directors approved the Consent Calendar Agenda Items 3 through 16, minus Agenda Item 8, as presented. (Motion carried 9-0-0)***

REPORTS/DISCUSSION ITEMS

17. Accept, Receive, and File the Fiscal Year 2024-25 CalOptima Health Audited Financial Statements

Back to Agenda

Chair Becerra noted that as the Chair of the Finance and Audit Committee (FAC), she would like to inform the Board and the public that the FAC convened on September 18, 2025, and during that meeting the committee received a comprehensive presentation from CalOptima Health's independent auditor, Baker Tilly (formerly Moss Adams). Chair Becerra reported that the audit was clean, with no findings. She also added that the full presentation is included in the Board materials for reference. Additionally, CalOptima Health's audit consultant is available online to address any questions the Board may have.

Action: ***On motion of Director Green, seconded and carried, the Board of Directors: Accepted, received, and filed the Fiscal Year 2024-25 CalOptima Health consolidated audited financial statements as submitted by independent auditors Baker Tilly US, LLP, previously Moss Adams LLP. (Motion carried 9-0-0)***

18. Approve Modifications to CalOptima Health Policy GG.1516: Hospital Acute Administrative Days

Director Helleland did not participate in this item due to his role as Chief Executive at Providence St. Joseph Hospital & Orange County and High Desert Service Area and left the room during the discussion and vote.

Vice Chair Sarmiento thanked staff for working with the Hospital Association of Southern California on this agenda item.

Action: ***On motion of Vice Chair Sarmiento, seconded and carried, the Board of Directors: Approved modifications to CalOptima Health Policy GG.1516: Hospital Acute Administrative Days, effective October 3, 2025. (Motion carried 8-0-0; Director Helleland recused)***

19. Approve Actions Related to the Medi-Cal Eligibility Outreach Strategy

The Board heard a public comment on this item as noted under the Public Comments section above.

Action: ***On motion of Director Contratto, seconded and carried, the Board of Directors: 1.) Authorized the Chief Executive Officer, or designee(s), to expand and extend the Medi-Cal Eligibility Outreach Strategy to support members and providers through December 31, 2028; 2.) Appropriated and allocated up to $5 million from the $38 million Community Reinvestment Program commitment for a Community Engagement and Enrollers Notice of Funding Opportunity as part of the Medi-Cal Eligibility Outreach Strategy; 3.) Appropriated and allocated up to $2 million from the remaining balance of the Community Reinvestment Program commitment to fund the County of Orange Social Services Agency (OC SSA) eligibility staff to support enrollment activities at CalOptima Health-hosted and sponsored events to support the Medi-Cal Eligibility Outreach Strategy; 4.) Authorized the Chief Executive Officer, or designee(s), to enter into a Memorandum of Understanding with OC SSA to support county eligibility staff participation at CalOptima Health-hosted and/or sponsored events through December 31, 2028; and 5.) Appropriated $12 million from the remaining balance of the Community***

Reinvestment Program commitment for future Board-approved Medi-Cal Eligibility Outreach Strategy activities. (Motion carried 9-0-0)

20. Authorize Amendment of the Contract with Camino Health Center to Provide Medical Services at the allcove® San Juan Capistrano Mental Health Youth Center Location

Chair Becerra did not participate in this item due to her role as Chief Executive Officer of the Coalition of Orange County Community Health Centers and left the room during the discussion and vote.

The Board heard two public comments regarding this agenda item as noted under the Public Comments section above.

Action: ***On motion of Director Contratto, seconded and carried, the Board of Directors: Authorized the Chief Executive Officer, with the assistance of Legal Counsel, to execute an amendment to the Professional Services Contract with Camino Health Center to establish payment terms to provide medical services at the allcove® San Juan Capistrano Mental Health Youth Center to CalOptima Health's Medi-Cal members who are not assigned for primary care services with Camino Health Center for the period of October 2, 2025, through June 30, 2028. (Motion carried 8-0-0; Chair Becerra recused)***

21. Approve Actions Related to the Housing and Homelessness Incentive Program – Funding Allocations

Director Contratto did not participate due to her role as Chief Strategy Officer at Be Well OC and left the room during the discussion and vote.

The Board heard one public comment as noted under the Public Comments section above.

Action: ***On motion of Director Mayorga, seconded and carried, the Board of Directors: 1.) Rescinded the following Board-approved grants and transfer the funds of $14.0 million in aggregate to Housing and Homelessness Incentive Program (HHIP) Priority 3: Partnerships and capacity to support referrals (capital projects): a.) Orange County Housing Finance Trust; b.) City of Irvine; and c.) Mind OC; and 2.) Approved allocation of up to $18.0 million in HHIP funds to Priority 3: Partnerships and capacity to support referrals (capital projects). (Motion carried 8-0-0; Director Contratto recused)***

22. Approve Actions Related to the Housing and Homelessness Incentive Program – Notice of Funding Opportunities

Vice Chair Sarmiento suggested amending the motion to add an additional $25 million for this action given the interest and need in the community.

Mr. Hunn suggested the Board approve this motion as originally presented and staff will bring an action for additional funding back to the Board for consideration.

Vice Chair Sarmiento, withdrew his amended motion and the Board took the following action:

Action: ***On motion of Vice Chair Sarmiento, seconded and carried, the Board of Directors: 1.) Upon Board approval of Report Item 21, authorize CalOptima Health staff to develop a Notice of Funding Opportunity (NOFO) Round 7 totaling approximately $27.8 million to be released in Quarter 3 of 2026: a.) $250,000 for equity grants under Housing and Homelessness Incentive Program (HHIP) Priority Area 2; b.) $25.0 million for capital projects under HHIP Priority Area 3; and c.) $2.5 million for system change grants under HHIP Priority Area 4; and 2.) Approved the allocation of up to $7.0 million of HHIP Priority Area 3 funds for general contractor services and furniture, fixtures and equipment for the Street Medicine Support Center at 7900 Garden Grove Boulevard, Garden Grove, California. (Motion carried 9-0-0)***

CLOSED SESSION

The Board adjourned to Closed Session at 3:41 p.m. Pursuant to Government Code section 54956.87, subdivision (b) HEALTH PLAN TRADE SECRETS: Covered California and CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION: Significant exposure to litigation pursuant to Government Code section 54956.9(d)(2) and (e)(1): 4 potential cases.

The Board returned to Open Session at 5:53 p.m., and the Clerk re-established a quorum.

ROLL CALL

Members Present: Isabel Becerra, Chair; Supervisor; Maura Byron; Supervisor Doug Chaffee; Blair Contratto; Norma García Guillén; Catherine Green, R.N.; Brian Helleland; Jose Mayorga, M.D.

Members Absent: Vicente Sarmiento, Vice Chair (left the meeting at 5:48 p.m.); Veronica Kelley (non-voting)

CLOSED SESSION

Chair Becerra noted for the record that the Board met in Closed Session and asked the Clerk to read the report out for Agenda Item CS-1.

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

The Board met in Closed Session and approved the following action for CS-1.:

Action: ***Authorized the CEO or delegate to contract with providers for the Covered California program within revised rate ranges. (Motion carried; 6-0-0; Chair Becerra and Directors Helleland and Mayorga absent)***

Chair Becerra reported for Agenda Item CS-2., that the Board met in closed session and gave direction to Special Counsel, Bird Marella, to prepare the report for public release before the next regularly scheduled meeting.

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

Director Byron thanked CalOptima Health for allowing Family Support Network (FSN) to convene its

Wraparound Orange County Resource Fair at CalOptima Health offices. She noted that it was a fantastic event with approximately 150 attendees and 32 vendors. Director Byron also noted that FSN is celebrating 40 years of service to the special needs community in Orange County. Over the past four decades, FSN has proudly served around 120,000 families. Director Byron also congratulated CalOptima Health on 30 years of service.

Director García Guillén congratulated CalOptima Health on 30 years of service in Orange County. She also congratulated FSN on its 40 years of service in Orange County.

Director Mayorga echoed the sentiment shared in recognition of CalOptima Health's 30-year milestone. Speaking personally, as someone who has spent his entire career practicing medicine in this community, he vividly recalls the early efforts and initiatives aimed at caring for those who are underserved and disenfranchised. Over the years, Director Mayorga noted that he has witnessed the incredible dedication and resilience of this organization. Despite the many challenges CalOptima Health has faced, whether through pandemics, funding cuts, or other crises, its commitment to the community has remained unwavering. The work being done today is a testament to that enduring mission. At the heart of it all, it has always been about the members, the patients, and the community it serves. Director Mayorga expressed his gratitude to those who came before us, including past Board members, and to all who continue to contribute to this important work. Here is to 30 more years of service and impact. Thank you.

Director Contratto thanked Nancy Huang and her team for delivering another clean audit, and to Mr. Hunn and the finance team for the well-deserved recognition from the auditors. Their meticulous work reflects the integrity of CalOptima Health's financial reporting. Director Contratto also thanked Mr. Hunn and Ms. Kim for introducing the employees celebrating 30 years of service, it was truly heartwarming to honor their dedication. Congratulations to all!

Director Green congratulated CalOptima Health on 30 years of service and the employees celebrating 30 years at CalOptima Health.

Director Helleland congratulated CalOptima Health on 30 years and expressed appreciation to leadership for their collaboration and support. Director Helleland also thanked CalOptima Health on behalf of his hospital colleagues, for providing the necessary clarification on policies approved today, which helped ensure alignment and understanding.

Chair Becerra thanked her colleagues for their comments and closed by offering another round of congratulations to the staff and leadership in celebration of CalOptima Health's 30-year milestone. She added that she looks forward to continuing to collaborate and build on the great work CalOptima Health and the Board has accomplished together.

ADJOURNMENT
Hearing no further business, Chair Becerra adjourned the meeting at 5:59 p.m.

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Sharon Dwiers
Clerk of the Board

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SPECIAL MEETING
OF THE
CALOPTIMA HEALTH BOARD OF DIRECTORS

October 16, 2025

A Special Meeting of the CalOptima Health Board of Directors (Board) was held on October 16, 2025, at CalOptima Health, 505 City Parkway West, Orange, California. The meeting was held in person and via Zoom webinar as allowed for under Assembly Bill 2449, which took effect after Governor Newsom ended the COVID-19 state of emergency on February 28, 2023. The meeting recording is available on CalOptima Health's website under View Past Meeting Materials. Chair Isabel Becerra called the meeting to order at 2:04 p.m., and Director Jose Mayorga led the Pledge of Allegiance.

ROLL CALL

Members Present: Isabel Becerra, Chair; Supervisor Vicente Sarmiento, Vice Chair; Maura Byron; Supervisor Doug Chaffee; Blair Contratto; Norma García Guillén; Catherine Green, R.N.; Jose Mayorga, M.D.

(All Board members participated in person)

Members Absent: Brian Helleland; Veronica Kelley (non-voting)

Others Present: Michael Hunn, Chief Executive Officer; James Novello, Outside General Counsel, Kennaday Leavitt; Nancy Huang, Chief Financial Officer; John Tanner, Chief Compliance Officer; Sharon Dwiers, Clerk of the Board

PRESENTATIONS/INTRODUCTIONS

None.

MANAGEMENT REPORTS

None.

PUBLIC COMMENTS

There were no public comments.

CONSENT CALENDAR

None.

CLOSED SESSION

The Board adjourned to Closed Session at 2:07 p.m. CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION Significant exposure to litigation pursuant to Government Code section 54956.9(d)(2) and (e)(1): 4 potential cases.

The Board returned to Open Session at 4:00 p.m., and the Clerk re-established a quorum.

ROLL CALL

Members Present: Isabel Becerra, Chair; Vicente Sarmiento, Vice Chair; Maura Byron; Supervisor Doug Chaffee; Blair Contratto; Norma García Guillén; Catherine Green, R.N.; Jose Mayorga, M.D.

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Members Absent: Brian Helleland; Veronica Kelley (non-voting)

CLOSED SESSION

Chair Becerra noted for the record that the Board met in Closed Session, and Anni Safarloo, Special Counsel, Liebert Cassidy Whitmore (LCW) will be reporting out.

Anni Safarloo, Special Counsel, LCW, read into the record the following:

The Board met in Closed Session to CONFERENCE WITH LEGAL COUNSEL pursuant to Government Code section 54956.9 (d)(2) and (e)(1). From those discussions, the Board voted to take two actions.

First Action: ***The Board approved an October 16, 2025, investigation report prepared by Bird Marella. The votes were as follows: The ayes were Chaffee, Sarmiento, Green, Mayorga, Garcia Guillen, Byron, Becerra and Contratto. Absent was Director Helleland.***

Second Action: ***The Board voted to waive attorney client privilege as to the investigation report prepared by Bird Marella for the purpose of public release, unanimously approved by the Board on October 16, 2025 authorized disclosures of the summaries of prior closed session discussions contained in the report pursuant to the Ralph M. Brown Act; direct counsel to provide notice by October 22, 2025, to affected individuals in the report and provide a seven-day period for any judicial action from the date of that notice and authorized public release of the report unless a court orders otherwise; and directed counsel to work with CalOptima's staff on publicizing the report once released. The votes were as follows: The ayes were Sarmiento, Byron, Chaffee, Green, Mayorga, Garcia Guillen, Byron, Becerra. The nays were Contratto. Absent was Director Helleland.***

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

Director Contratto thanked the Legal Ad Hoc for the incredible amount of work that they did in preparing the report and getting the Board to a final report. Director Contratto added that she is hopeful that at the Board's November meeting it will be able to address additional reports that the Board has reviewed.

ADJOURNMENT

Hearing no further business, Chair Becerra adjourned the meeting at 4:04 p.m.

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Sharon Dwiers
Clerk of the Board

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MINUTES

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

CALOPTIMA HEALTH
505 CITY PARKWAY WEST
ORANGE, CALIFORNIA

June 18, 2025

A Special Meeting of the CalOptima Health Board of Directors' (Board) Quality Assurance Committee (Committee) was held on June 18, 2025, at CalOptima Health, 505 City Parkway West, Orange, California. The meeting was held in person and at the teleconference location: Orange County Water District, 18700 Ward Street, Fountain Valley, CA 92708, which was accessible to members of the public and via Zoom webinar as allowed for under Assembly Bill (AB) 2449, which took effect after Governor Newsom ended the COVID-19 state of emergency on February 28, 2023. The meeting recording is available on CalOptima Health's website under Past Meeting Materials.

Chair Jose Mayorga called the meeting to order at 3:00 p.m., and Director Maura Byron led the Pledge of Allegiance.

CALL TO ORDER

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

(All Committee members in attendance participated in person, except for Director Catherine Green, who participated remotely under traditional Brown Act rules)

Members Absent: None.

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

ADVISORY COMMITTEE UPDATES

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

Monica Macias-Garcia, Director, CalOptima Health PACE, provided a brief overview of the PACE Member Advisory Committee (MAC) activities. Ms. Macias-Garcia noted that CalOptima Health leadership continues to monitor the transportation situation. She reported that based on feedback from PACE participants, the situation was improving.

2. Whole Child Model Family Advisory Committee Updates

Back to Agenda

Lori Sato, a member of the CalOptima Whole Child Model Family Advisory Committee, shared updates on the committee's recent two-month recruitment campaign. The recruitment campaign resulted in five new applications, three for new appointments, two for reappointments, and one each for a consumer advocate and a community-based organization representative. These appointments are expected to be approved at the August 7, 2025, Board meeting, allowing the committee to be fully staffed. Additionally, Ms. Sato expressed her appreciation for the contributions made during recent meetings with staff and their efforts in addressing the concerns of parents of children with special needs.

PUBLIC COMMENTS
There were no public comments.

CONSENT CALENDAR
3. Approve the Minutes of the March 12, 2025, Regular Meeting of the CalOptima Health Board of Directors' Quality Assurance Committee

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

REPORTS/DISCUSSION ITEMS
4. Recommend New Appointments and Reappointments to the CalOptima Health Whole-Child Model Family Advisory Committee.
This item was continued to the August 7, 2025, Board meeting.

INFORMATION ITEMS
5. Update on Quality Improvement Programs

a. Transplant Program Update
Richard Lopez, M.D., Medical Director, provided an in-depth update on the CalOptima Health transplant program. He noted that CalOptima Health facilitates transplants to approximately 150 members annually, including bone marrow, heart, liver, kidney, lung, and simultaneous pancreas-kidney procedures. These are performed at certified Centers of Excellence, many of which are outside Orange County. Dr. Lopez stated that key partners include Children's Hospital Los Angeles, Children's Hospital Orange County, City of Hope, University of California, Irvine (UCI), University of California, San Diego, and Loma Linda. CalOptima Health also provides comprehensive support services, such as transportation to and from the center of excellence, lodging with the caregiver near the center, meals for both the patient and caregiver, and when needed home health care services and pharmacy services.

Dr. Lopez provided an overview of enhancements to the program that included establishing strong contracts with high-performing centers, promoting adherence to national guidelines, and improving coordination and communication. Additionally, CalOptima Health identified an opportunity for cost-saving measures, such as the recruitment of a transplant specialist, shifting to UC transplant rates and reducing referrals to non-contracted centers. These cost saving measures led to a 40% reduction in transplant-related expenses in 2024 saving over $24 million and an average cost per day of approximately 25%. Looking ahead, the program aims to track patient outcomes more closely and

expand its transplant network, particularly in Los Angeles. Dr. Lopez concluded by reaffirming CalOptima Health's commitment to delivering high-quality, cost-effective transplant care.

Dr. Mayorga asked whether the extra services provided to transplant members, like meals and housing, were only done during the surgery. Dr Lopez clarified that services could be provided prior to the operation as many patients who are on the waiting list are usually already in the hospital, so their caregiver is allowed to stay with the member in local housing even after surgery for further monitoring.

b. Accreditation Status Update

Linda Lee, Executive Director of Quality Improvement, provided an update on CalOptima Health's progress toward maintaining its long-standing health plan accreditation with the National Committee for Quality Assurance (NCQA) and pursuing its first-ever health equity (HE) accreditation. Ms. Lee stated that the health plan accreditation review spans a 24-month look back period from April 2025 to April 2027. She also stated that the health equity accreditation file review commences next year with a service date of April 6, 2027. The HE accreditation has a 6-month review period ending in a virtual audit on October 7, 2025. Ms. Lee stated that CalOptima Health is currently on track to meet both deadlines and will be bringing updates to this Committee in the future. Ms. Lee further explained that an external consulting team of NCQA surveyors has been reviewing documents and training stakeholders to ensure compliance. She clarified that the external team would not be auditing CalOptima Health to avoid conflict of interest. Ms. Lee explained that most documents for the HE accreditation are already compliant, and ongoing efforts include submitting year-one documents and addressing gaps identified in a prior assessment. The team is also preparing for upcoming changes to NCQA standards expected in 2026. Lastly, Ms. Lee stated that for next steps consultants will continue to work with staff. One pending task is to analyze newly completed HEDIS results to identify and act on health disparities. The next major milestone is the HE surveys on October 7, 2025.

c. Credentialing Update

Ms. Lee addressed ongoing challenges with credentialing at CalOptima Health, noting a backlog that had built up over time. Remediation efforts began in August 2024, including the engagement of an external credentialing verification organization (CVO) in February 2025 to streamline the process by leveraging existing credentials from other plans. Ms. Lee explained that additional staff members were assigned to handle the high volume of provider inquiries, and robotic process automation was introduced in March 2025 to reduce manual data entry. Despite these efforts, the backlog persisted, prompting a more aggressive remediation plan in April 2025. The remediation plan included hiring temporary staff and implementing voluntary overtime shifts, resulting in the processing of 130–200 files weekly. With that new strategy, the data showed a downward trend in total inventory and an increase in closed files, indicating progress. Furthermore, the Credentialing team also added two full-time staff to manage unexpected administrative demands from the CVO. Ms. Lee stated that CalOptima Health is also transitioning to a new credentialing system that will integrate with provider contracting and data management systems to streamline workflows and improve the entire provider onboarding process over time. Currently, daily monitoring of credentialing volumes is now in place to ensure timely onboarding and reduce manual work.

Additionally, Ms. Lee shared a regulatory update from the Department of Health Care Services (DHCS). As of May 5, 2025, DHCS qualified autism service providers can now apply to be Medi-Cal

enrolled and offer services in Medi-Cal fee-for-service or through a Medi-Cal managed care plan. Ms. Lee stated that applications submitted by June 30, 2025, will be retroactively effective from July 1, 2025, while later submissions will be processed in order, potentially taking up to a year. Existing contracted providers must also enroll in Medi-Cal. Ms. Lee explained that CalOptima Health notified providers via email, fax, and a webinar, and is requiring proof of submission of their Medi-Cal application before continuing with credentialing.

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

d. Utilization Management Update

Kelly Giardina, Executive Director, Clinical Operations, provided a quarter one 2025 update on the Utilization Management Committee along with Robin Hatam, M.D., Medical Director. Ms. Giardina highlighted the launch of the Emergency Department Diversion (EDD) Program at UCI in February 2025. Since its launch the program has already supported 90 members face-to-face and improved coordination between emergency departments and community services. Additionally, materials have been created for the UCI emergency department staff to share with members. Ms. Giardina explained that CalOptima Health has been a support for some delegated health network partners so when issues arise CalOptima Health can connect both the member and the hospital team to their health network leaders in real time. Through the EDD program, CalOptima Health along with UCI has been helping members to better navigate CalAIM community services and supports.

Additionally, Ms. Giardina noted that the Transitional Care Services (TCS) workgroup enhanced support for members during care transitions, such as sharing resources where members can access ambulatory care if there are delays. Resources also include after-hours access and outreach to OneCare members to work with them in understanding the TCS program. Ms. Giardina noted that CalOptima Health has launched a campaign to connect with OneCare members via text to connect them with a personal care coordinator or case manager that delivers transitions of care services.

Ms. Giardina reported that the over/under-utilization group focused on refining the prior authorization process with external consultants, aiming to streamline workflows and improve visibility through dashboards. The gender-affirming care group completed cultural competency training for all staff and providers and is addressing network gaps. The Early and Periodic Screening Diagnostic and Treatment (EPSDT) workgroup worked on expanding the private duty nursing network and developed dashboards for dental, vision, and hearing services. Enhanced Care Management oversight included medical director rounding and case reviews with high-volume providers. Utilization data showed rising obstetrics admissions and emergency department visits among Medi-Cal adults 18 and older. Ms. Giardina noted that data represented was from November 2023 through October 2024. The data showed stable pediatric inpatient metrics and declining emergency department visits for Whole Child Model members, with the total volume ranging from 53 to 81 admissions per month. Additionally, for OneCare members, admissions and readmissions were low, with emergency department visits driven by conditions like urinary tract infections and cognitive symptoms.

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

Robin Hatam, M.D., Medical Director, provided an overview of the organization's health oversight activities, focusing on delegated health networks. Dr. Hatam explained that quarterly clinical

meetings are held with each network, attended by internal leadership and their counterparts from the networks, including medical directors. These meetings review submitted work plans and key utilization metrics such as emergency department utilization, readmission rates, and case management engagement. If metrics fall short of targets, the team discusses interventions. In addition to these quarterly meetings, a monthly dashboard tracks performance across delegated functions like utilization and case management, credentialing, claims, and customer service. Dr. Hatam noted that metrics are reviewed monthly and signs of non-compliance triggers one-on-one meetings with business owners and delegated health networks. If non-compliance is unresolved, a new policy is in place that allows escalations to corrective action plans. He also highlighted recent efforts, including an ad hoc review of pediatric denials and the development of a case management workbook to guide expectations around enrollment and staffing. A biweekly forum with health networks supports ongoing dialogue on topics like quality measures. He also described support for inpatient and skilled nursing facilities, including transitional care coordination and quarterly meetings to address services and operational issues. Lastly, Dr. Hatam discussed a pilot program at UCI's emergency room, where a social worker connects frequent emergency department users with appropriate outpatient services. This initiative, supported by a medical director with emergency department experience, aims to reduce unnecessary emergency department visits and is available to all CalOptima Health members.

Ms. Giardina responded to Committee members' comments and questions regarding Dr. Hatam's update.

6. Quarterly Reports to the Quality Assurance Committee

a. Quality Improvement Health Equity Committee Report

Ms. Lee presented an update on the work completed by the Quality Improvement Health Equity Committee (QIHEC) during the first quarter of 2025. The committee reviewed and acted on a broad range of quality oversight functions, including potential quality issues, oversight of credentialing of both physician providers and facilities, as well as credentialing facility site reviews. Ms. Lee noted that the committee also reviewed performance improvement projects, access and availability, member experience, and care coordination. Furthermore, key documents that were approved included evaluations and work plans for population health management, cultural and linguistic services, utilization and care management, and quality improvement programs. The committee also approved several policies related to corrective actions, service availability changes, and member medical record requests. Ms. Lee reported that subcommittees, such as Grievance and Appeals, Member Experience, and Population Health Management, reported their activities and were approved. However, Ms. Lee noted that CalAIM community supports did not meet the benchmark of 95% in November and December of 2024 due to staffing shortages. A corrective action plan (CAP) was immediately implemented by the QIHEC committee that included cross training of staff so that coverage could occur, and the addition of temporary staff. Resulting in 98% compliance and improved turnaround times by January 2025. The CAP was later reviewed and closed by the Quality Improvement Committee.

Ms. Lee highlighted that CalOptima Health achieved a three-star rating from the Centers for Medicare & Medicaid Services for the Health Risk Assessment measure. The Credentialing and Peer Review Committee reviewed and approved seven policies related to credentialing; the committee approved the credentialing clean/closure list and recommended the requiring of primary care provider minimum appointment hours. Ms. Lee noted that the Member Experience subcommittee approved its

charter, changing the quorum from seven to nine voting members, and issued corrective action plans to health networks based on quarter four 2024 performance on network adequacy. The Member Experience committee further made recommendations to prioritize the hiring of rheumatology, neurology, and urology specialists due to appointment delay issues. Furthermore, the Population Health Management subcommittee also updated its charter to add the CalOptima Health Chief Medical Officer as a voting member of the subcommittee and recommended follow-up with Access California Services to educate CalOptima Health benefits for the South Asian, Middle Eastern, and North African (SAMENA) collective, a community-based organization advancing care for SAMENA individuals. The Benefit Management subcommittee reviewed prior authorization codes and identified 19 codes for which prior authorization will be required and removed 24 codes from the prior authorization requirement. Finally, Ms. Lee reported that the Pharmacy and Therapeutics Committee approved drug criteria and formulary updates.

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

b. Member Grievances and Appeals Report

Ladan Khamseh, Executive Director, Operations, provided an overview of the first quarter 2025 grievances and appeals report. Overall, CalOptima Health received a total of 4,046 grievances and 324 appeals for the combined Medi-Cal and OneCare lines of business. The turnaround time for both complaint types remained compliant, averaging a closure rate of 23 days.

For the grievances, Ms. Khamseh reported that Medi-Cal experienced a decrease in grievances from 4,018 in the fourth quarter 2024 to 3,675 in the first quarter 2025, representing a decrease of 9% from prior quarter. Grievance types making up the overall first quarter volume for Medi-Cal included dissatisfaction in provider/staff attitude, transportation issues, and grievances related to provider services, specifically delays in referral submissions by treating providers. Ms. Khamseh noted that OneCare experienced a decrease in grievances from 419 in the fourth quarter 2024 to 371 in the first quarter 2025, representing a decrease of 11% from prior quarter. Grievance types making up the volume for OneCare included dissatisfaction in provider/staff attitude, telephone accessibility with providers offices, referral submission delays, and transportation grievances regarding driver punctuality and scheduling of services.

For the appeals, Ms. Khamseh reported that Medi-Cal experienced a decrease in appeals from 346 in the fourth quarter 2024 to 265 in the first quarter 2025, representing a decrease of 23.4%, with an overturn rate of 26%. The overall appeal volume was for redirection or modifications to community specialists, CalAIM personal care/homemaker services, and housing tenancy. Ms. Khamseh noted that OneCare experienced an increase in appeals from 41 in the fourth quarter 2024 to 59 in the first quarter 2025 representing an increase of 44%, with an overturn rate increase from 44% to 47%. She noted that the contributing factors in the appeals volume increase were inpatient hospital care with non-contracted providers, redirected authorizations from CalOptima Health tertiary providers to community providers who can treat the condition, and durable medical equipment requests.

Ms. Khamseh provided detailed information to committee members, on the grievances and appeals for both Medi-Cal and OneCare including steps taken to address current trends in grievances and appeals. She noted that CalOptima Health monitors all grievances and appeals and meets with vendors, staff and provider offices' staff to continually improve member satisfaction.

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

c. Program of All-Inclusive Care for the Elderly Report

Monica Macias-Garcia, Director, PACE, presented the 2024 participant satisfaction survey results, which were delayed due to fire-related disruptions affecting the research vendor. The survey evaluated nine service areas, including transportation, medical care, social work, meals, and overall satisfaction. Ms. Macias-Garcia noted that CalOptima Health PACE scored above both the national and CalPACE averages in several categories, including center aide services, medical care, social work, activities, and overall satisfaction. However, four areas were identified for improvement. Transportation, while scoring 90%, fell short of the 93.6% goal, prompting changes such as a new transportation manager and the addition of a supplemental vendor. Meal satisfaction dropped from 88% to 79%, leading to plans for participant focus groups and demographic analysis. Home care services also underperformed, with efforts underway to standardize service authorization and educate participants on service expectations. Lastly, while overall satisfaction remained strong at 90%, staff training in customer service and faster communication were identified as areas for enhancement. Ms. Macias-Garcia noted that CalOptima Health ranked fourth among PACE programs in California, though specific rankings of other programs were not disclosed by the surveyor.

Ms. Macias-Garcia further provided an update on the non-clinical work plan, focusing on three key areas: enrollment, alternative care site partnerships, and transportation provider performance. She stated that the team is analyzing participant enrollment trends and working to improve the current 56% conversion rate toward the 70% goal. Strategies are being developed to understand and address the reasons behind the shortfall. In terms of partnerships with alternative care sites like CBAS centers, the goal is to increase day center authorizations to 15%, though the current rate is only 4%. Ms. Macias-Garcia reported that on a positive note, transportation provider performance had shown improvement, with zero violations reported in both quarter four of 2024 and quarter one of 2025. She noted that the data for quarter two of 2025 was still being finalized.

There were no questions from the Committee.

COMMITTEE MEMBER COMMENTS

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

ADJOURNMENT

Hearing no further business, Chair Mayorga adjourned the meeting at 4:46 p.m.

/s/ Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: October 8, 2025

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CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 6, 2025
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar
6. Approve Modifications to CalOptima Health Quality Improvement Policies

Contacts
Richard Lopez, M.D., Medical Director, Medical Management, (657) 900-1483
Linda Lee, Executive Director, Quality Improvement, (657) 900-1069

Recommended Action
Approve modifications to the following CalOptima Health policies pursuant to CalOptima Health's annual review process:

- GG.1650: Credentialing and Recredentialing of Practitioners; and
- GG.1651: Assessment and Re-Assessment of Organizational Providers.

Background/Discussion

Modifications to Existing Quality Improvement Policies and Procedures
CalOptima Health regularly reviews its policies to ensure they are up to date and aligned with federal and state health care program requirements, regulatory and contractual obligations, as well as CalOptima Health operations.

Below are the existing Quality Improvement policies that require modifications:

- ***GG.1650: Credentialing and Recredentialing of Practitioners [Covered California, Medi-Cal, OneCare, PACE]*** describes the process by which CalOptima Health evaluates and determines whether to approve or decline practitioners for participation in CalOptima Health programs. CalOptima Health staff revised this policy pursuant to CalOptima Health's annual review process, and revisions include the following:

Policy Section	Change
Section II.J.7.vi	Clarifies the inclusion of Qualified Autism Services (QAS) providers, also known as Applied Behavior Analysis providers, as other medical practitioners requiring Medi-Cal enrollment and credentialing.
Section II.N	Adopts the credentialing and recredentialing conducted by a Federally Qualified Health Center (FQHC) for practitioners, where CalOptima Health will no longer credential or recredential FQHC practitioners who practice exclusively with a FQHC and who provide care for a Member only as a result of the Member being directed to the FQHC.
Section III.A.3.k	Removes the requirement for practitioners to be Medicare enrolled to align with adjustments to regulatory requirements. Verbiage was also corrected to provide consistency.

- ***GG.1651: Assessment and Reassessment of Organizational Providers [Covered California (Effective 2027), Medi-Cal, OneCare, PACE]*** describes the process by which

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CalOptima Health evaluates and determines whether to approve or decline Organizational Providers (OPs) for participation in CalOptima Health programs. CalOptima Health staff revised this policy pursuant to CalOptima Health's annual review process, and revisions include the following:

Policy Section	Change
Section II.F.22	Adds Qualified Autism Services (QAS) providers, also known as Applied Behavior Analysis providers, as a provider type required to be Medi-Cal enrolled and fully credentialed.
Section II.K.1-2	Clarifies the Organizational Provider (OP) types that are required to be enrolled with the Medicare Program.

Fiscal Impact
The recommended action is operational in nature. Staff included and will include any anticipated costs in current and future operating budgets.

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

Concurrence
Troy R. Szabo, Outside General Counsel, Kennaday Leavitt
Board of Directors' Quality Assurance Committee

Attachments
1. GG.1650: Credentialing and Recredentialing of Practitioners Final Policy Packet
2. GG.1651: Assessment and Reassessment of Organizational Providers Final Policy Packet

/s/ Michael Hunn *10/30/2025*
Authorized Signature **Date**

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Policy:	GG.1650
Title:	**Credentialing and Recredentialing of Practitioners**
Department:	Medical Management
Section:	Quality Improvement
CEO Approval:	*/s/*
Effective Date:	06/01/2017
Revised Date:	08/01/2025
Applicable to:	☐ Administrative ☒ Covered California [Effective 2027] ☒ Medi-Cal ☒ OneCare ☒ PACE

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I. PURPOSE

This policy defines the process by which CalOptima Health evaluates and determines whether practitioners meet the qualifications for participation in CalOptima Health programs.

II. POLICY

A. CalOptima Health shall establish guidelines by which CalOptima Health shall evaluate and select practitioners to participate in CalOptima Health, in accordance with applicable laws, regulations, and regulatory guidance.

B. CalOptima Health may delegate its authority to perform Medi-Cal screening and enrollment activities to a Delegate. If CalOptima Health chooses to delegate this function, the following shall occur:

1. The delegation must be in a written subcontract or agreement, where CalOptima Health remains contractually responsible for the completeness and accuracy of the screening and enrollment activities.

2. CalOptima Health shall evaluate the Delegate's ability to perform these activities, including an initial review to ensure that the Delegate has the administrative capacity, experience, and budgetary resources to fulfill its responsibilities.

3. CalOptima Health shall continuously monitor, evaluate, and approve the delegated functions.

4. CalOptima Health shall notify the Department of Health Care Services (DHCS) sixty (60) calendar days prior to delegating the screening and enrollment to a Delegate and shall submit policies and procedures (P&Ps) that outline the delegation authority, as well as CalOptima Health's monitoring and oversight activities.

C. CalOptima Health may delegate Credentialing and Recredentialing activities to a Delegate, including Health Networks or a Credentialing Verification Organization (CVO), in accordance with CalOptima Health Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities.

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1. Credentialing delegated entities shall perform delegated Credentialing functions that, at minimum, meet the requirements as outlined in this policy.

2. CalOptima Health may accept evidence of NCQA Provider Organization Certification in lieu of a monitoring site visit of delegated physician organization.

D. The Chief Medical Officer (CMO) or Designee shall have direct responsibility over and actively participate in the Credentialing program. The responsibilities include, but are not limited to, chairing the Credentialing and Peer Review Committee (CPRC), reviewing and approving practitioner files, and ensuring Credentialing policies are adhered to.

E. CalOptima Health's CPRC shall be responsible for reviewing a practitioner's Credentialing information and determining such practitioner's participation in CalOptima Health.

F. CalOptima Health and delegated entities shall ensure that any practitioner in its Medi-Cal provider network for whose provider type has an enrollment pathway with DHCS, including ordering, referring and prescribing providers, is screened and enrolled with DHCS in the Medi-Cal Program in accordance with DHCS All Plan Letter (APL) 22-013: Provider Credentialing/Re-credentialing and Screening /Enrollment, including any superseding APL, and Title 42, CFR, Part 455.

1. State-level enrollment pathways are available either through the DHCS' Provider Enrollment Division (PED) or another state department with a recognized enrollment pathway.

2. CalOptima Health may enroll providers through the screening and enrollment process outlined in Section III.G, in compliance with DHCS requirements, or CalOptima Health may direct network providers to enroll through a state-level enrollment pathway.

3. Practitioners that do not have a state level enrollment pathway do not need to be enrolled in Medi-Cal~~,~~ but must comply with CalOptima Health's vetting process.

G. CalOptima Health and its Delegates may allow practitioners in its Medi-Cal provider network to participate in the network for up to one hundred twenty (120) calendar days if the practitioner has a pending enrollment application in review with DHCS' PED or a DHCS approved screening and enrollment process.

1. CalOptima Health and Delegates shall terminate its contract with the practitioner no later than fifteen (15) calendar days of the practitioner receiving notification from DHCS that the practitioner has been denied enrollment of the Medi-Cal program, or upon the expiration of the first one hundred twenty (120) calendar day period.

2. CalOptima Health and Delegates shall not continue to contract with a practitioner during the period in which the practitioner resubmits its enrollment application to DHCS or approved screening and enrollment process and shall only re-initiate a contract upon the practitioner's successful enrollment as a Medi-Cal practitioner.

3. If the practitioner termination impacts Member access, CalOptima Health shall notify DHCS prior to terminating the practitioner and shall submit a plan of action for continuity of services for review and approval before the termination.

H. CalOptima Health and Delegates shall credential, prior to services being rendered, and recredential all contracted practitioners that render services to Members and are:

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1. Licensed, certified, or registered by the state of California to practice independently (without direction or supervision);

    a. CalOptima Health shall not require the licensure of a health professional employed by a tribal health program under the state or local law where the Tribal Health Program is located, if the professional is licensed in another state, in accordance with 25 United States Code (USC) § 1621t.

    b. CalOptima Health and Delegated shall allow out-of-state licensed psychologists, clinical social workers, marriage and family therapists, or professional clinical counselors to provide Specialty Mental Health Services (SMHS) or mental health services under the Medi-Cal program with an approved Professional Licensing Waiver (PLW) from DHCS.

2. Contracted with CalOptima Health to provide care under CalOptima Health's programs (including those practitioners who render care in contracted Federally Qualified Health Centers (FQHC) and community clinics that perform Primary Care and Specialty Care services);

3. In an independent relationship with CalOptima Health;

    a. An independent relationship exists when the CalOptima Health directs its Members to see a specific practitioner or group of practitioners, including all practitioners whom a Member can select as a primary care practitioner; and

4. Providing care to Members under CalOptima Health's programs.

I. CalOptima Health and Delegates shall credential and recredential all contracted practitioners that render services to Members in the following settings:

1. Individual or group practices;

2. Locum Tenens:

    a. CalOptima Health shall provisionally credential the practitioner if the locum tenens works less than sixty (60) calendar days.

    b. CalOptima Health shall fully credential the practitioner if the locum tenens works sixty (60) calendar days or more.

3. Facilities;

4. Telemedicine/telehealth (i.e., virtual care visit); or

5. Rental and preferred provider organization networks.

J. CalOptima Health and Delegates shall credential and recredential the following practitioners including, but not limited to:

1. Medical Doctor (MD).

2. Doctor of Osteopathy (DO).

3. Doctor of Chiropractic Medicine (DC).

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4. Doctor of Dental Surgery (DDS).

5. Doctor of Podiatric Medicine (DPM)

6. Nurse Practitioners (NP).

7. Other medical practitioners who may be within the scope of Credentialing (e.g., Physician Assistant).

   a. Behavioral health practitioners, including but not limited to:

      i. Psychiatrists and other physicians.

      ii. Addiction medicine specialists.

      iii. Doctoral or master's level psychologists.

      iv. Master's-level clinical social workers.

      v. ~~-~~Master's-level clinical nurse specialists or psychiatric nurse practitioners.

      vi. Other behavioral healthcare specialists who may be within the scope of credentialing (e.g., licensed professional counselors~~)~~, qualified autism services (QAS) providers also known as applied behavior analysis providers, etc.).

K. CalOptima Health and Delegates shall credential and recredential Non-Physician Medical Practitioners (NMP) who meet license and state board requirements for the scope of their practice and who do not have an independent relationship with CalOptima Health.

   1. Credentialed and recredentialed NMPs include:

      a. NMPs who provide services under the supervision of a practicing, licensed, and credentialed Physician Practitioner and have executed a signed agreement as required by the applicable state of California board with the NMP;

         i. Physician supervision is not required for services rendered by certain classes of Nurse Practitioners (NPs) pursuant to California Business Professional Code (BPC) §§ 2837.103 and 2837.104.

      b. NMPs who provide services as part of an Organized Health Care System that is credentialed with CalOptima Health and have a signed agreement as required by the applicable state of California board between the NMP and the Organized Health Care System; or

      c. NMPs who are not Physician Assistants (PAs) and who provide services under the employment agreement of a credentialed Physician Practitioner.

   2. An NMP shall notify CalOptima Health immediately if the supervising Physician Practitioner no longer meets the CalOptima Health Credentialing requirements, or if there is a change in the supervising Physician Practitioner, or NMP's employment with the entity or Organized Health System.

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L. For practitioners in the Medi-Cal provider network not required to be credentialed and/or who do not have a corresponding state-level enrollment pathway, ~~including but not limited to Behavior Management Technicians (BMT), Behavior Health Technicians (BHT), and Behavior Management Associates (BMA),~~ CalOptima Health shall at minimum verify the qualifications and vet the practitioner for the following:

1. Sufficient experience to provide services similar to the services for which they are contracted to provide within the service area;

2. Business licensing that meets industry standards, if applicable;

3. No history of Fraud, Waste, and/or abuse;

4. No recent history of criminal activity, including a history of criminal activities that endanger Members and/or their families; and

5. No history of liability claims against the practitioner.

M. CalOptima Health does not credential or recredential:

1. Practitioners who practice exclusively within the inpatient setting (*e.g.*, hospitalists) and provide care for a Member only as a result of the Member being directed to the hospital or inpatient setting;

2. Practitioners ~~that~~who practice exclusively within freestanding facilities and provide care for a Member only as a result of the Member being directed to the facility (*e.g.*, diagnostic radiologists, urgent care, emergency medicine);

3. Pharmacists who work for a Pharmacy Benefit Manager (PBM) to which CalOptima Health delegates Utilization Management functions (Credentialing of pharmacies and their professional and technical staff shall be conducted by the PBM, in accordance with CalOptima Health Policy GG.1406: Pharmacy Network Credentialing and Access);

4. Covering practitioners who do not have an independent relationship with CalOptima Health;

5. Practitioners who do not provide care for a Member in a treatment setting (e.g., external physician reviewer);

6. Health care professionals who are permitted to furnish services only under the direct supervision of another practitioner;

7. Students, residents, and fellows, where applicable;

8. Rental network practitioners who provide out-of-area care only, and Members are not required or given an incentive to seek care from them.

9. Health care professionals who are permitted to furnish services as part of a letter of agreement (LOA) or a continuity of care arrangement.

N. CalOptima Health adopts the Credentialing and Recredentialing conducted by Federally Qualified Health Centers (FQHCs) and does not credential or recredential practitioners who practice exclusively

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within a FQHC and who provide care for a Member only as a result of the Member being directed to the FQHC.

~~N.~~O. CalOptima Health and Delegates shall recredential a practitioner at least every three (3) years, utilizing a thirty-six (36~~)~~) month cycle to the month, not to the day.

~~O.~~P. CalOptima Health and Delegates shall ensure that all practitioners maintain current California licensure and shall monitor various state and federal boards, agencies, and databanks for adverse activities in accordance with CalOptima Health Policy GG.1607: Monitoring Adverse Actions.

~~P.~~Q. CalOptima Health and Delegates shall notify the practitioner, in writing, of the Credentialing or Recredentialing decision within thirty (30) calendar days of the date of the approval or denial of the application.

~~Q.~~R. CalOptima Health and Delegates shall not discriminate against any practitioner during the Credentialing and Recredentialing process.

1. CalOptima Health and Delegates shall not discriminate, in terms of participation, reimbursement, or indemnification, against any practitioner who is acting within the scope of their license, certification, or registration under federal and state law, solely on the basis of the license, or certification. This prohibition shall not preclude CalOptima Health from:

    a. Refusing to grant participation to a practitioner in excess of the number necessary to meet the needs of Members;

    b. Using different reimbursement amounts for different specialties, or for different practitioners in the same specialty; and

    c. Implementing measures designed to maintain quality and control costs consistent with CalOptima Health's responsibilities.

2. CalOptima Health and Delegates shall not discriminate against a practitioner that serves high-risk populations or specializes in the treatment of costly conditions.

3. CalOptima Health and Delegates shall not base Credentialing and Recredentialing decisions on a practitioner's race, ethnicity, national identity, gender, age, sexual orientation, or the type of procedure, or patient's insurance coverage, in which the practitioner specializes.

~~R.~~S. CalOptima Health and Delegates shall maintain the confidentiality of Credentialing and Recredentialing files, in accordance with CalOptima Health Policy GG.1659: System Controls of Provider Credentialing Information

~~S.~~T. CalOptima Health and Delegates shall ensure that information collected on the application is no more than six (6) months old from the date of the final decision made by the respective Credentialing committee.

1. If CalOptima Health or a Delegate is unable to render a decision within six (6) months, the application shall be considered expired, and Credentialing will re-initialize.

~~T.~~U. Except as provided in CalOptima Health Policy GG.1608: Full Scope Site Reviews, CalOptima Health does not delegate the Facility Site Review (FSR) and Medical Record Review (MRR) processes to a Health Network. CalOptima Health assumes all authority, responsibility, and

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coordination of FSRs, MRRs, and Physical Accessibility Review Surveys (PARS) and reports its findings to Health Networks to incorporate the documents to support review prior to Credentialing decisions.

III. PROCEDURE

A. Practitioner Initial Credentialing

1. A practitioner shall initiate the Credentialing process with CalOptima Health or a Delegate.

   a. Upon receipt of interest and/or request from the practitioner, CalOptima Health or Delegate shall send a notification electronically, explaining the expectations for completion and submission of the Credentialing application and required documents.

   b. Practitioners shall meet the Minimum Provider Standards as outlined in CalOptima Health Policy GG.1643: Minimum Provider Credentialing Standards, and CalOptima Health will verify that the Physician Practitioner meets the minimum standards as provided in that policy.

   c. Practitioners shall submit a current, signed, and dated application with attestation to CalOptima Health.

   d. CalOptima Health or its Delegate shall assess and verify the qualifications of a practitioner and make a credentialing decision within one hundred eighty days (180) of the signed attestation date.

   e. CalOptima Health or its Delegate shall assess and verify the qualifications of a Behavioral Health Provider in the Covered California provider network within sixty (60) days after receiving a complete Credentialing application in accordance with California Health & Safety Code § 1374.197.

      i. CalOptima Health or its Delegate shall provide written acknowledgement of receipt and inform the Behavioral Health Provider whether the application is complete and includes all the elements necessary for CalOptima to conduct its credentials verification process, within seven (7) business days of receiving a Credentialing application.

   f. CalOptima Health shall provide written acknowledgement to an Indian Health Care Provider (IHCP) within fifteen (15) days of receiving a complete Credentialing application in accordance with DHCS APL: 24-002 Medi-Cal Managed Care Plan Responsibilities for Indian Health Care Providers and American Indian Members, or a superseding APL.

   g. Practitioners shall attest to:

      i. Any work history gap that exceeds six (6) months and include written clarification;

      ii. The essential functions of the position that the practitioner cannot perform, with or without accommodation (i.e., health status);

      iii. Lack of present illegal drug use that impairs current ability to practice;

      iv. History of criminal convictions;

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v. History of any loss, or limitation, of licensure, or privileges, or disciplinary activity;

vi. Current malpractice insurance coverage; and

vii. The correctness and completeness of the application;

h. Practitioners shall complete an HIV/AIDS Specialist Screening Form, and HIV/AIDS Specialists shall attest to meet the qualifications specified in 28 California Code of Regulations (CCR) § 1300.74.16(e).

i. All Credentialing applications shall be signed. Faxed, digital, electronic, scanned, or photocopied signatures are acceptable; however, signature stamps are not acceptable.

j. A practitioner shall ensure that all information included in a Credentialing application is no more than six (6) months old.

k. CalOptima Health and its Delegate shall return an incomplete application to a practitioner, and such incomplete application will not be processed until the practitioner submits all the required information.

l. If the required information is not received within sixty (60) calendar days of the date of initial receipt of application, CalOptima Health shall consider the application withdrawn.

i. If an application has been withdrawn and the applicant wishes to apply to be credentialed, a new application must be submitted to CalOptima Health.

m. An NMP, other than a PA, who does not have an independent relationship with CalOptima Health or a Delegate, and is supervised by a Physician Practitioner, must include a signed supervisory agreement or delegation of services agreement indicating the name of supervising Physician Practitioner who is practicing, licensed, and credentialed by CalOptima Health; stating the NMP agrees to follow protocols developed for practice by the supervising Physician Practitioner based on skills and area of specialty or provide a copy of the employment agreement with the credentialed practitioner.

n. A PA who does not have an independent relationship with CalOptima Health or a Delegate and is supervised by Physician Practitioner or has an agreement with an Organized Health Care System, must include:

i. A delegation of services agreement indicating name of supervising Physician Practitioner who is practicing, licensed, and credentialed by CalOptima Health; statement that the NMP agrees to follow protocols developed for practice by the supervising physician based on skills and area of specialty or provide a copy of the employment agreement with the credentialed Physician Practitioner; or

ii. A signed Practice Agreement between the NMP and the Organized Health Care System stating that the PA agrees to follow protocols developed for practice by the Organized Health Care System based on skills and area of specialty or provide a copy of the Practice Agreement with the credentialed Organized Health Care System.

2. Upon receipt of a complete Credentialing application, CalOptima Health, its Delegates, or CVO shall verify the information provided through primary source or a contracted agent of the primary

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source using NCQA-accepted and/or industry-recognized verification sources. This information includes, but is not limited to:

a. A current, valid California license to practice in effect at the time of the Credentialing decision (verification time limit: 120 calendar days);

b. Board Certification, as applicable, unless exempt from the Board Certification requirement pursuant to CalOptima Health Policy GG.1633: Board Certification Requirements for Physicians (verification time limit: 120 calendar days); and

c. Education and training, including evidence of graduation from an appropriate professional school, continuing education requirements, and if applicable, completion of residency and specialty training.

d. Current (within last three (3) years) full scope FSR/MRR, and PARS for Primary Care practitioners in the Medi-Cal provider network, as applicable, pursuant to CalOptima Health Policy GG.1608: Full Scope Site Reviews;

e. Active enrollment status with Medi-Cal for providers in the Medi-Cal provider network, as required; and

f. Medicare program enrollment opt-out status (i.e. not on the opt-out list).

3. CalOptima Health, its Delegates, or CVO shall collect and verify the following information from each practitioner, as applicable, but need not verify this information through a primary source (see Attachment A). ~~CalOptima Health may use a signed attestation to validate these qualifications.~~ This information includes, but is not limited to:

a. Work history, including all post-graduate activity in the last five (5) years (on initial Credentialing). The practitioner shall provide a written explanation of any gaps of six (6) months or more (verification time limit: 180 calendar days);

b. Confirmation that the practitioner has hospital admitting staff privileges that are in good standing or confirmation that the practitioner refers patients to hospital-based practitioners (hospitalists), as applicable;

i. History of any suspension or curtailment of hospital and clinic privileges.

ii. Any alternative admitting arrangements must be documented in the Credentialing file.

c. A valid Drug Enforcement Administration (DEA) or valid Controlled Dangerous Substances (CDS) certificate, if applicable, in effect at the time of the Credentialing decision; DEA certificate must show an address within the state of California;

i. DEA and CDS-eligible practitioner who do not have a certificate, and for whom prescribing controlled substance is in the scope of their practice shall have in place a designated practitioner to write prescriptions on their behalf;

ii. This requirement is not applicable for practitioner who do not prescribe controlled substances and that in their professional judgment, the patients receiving their care do not require controlled substances; however, such practitioners must provide a written

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description of their process for handling instances when a patient requires a controlled substance.

d. Current malpractice insurance in the minimum amounts of one million dollars ($1,000,000.00) per occurrence and three million dollars ($3,000,000.00) aggregate per year at the time of the Credentialing decision (verification time limit: 120 calendar days);

   i. For Behavioral Health Service Providers, the minimum amounts shall be no less than one million dollars ($1,000,000.00) per incident and one million dollars ($1,000,000.00) aggregate per year at the time of the Credentialing decision (verification time limit: 120 calendar days).

e. Practitioner information entered in the National Practitioner Data Bank (NPDB), including malpractice history, (verification time limit: 120 calendar days) if applicable;

f. No exclusion or preclusion from participation at any time in federal or state health care programs based on conduct within the last ten (10) years, as set forth in 42 USC § 1320a-7(a), as follows:

   i. A conviction of a criminal offense related to the delivery of an item, or service, under federal, or state, health care programs;

   ii. A felony conviction related to neglect or abuse of patients in connection with the delivery of a health care item or service;

   iii. A felony conviction related to health care fraud; or

   iv. A felony conviction related to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

g. No history of professional liability claims that resulted in settlements or judgments paid by, or on behalf of, the practitioner in the last five (5) years;

h. No history of state sanctions, restrictions on licensure, or limitations on scope of practice, which may include accusations, probation, a previously filed 805 and 805.1 report with a licensing board; and

~~i. Current (within last three (3) years) full scope FSR/MRR, and PARS for primary care practitioners in the Medi-Cal provider network, as applicable, pursuant to CalOptima Health Policy GG.1608: Full Scope Site Reviews;~~

~~j. Active enrollment status with Medi-Cal for providers in the Medi-Cal provider network, as required;~~

~~k. Active enrollment status with Medicare for OneCare, as required (*i.e.*, has not opted-out of Medicare program); and~~

~~l.~~i. HIV/AIDS Specialist Screening Form and Attestation from each practitioner, as applicable.

4. CalOptima Health, a Delegate, or CVO shall verify qualifications for the following practitioner types in the Medi-Cal provider network in accordance with the following CalOptima Health policies:

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a. For doulas and comply with the requirements, in accordance with CalOptima Health Policy GG.1707: Doula Services.

b. For Community Health Workers (CHW) and comply with the requirements in accordance with CalOptima Health Policy GG.1213: Community Health Worker Services.

B. Practitioner Recredentialing

1. CalOptima Health or a Delegate shall recredential a practitioner at least every three (3) years after initial Credentialing. At the time of Recredentialing, CalOptima Health, its Delegate, or CVO shall:

   a. Collect and/or verify, where applicable, at a minimum, all of the information required for initial Credentialing, as set forth in Section III.A of this policy, including any change in work history, except historical data already verified at the time of the initial Credentialing of the practitioner; and

   b. Include documentation that information from other sources, such as the following data, was incorporated in the decision-making process, which shall have been reviewed no more than one hundred twenty (120) calendar days before the Recredentialing decision is made.

      i. Member Grievances and Appeals, including number and type during the past three (3) years;

      ii. A review of any Grievances, or quality cases, filed against a practitioner in the last three (3) years;

      iii. Information from quality review activities;

      iv. Member satisfaction, if applicable; and

      v. Compliance with the terms of the practitioner's contract.

   c. All Recredentialing applications must include the attestations as contained in the practitioner's initial Credentialing application and shall be signed. Faxed, digital, electronic, scanned, or photocopied signatures are acceptable; however, signature stamps are not acceptable.

2. Current (within the last three (3) years) full scope FSR/MRR and PARS, as applicable, pursuant to CalOptima Health Policy GG.1608: Full Scope Site Reviews.

3. CalOptima Health or its Delegate shall ensure that all practitioners maintain current DEA certification and medical malpractice insurance and shall validate this information at Recredentialing review.

4. CalOptima Health or its Delegate shall ensure that all practitioners maintain current California licensure in the interval between Recredentialing cycles.

   a. CalOptima Health or its Delegate documents the license expiration date into the Credentialing files and/or system and monitors all licenses that will expire monthly.

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b. CalOptima Health or its Delegate monitors the NPDB and/or the state licensing board for suspensions, restrictions, revocations, surrenders, and disciplinary actions on a monthly basis according to Policy GG.1607 Monitoring Adverse Actions.

C. Practitioner Rights

1. Applicants for Credentialing will receive practitioner rights included in the Credentialing application, as follows:

a. Right to review information:

i. Practitioners will be notified of their right to review information that CalOptima Health or its Delegate has obtained to evaluate the practitioner's Credentialing application, attestation, or curriculum vitae. This includes non-privileged information obtained from any outside source (*e.g.*, malpractice insurance carriers, state licensing boards), but does not extend to review of information, references, or recommendations protected by law from disclosure (*i.e.*, peer-review protected information).

b. Right to correct erroneous information:

i. All practitioners will be notified by email or certified mail when Credentialing information obtained from other sources during Credentialing varies from that provided by the practitioner in the Credentialing application;

ii. All practitioners have the right to correct erroneous information, as follows:

a) The practitioner has forty-eight (48) hours, excluding weekends, from date of notification to correct erroneous information;

b) Requests for correction of erroneous information must be submitted by email or certified mail on the practitioner's letterhead with a detailed explanation regarding the erroneous information, as well as copy(ies) of corrected information; and

c) For practitioners credentialed directly CalOptima Health, mailed submissions must be sent to CalOptima Health's Quality Improvement (QI) Department using the following address or email:

Attn Quality Improvement Department – Credentialing
CalOptima Health
505 City Parkway West
Orange CA 92868

~~Email: mycredentialingupdates@caloptima.org~~
Email: mycredentialingupdates@caloptima.org

d) For practitioners credentialed by a Delegate, the practitioner shall contact their Delegate directly to address any erroneous information.

iii. CalOptima Health is not required to reveal the source of information, if the information is not obtained to meet CalOptima Health's Credentialing verification requirements, or if federal or state law prohibits disclosure.

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iv. Documentation of receipt of corrections:

a) CalOptima Health or its Delegate shall document receipt of corrected information in the practitioner's Credentialing file.

b) A practitioner shall be notified via ~~a~~ fax, email, or certified letter to document receipt of the identified erroneous information.

v. Right to be notified of application status

a) Practitioners may receive the status of their Credentialing or Recredentialing application, upon request.
b) Practitioners can contact the QI Department by phone or e-mail requesting the status of their application. The QI Department will aim to respond within seven (7) business day of the status of the practitioner's application with respect to outstanding information required to complete the application process.

D. Credentialing Committee

1. CalOptima Health or Delegates shall designate a Credentialing committee that uses a peer-review process to make recommendations and decisions regarding ~~Assessment~~credentialing and ~~Reassessment~~recredentialing.

2. CalOptima Health shall designate the Credentialing and Peer Review Committee (CPRC) that uses a peer-review process to make recommendations and decisions regarding Credentialing and Recredentialing for practitioners in CalOptima Health Community Network, CalOptima Direct, or Program of All-Inclusive Care for the Elderly.

3. CPRC shall include representation from a range of practitioners participating in the organization's network and shall be responsible for reviewing a practitioner's Credentialing and Recredentialing files and determining the practitioner's participation in CalOptima Health programs.

4. Completed Credentialing and Recredentialing files will either be presented to the CMO or Designee on a clean file list for signature or will be presented at CPRC for review and approval.

a. A clean file consists of a complete application with a signed attestation and consent form, supporting documents, and verification of no more than one (1) professional review or malpractice claim(s) that resulted in settlements or judgments greater than twenty-five thousand dollars ($25,000) paid by, or on behalf of, the practitioner within the last seven (7) years from the date of the Credentialing or Recredentialing review.

i. A clean file shall be considered approved and effective on the date that the CMO or Designee reviews and approves a practitioner's Credentialing, or Recredentialing, file, and deems the file clean.

ii. Clean file lists approved by the CMO or Designee shall be presented at the CPRC for final approval and be reflected in the meeting minutes.

b. Files that do not meet the clean file review process and that require further review by CPRC include, but are not limited to, those files that include more than one (1) malpractice claim that resulted in a settlement or judgment greater than twenty-five thousand dollars ($25,000), or NPDB query identifying medical board investigations, or other actions.

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i. Non-clean list files will be reviewed by CPRC for determination to accept, or deny, the application.

ii. CPRC shall give thoughtful consideration to the information presented in the Credentialing file, which consideration shall be reflected in the minutes of the CPRC meeting.

iii. CPRC meetings and decisions may take place in real-time, or as a virtual meeting via telephone or video conference but may not be conducted through e-mail.

5. Practitioner files identified as not meeting Credentialing criteria with exceptions or potential exceptions, which may include serious quality deficiencies that result in the suspension or termination of a practitioner, shall be referred to the CMO or designee for review.

   a. The CMO or Designee shall review each file for practitioners who do not meet Credentialing criteria and make recommendations regarding approving or denying Credentialing of the practitioner to the CPRC. For practitioner files not meeting criteria on an administrative basis only, the file may be approved or denied by the CMO or Designee.

6. The CPRC shall make a final determination based on the practitioners' ability to deliver care based on the Credentialing information collected from the file review process and that is verified prior to making a Credentialing decision.

   a. The QI Department shall send the practitioner a decision letter within thirty (30) calendar days of the decision indicating:

      i. Acceptance;

      ii. Acceptance with restrictions along with appeal rights information, in accordance with CalOptima Health Policy GG.1616: Fair Hearing Plan for Practitioners; or

      iii. Denial of the application along with appeal rights information, in accordance with CalOptima Health Policy GG.1616: Fair Hearing Plan for Practitioners, with a letter of explanation forwarded to the applicant.

   b. CalOptima Health shall render a final Credentialing decision within one hundred eighty (180) calendar days from the date of the signed attestation that confirms the correctness and completeness of the application.

      i. If CalOptima Health is unable to render a decision within one hundred eighty (180) calendar days from the date of the signed attestation for any practitioner, during the practitioner's Credentialing or Recredentialing process, the practitioner must attest that the information on the application remains correct and complete, by resigning and redating the attestation.

7. If CalOptima Health terminates a practitioner during the Recredentialing process for administrative reasons (*i.e.*, the practitioner failed to provide complete Credentialing information) and not for quality reasons (*i.e.,* medical disciplinary cause or reason), CalOptima Health may reinstate the practitioner within thirty (30) calendar days of termination and is not required to perform initial Credentialing. However, CalOptima Health must re-verify credentials that are no longer within the verification time limit. If the reinstatement would be more than thirty (30)

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calendar days after termination, CalOptima Health must perform initial Credentialing of such practitioner.

a. Termination of privileges includes failure or refusal to renew a contract or to renew, extend, or reestablish any staff privileges, if the action is based on medical disciplinary cause or reason.

E. CalOptima Health and Delegates shall monitor and prevent discriminatory practices. Activities, including, but are not limited to:

1. Monitoring:

a. Conduct periodic audits of Credentialing files (in-process, denied, and approved files) to ensure that practitioners are not discriminated against as set forth in Section II.Q.;

b. Review practitioner complaints to determine if there are complaints alleging discrimination; and

c. On a quarterly basis, the QI Department shall review Grievances, Appeals, and potential quality-of-care issues for complaints alleging discrimination and will report outcomes to the CPRC for review and determination.

2. Prevention:

a. The QI Department shall maintain a heterogeneous CPRC and will require those responsible for Credentialing decisions to sign a statement affirming that they do not discriminate.

b. QI Department staff shall remove identifying information, such as name and affiliation, from the practitioner and provider files when presenting cases to CPRC to remove bias and prevent discrimination.

F. Upon acceptance and approval of a Credentialing application, the QI Department shall share the credentialing profile with Contracting, Provider Relations, and Provider Data Management Service (PDMS) Departments. This practitioner profile shall be generated from the Credentialing database to ensure that the information is consistent with data verified during the Credentialing process (*i.e.*, education, training, Board Certification, and specialty). The PDMS Department will enter the contract and Credentialing data into CalOptima Health's core business system and/or will verify the Credentialing data in the system, which updates pertinent information into the online provider directory.

G. Practitioner Screening and Enrollment (Medi-Cal Providers Only)

1. CalOptima Health shall access the California Health and Human Services' (CHHS) Open Data Portal to obtain a list of currently enrolled Medi-Cal fee-for-service (FFS) practitioners or obtain a PED approval letter as an acceptable form of initial enrollment verification conducted by DHCS.

2. If a practitioner is already enrolled with DHCS as a Medi-Cal FFS practitioner, then the practitioner screening and enrollment process does not need to be completed by CalOptima Health.

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3. If a practitioner is not already enrolled with DHCS as a Medi-Cal FFS practitioner, then CalOptima Health may complete screening and enrollment established by CalOptima Health.

   a. CalOptima Health shall notify DHCS and submit its P&Ps for approval prior to implementation. The P&Ps must define the scope of their enrollment process if CalOptima Health does not enroll all provider types.

   b. CalOptima Health shall complete the process and provide the applicant with a written determination on CalOptima Health letterhead within one hundred twenty (120) calendar days of its receipt of a practitioner application.

   c. CalOptima Health shall submit a list of its newly enrolled practitioners every six months to CalOptima Health's DHCS Managed Care Operations Division (MCOD) contract manager.

   d. CalOptima Health shall collect all the appropriate information, data elements, and supporting documentation required for each provider type and ensure that the application is reviewed for both accuracy and completeness.

      i. CalOptima Health shall inform practitioners seeking to enroll with CalOptima Health of the differences between CalOptima Health's and DHCS's provider enrollment processes, including the practitioner's right to enroll through DHCS, at the time of application. CalOptima Health will provide required disclosures that include, but are not limited to, the following elements:

         a) A statement that certain enrollment functions will not be performed by CalOptima Health but will continue to be performed by DHCS, including fingerprinting, criminal background checks, and decisions to deny or terminate enrollment.

         b) A notice that some of the enrollment requirements and rights found in the state enrollment process may not be applicable when a practitioner chooses to enroll through CalOptima Health, including provisional practitioner status with Medi-Cal FFS, processing timelines of the enrollment application, and the ability to appeal CalOptima Health's decision to suspend the enrollment process.

         c) A provision informing the practitioner that if CalOptima Health receives any information that impacts the practitioner's eligibility for enrollment, CalOptima Health will suspend processing of the practitioner's enrollment application and make the practitioner aware of the option to apply through DHCS' Medi-Cal FFS practitioner enrollment process.

         d) A statement clarifying that in order for the practitioner to participate in the Medi-Cal FFS program, the practitioner must enroll through DHCS, and that enrolling through DHCS will also make the practitioner eligible to contract with CalOptima Health.

      ii. CalOptima Health may collect an application fee, not to exceed the Medi-Cal FFS enrollment application fee amount.

      iii. CalOptima Health shall obtain the practitioner's consent in order to share information relating to the practitioner's application and eligibility with DHCS.

      iv. CalOptima Health shall collect and maintain the original signed Medi-Cal Provider Agreement and Network Provider Agreement for each practitioner.

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v. CalOptima Health shall maintain all practitioner enrollment documentation in a secure manner to ensure confidentiality of the practitioner's personal information.

vi. Enrollment records shall be made available upon request to DHCS, CMS or other authorized governmental agencies.

e. Practitioners that apply as a partnership, corporation, governmental entity, or nonprofit organization must disclose ownership or control information as required by 42 CFR § 455.104.

i. Practitioners who are unincorporated sole proprietors are not required to disclose the ownership or control information.

ii. Upon CalOptima Health's request, a practitioner must submit within thirty-five (35) calendar days:

a) Full and complete information about the ownership of any subcontractor with whom the practitioner has had business transactions totaling more than twenty-five thousand dollars ($25,000) during the twelve (12) month period ending on the date of the request; and,

b) Any significant business transactions between the practitioner and any wholly owned supplier, or between the practitioner and any subcontractor, during the five (5)-year period ending on the date of the request.

f. CalOptima Health shall screen initial practitioner applications, including applications for a new practice location, and any applications received in response to a practitioner's reenrollment or revalidation request to determine the practitioner's categorical risk level as limited, moderate, or high.

i. If a practitioner fits within more than one risk level, CalOptima Health must screen the practitioner at the highest risk level.

ii. A practitioner's designated risk level is also affected by findings of license verification, site reviews, checks of suspended and terminated practitioner lists, and criminal background checks.

iii. CalOptima Health shall not enroll a practitioner who fails to comply with the screening criteria for that practitioner's assigned level of risk.

g. Practitioners are subject to screening based on verification of the following requirements:

i. Limited-Risk Practitioners:

a) Meet state and federal requirements;

b) Hold a license certified for practice in the state and has no limitations from other states; and

c) Have no suspensions or terminations on state and federal databases.

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ii. Medium-Risk Practitioners:

a) Screening requirements of limited-risk practitioners; and

b) Pre-enrollment and post-enrollment onsite visits to verify that the information submitted to CalOptima Health and DHCS is accurate and to determine compliance with state and federal enrollment requirements.

iii. High-Risk Practitioners:

a) Screening requirements of medium-risk practitioners; and

b) Criminal background checks based in part on a set of fingerprints.

h. CalOptima Health and DHCS shall adjust the categorical risk level when any of the following circumstances occur:

i. The state imposes a payment suspension on a practitioner based on a credible allegation(s) of Fraud, Waste, or abuse.

ii. The practitioner has an existing Medicaid overpayment based on Fraud, Waste, or abuse.

iii. The practitioner has been excluded by the Office of Inspector General or another state's Medicaid program within the previous ten (10) years, or when a state or federal moratorium on a provider type has been lifted.

iv. The practitioner would have been prevented from applying for enrollment due to a moratorium and the moratorium was lifted in the past six (6) months.

i. Additional criteria for high-risk practitioners

i. Any person with a five percent (5%) or more direct or indirect ownership and is a high-risk applicant or where information discovered in the onsite or data analysis may lead to this type of request.

ii. CalOptima Health shall direct practitioners to fill out Form BCIA 8016 on the California Department of Justice (DOJ) website and ensure that practitioners include the correct agency information on the Live Scan form when submitting their application. The agency-specific information shall include the following information:

Applicant Submission

Field	**Entry**
ORI (Code assigned by DOJ)	CA0341600
Authorized Applicant Type	High Risk Medi-Cal Provider
Type of License/Certification/Permit OR Working Title	MCMC

Contributing Agency Information

Field	**Entry**
Agency Authorized to Receive Criminal Record Information	Department of Health Care Services
Mail Code (Five-digit code assigned by DOJ)	19509

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Street Address or PO Box	1700 K Street; MS 2200
Contact Name	MCMC
City	Sacramento
State	CA
ZIP Code	95811
Contact Telephone Number	(916) 750-1509

iii. When fingerprinting is required, CalOptima Health must furnish the practitioners with the Live Scan form and instructions on where to deliver the completed form.

iv. The practitioner must deliver the completed Live Scan form to the California DOJ and is responsible for paying for any Live Scan processing fees.

v. CalOptima Health shall notify DHCS upon initiation of each criminal background check for a practitioner that has been designated as high risk.

vi. CalOptima Health shall maintain the security and confidentiality of all of the information it receives from DHCS relating to the practitioner's high-risk designation and the results of the criminal background checks.

j. Site Visits

i. CalOptima Health shall conduct pre- and post-enrollment site visits of medium-risk and high-risk practitioners to verify that the information submitted to CalOptima Health and DHCS is accurate and to determine the applicant's compliance with state and federal enrollment requirements.

ii. CalOptima Health shall conduct post-enrollment site visits for medium-risk practitioners at least every five (5) years and their high-risk practitioners every three (3) years or as necessary to verify that the information submitted to CalOptima Health and DHCS is accurate and determine if practitioners are in compliance with state and federal enrollment requirements.

iii. Onsite visits may be conducted for many reasons, including, but not limited to, the following:

a) The practitioner was temporarily suspended from the Medi-Cal program;

b) The practitioner's license was previously suspended;

c) There is conflicting information in the practitioner's enrollment application;

d) There is conflicting information in the practitioner's supporting enrollment documentation; and

e) As part of the practitioner enrollment process, CalOptima Health receives information that raises a suspicion of fraud.

k. Federal and State Database Checks

i. CalOptima Health shall check the following databases to verify the identity and determine the exclusion and/or enrollment status of all practitioners:

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a) Social Security Administration's Death Master File;

b) National Plan and Provider Enumeration System (NPPES);

c) List of Excluded Individuals/Entities (LEIE);

d) System for Award Management (SAM);

e) CMS' Medicare Exclusion Database (MED);

f) DHCS' Suspended and Ineligible Provider List;

g) Restricted Provider Database (RPD); and

h) CHHS Open Data Portal.

ii. CalOptima Health shall also review the SAM, LEIE, and RPD databases on a regular basis, and at least monthly, to ensure that contracted practitioners continue to meet enrollment criteria and take appropriate action in connection with the exclusion.

iii. Any practitioners terminated from the Medicare or Medicaid/Medi-Cal program may not participate in CalOptima Health's practitioner network.

l. If CalOptima Health declines to enroll a practitioner, it must refer the practitioner to DHCS for further enrollment options.

m. If CalOptima Health acquires information, either before or after enrollment, that may impact the practitioner's eligibility to participate in the Medi-Cal program, or a practitioner refuses to submit to the required screening activities, CalOptima Health may decline to accept that practitioner's application.

n. If at any time CalOptima Health determines that it does not want to contract with a prospective practitioner, and/or that the prospective practitioner will not meet enrollment requirements, CalOptima Health must immediately suspend the enrollment process of that practitioner.

o. CalOptima Health is not obligated to establish an appeal process for screening and enrollment decisions. Practitioners may only appeal a suspension or termination to DHCS when the suspension or termination occurs as part of DHCS' denial of the Medi-Cal FFS enrollment application.

p. All practitioners must resubmit and recertify the accuracy of their enrollment information as part of the revalidation process at least every five (5) years to ensure that all enrollment information is accurate and up-to-date.

q. CalOptima Health shall retain all practitioner screening and enrollment materials and documents for ten (10) years.

r. CalOptima Health shall make all screening and enrollment documents and materials promptly available to DHCS, CMS, and any other authorized governmental entities upon request.

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IV. ATTACHMENT(S)

A. CalOptima Health Primary Source Verification Table

V. REFERENCE(S)

A. California Business and Professions Code §§ 805, 2837.103, 2837.104 and 3500-3502.3
B. California Evidence Code § 1157
C. California Health & Safety Code § 1374.197
D. CalOptima Health Contract for Health Care Services
E. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
F. CalOptima Health Contract with Covered California
G. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
H. CalOptima Health PACE Program Agreements
I. CalOptima Health Policy GG.1213: Community Health Worker Services
J. CalOptima Health Policy GG.1406: Pharmacy Network: Credentialing and Access
K. CalOptima Health Policy GG.1602: Non-Physician Medical Practitioner (NMP) Scope of Practice
~~L.~~A. ~~CalOptima Health Policy GG.1659: System Controls of Provider Credentialing Information~~
~~M.~~L. CalOptima Health Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities
~~N.~~M. CalOptima Health Policy GG.1607: Monitoring Adverse Actions
~~O.~~N. CalOptima Health Policy GG.1608: Full Scope Site Reviews
~~P.~~O. CalOptima Health Policy GG.1616: Fair Hearing Plan for Practitioners
~~Q.~~P. CalOptima Health Policy GG.1619: Delegation Oversight
~~R.~~Q. CalOptima Health Policy GG.1633: Board Certification Requirements for Physicians
~~S.~~R. CalOptima Health Policy GG.1643: Minimum Provider Credentialing Standards
~~T.~~S. CalOptima Health Policy GG.1651: Assessment and Re-Assessment of Organizational Providers
T. CalOptima Health Policy GG.1659: System Controls of Provider Credentialing Information
U. CalOptima Health Policy GG.1707: Doula Services
V. CalOptima Health Policy HH.1101: CalOptima Health Provider Complaint
W. CalOptima Health Policy MA.9006: Provider Complaint Process
X. Department of Health Care Services (DHCS) All Plan Letter (APL) 16-009: Adult Immunizations as a Pharmacy Benefit (Revised 12/23/2016)
U. Department of Health Care Services (DHCS-) All Plan Letter (APL) 22-013: Provider Credentialing / Recredentialing and Screening / Enrollment (Revised 08/24/2022)
V. Department of Health Care Services (DHCS-) All Plan Letter (APL) 23-024: Doula Services (Supersedes APL 22-031) (Revised 11/03/2023)
W. ~~DHCS APL~~Department of Health Care Services (DHCS) All Plan Letter (APL) 24-002: Medi-Cal Managed Care Plan Responsibilities for Indian health Care Providers and American Indian Members
X. Department of Health Care Services (DHCS-) All Plan Letter (APL) 24-006: Community Health Worker Services Benefit (Supersedes APL 22-016)
Y. Department of Health Care Services (DHCS-) All Plan Letter (APL) 24-015: California Children's Services Whole Child Model Program (Supersedes APL 23-034)
U. Medicare Managed Care Manual, Chapter 6: Relationships with Providers
V. ~~NCQA~~National Committee for Quality Assurance (NCQA) Standards and Guidelines
W. Title 42, Code of Federal Regulations (CFR), §§ 422.204(a), 422.205, 438.12, 438.214, 460.64, 460.71, and Part 455, Subpart E
X. Title 42, United States Code (USC), §1320a-7(a)
Y. Title XVIII and XIV of the Social Security Act

VI. REGULATORY AGENCY APPROVAL(S)

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Date	Regulatory Agency	Response
04/28/2015	Department of Health Care Services (DHCS)	Approved as Submitted
09/20/2018	Department of Health Care Services (DHCS)	Approved as Submitted
10/13/2020	Department of Health Care Services (DHCS)	No Reply 60 Days
05/05/2022	Department of Health Care Services (DHCS)	Approved as Submitted
10/26/2022	Department of Health Care Services (DHCS)	Approved as Submitted
01/09/2023	Department of Health Care Services (DHCS)	Approved as Submitted
07/11/2023	Department of Health Care Services (DHCS)	Approved as Submitted
06/13/2024	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
06/01/2017	Regular Meeting of the CalOptima Board of Directors
09/06/2018	Regular Meeting of the CalOptima Board of Directors
10/01/2020	Regular Meeting of the CalOptima Board of Directors
04/07/2022	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	06/01/2017	GG.1650	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	01/01/2018	GG.1650	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	09/06/2018	GG.1650	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	02/01/2019	GG.1650	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	10/01/2020	GG.1650	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	04/07/2022	GG.1650	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE

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Action	Date	Policy	Policy Title	Program(s)
Revised	12/31/2022	GG.1650	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare PACE
Revised	04/01/2023	GG.1650	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare PACE
Revised	05/01/2024	GG.1650	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare PACE
Revised	04/01/2025	GG.1650	Credentialing and Recredentialing of Practitioners	Covered California Medi-Cal OneCare PACE
Revised	05/01/2025	GG.1650	Credentialing and Recredentialing of Practitioners	Covered California Medi-Cal OneCare PACE
Revised	08/01/2025	GG.1650	Credentialing and Recredentialing of Practitioners	Covered California Medi-Cal OneCare PACE

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IX. GLOSSARY

Term	Definition
Abuse	Covered California: Excessive, or improper use of something, or the use of something in a manner contrary to the natural or legal rules for its use; the intentional destruction, diversion, manipulation, misapplication, maltreatment, or misuse of resources; or extravagant or excessive use to abuse one's position or authority. Often, the terms fraud and abuse are used simultaneously with the primary distinction is the intent. Inappropriate practices that begin as abuse can quickly evolve into fraud. Abuse can occur in financial or non-financial settings. Examples of abuse include excessive charges, improper billing practices, payment for services that do not meet recognized standards of care and payment for medically unnecessary services. Medi-Cal: Practices that are inconsistent with sound fiscal and business practices or medical standards, and result in an unnecessary cost to the Medi-Cal program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to the Medi-Cal program. OneCare: A Provider practice that is inconsistent with sound fiscal, business, or medical practice, and results in an unnecessary cost to CalOptima Health and the OneCare program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to CalOptima Health and the OneCare program.
Appeal (Member)	Covered California: A review by CalOptima Health of an adverse benefit determination, which includes one of the following actions: 1. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a service; 4. Failure to provide services in a timely manner; or 5. Failure to act within the required timeframes for standard and expedited resolution of grievances and appeals in accordance with Health & Safety Code § 1368. Medi-Cal: A review by CalOptima Health of an adverse benefit determination, which includes one of the following actions: 1. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a service;

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Term	Definition
	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. PACE: A Member's action taken with respect to the PACE organization's noncoverage of, modification of, or nonpayment for, a service including denials, reductions or termination of services, as defined by federal PACE regulation 42 CFR § 460.122.
Behavioral Health Provider	A licensed practitioner including, but not limited to, physicians, nurse specialists, psychiatric nurse practitioners, licensed psychologists (PhD or PsyD), licensed clinical social worker (LCSW), marriage and family therapist (MFT or MFCC), professional clinical counselors and qualified autism service providers, furnishing covered services.
Board Certification/Certified	Certification of a physician by one (1) of the boards recognized by the American Board of Medical Specialties (ABMS), or American Osteopathic Association (AOA), as meeting the requirements of that board for certification.
Covered California: *Effective 01/01/2027 for CalOptima Health*	The California Health Benefit Exchange, doing business as Covered California and an independent entity within the Government of the State.
Credentialing	Covered California: The initial process by which the qualifications of a Provider is verified in order to make a determination relating to the Provider's eligibility for participation in CalOptima Health's programs. Medi-Cal: The process of determining a Provider or an entity's professional or technical competence, and may include registration, certification, licensure and professional association membership. OneCare: The process of obtaining, verifying, assessing, and monitoring the qualifications of a Provider to provide quality and safe patient care services. PACE: The recognition of professional or technical competence. The process involved may include registration, certification, licensure, and professional association membership.
Credentialing and Peer Review Committee (CPRC)	The Credentialing and Peer Review (CPRC) Committee makes decisions, provides guidance, and provides peer input into the CalOptima provider selection process and determines corrective action necessary to ensure that all practitioners and providers who provide services to CalOptima Members meet generally accepted standards for their profession in the industry. The CPRC

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Term	Definition
	meets at least quarterly and reports to the CalOptima Quality Improvement (QI) Committee.
Credentialing Verification Organization (CVO)	For purposes of this policy, an organization that collects and verifies Credentialing information.
Delegate	An organization or entity granted authority to perform an activity on behalf of CalOptima within agreed-upon parameters. Any party that enters into an acceptable written arrangement below the level of the arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Facility Site Review (FSR)	A DHCS tool utilized to assess the quality, safety and accessibility of primary care physicians (PCPs) and high-volume specialist physician offices.
Federally Qualified Health Center (FQHC)	A type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. An FQHC must be a public entity or a private non-profit organization. FQHCs must provide primary care services for all age groups.
Fraud	An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law, in accordance with Title 42 CFR § 455.2, Welfare and Institutions Code § 14043.1(i).
Grievance	Covered California: A written or oral expression of dissatisfaction regarding CalOptima Health, a Health Network, or a Provider, including quality of care concerns, Member's complaint about a delay or denial of payment on a claim, and shall include a complaint, dispute, request for reconsideration or Appeal made by a Member or the Member's representative. A complaint is the same as a Grievance. An inquiry is a request for more information that does not include an expression of dissatisfaction, including, but not limited to, questions pertaining to eligibility, benefits, or other CalOptima Health processes. If CalOptima Health is unable to distinguish between a Grievance and an inquiry, it must be considered a Grievance. Medi-Cal: 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. OneCare: An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken.

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Term	Definition
	PACE: A complaint, either written or oral, expressing dissatisfaction with service delivery or the quality of care furnished, as defined by the federal PACE regulation 42 CFR § 460.120.
Health Network	A ~~physician hospital consortium~~Physician Hospital Consortium (PHC), physician group under a shared risk contract, ~~or~~ health care service plan, such as a ~~health maintenance~~Health Maintenance Organization (HMO~~)~~), Subcontractor, or First Tier Entity, that contracts with CalOptima Health to provide ~~covered services~~Covered Services to ~~members assigned to that health network~~Members.
HIV/AIDS Specialist	A physician who holds a valid, unrevoked and unsuspended certificate to practice medicine in the state of California who meets any one of the following four (4) criteria: 1. Is credentialed as an "HIV Specialist" by the American Academy of HIV Medicine; 2. Is board certified, or has earned a Certificate of Added Qualification, in the field of HIV medicine granted by a member board of the American Board of Medical Specialties, should a member board of that organization establish board certification, or a Certificate of Added Qualification, in the field of HIV medicine; 3. Is board certified in the field of infectious diseases by a member board of the American Board of Medical Specialties and meets the following qualifications: (A) In the immediately preceding 12 months has clinically managed medical care to a minimum of 25 patients who are infected with HIV; and (B) In the immediately preceding 12 months has successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients, including a minimum of 5 hours related to antiretroviral therapy per year; or 4. Meets the following qualifications: (A) In the immediately preceding 24 months has clinically managed medical care to a minimum of 20 patients who are infected with HIV; and (B) Has completed any of the following: 1. In the immediately preceding 12 months has obtained board certification or recertification in the field of infectious diseases from a member board of the American Board of Medical Specialties; or 2. In the immediately preceding 12 months has successfully completed a minimum of 30 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients; or 3. In the immediately preceding 12 months has successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients and has successfully completed the HIV Medicine Competency Maintenance Examination administered by the American Academy of HIV medicine.
Indian Health Care Provider (IHCP)	A health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (IHCIA) at 25 USC § 1603.
Medical Record Review (MRR)	A DHCS tool utilized to audit PCP medical records for format, legal protocols, and documented evidence of the provision of preventive care and coordination and continuity of care services.

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Term	Definition
Member	An individual enrolled in a CalOptima program.
Minimum Physician Standards	Minimum standards that must be met in order for a Physician to be credentialed and contracted for participation in CalOptima programs.
Non-Physician Medical Practitioner (NMP)	A licensed practitioner, including but not limited to, a Nurse Practitioner (NP), Certified Nurse Midwife (CNM), Licensed Midwife (LM), Certified Nurse Specialists (CNS), Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), Speech Therapist (ST), or Audiologist furnishing covered services.
Organized Health Care System	Includes a licensed clinic as described in Chapter 1 (commencing with Section 1200) of Division 2 of the Health and Safety Code, an outpatient setting as described in Chapter 1.3 (commencing with Section 1248) of Division 2 of the Health and Safety Code, a health facility as described in Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code, a county medical facility as described in Chapter 2.5 (commencing with Section 1440) of Division 2 of the Health and Safety Code, an accountable care organization, a home health agency, a physician's office, a professional medical corporation, a medical partnership, a medical foundation, and any other entity that lawfully provides medical services and is in compliance with Article 18 (commencing with Section 2400) of Chapter 5.
Pharmacy Benefit Manager (PBM)	The entity that performs certain functions and tasks including, but not limited to, pharmacy Credentialing, contracting, and claims processing in accordance with the terms and conditions of the PBM Services Agreement.
Physical Accessibility Review Survey (PARS)	A DHCS tool used to assess the level of physical accessibility of provider sites, including specialist and ancillary service providers.
Physician Practitioner	A licensed practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), furnishing covered services.
Practice Agreement	The writing, developed through collaboration among one or more physicians and surgeons and one or more physician assistants, that defines the medical services the physician assistant is authorized to perform pursuant to BPC § 3502 and that grants approval for physicians and surgeons on the staff of an Organized Health Care System to supervise one or more physician assistants in the Organized Health Care System. Any reference to a delegation of services agreement relating to physician assistants in any other law shall have the same meaning as a Practice Agreement.
Primary Care	For purposes of this policy, a basic level of health care usually rendered in an ambulatory setting by a PCP.
Recredentialing	The process by which the qualifications of practitioners is verified in order to make determinations relating to their continued eligibility for participation in the CalOptima program.
Specialty Care	For purposes of this policy, specialty care given to Members by referral by other than a PCP.
Telehealth	The mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management and self-management of a Member's health care while the Member is at the originating site, and the health care provider is at a distant site. Telehealth facilitates Member self-management and caregiver support for Members and includes synchronous interactions and asynchronous store and forward transfers.

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Term	Definition
Utilization Management (UM)	Requirements or limits on coverage. UM may include, but is not limited to, prior authorization, quantity limit, or step therapy restrictions.
Waste	Covered California: Intentional or unintentional, extravagant careless or needless expenditures, consumption, mismanagement, use, or squandering of resources, to the detriment or potential detriment of entities, but without an intent to deceive or misrepresent. Waste includes incurring unnecessary costs because of inefficient or ineffective practices, systems, decisions, or controls. Medi-Cal: The overutilization or inappropriate utilization of services and misuse of resources, and typically is not a criminal or intentional act, as stated in CMS' Fraud, Waste, and Abuse Toolkit. OneCare: The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Health Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

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Policy:	GG.1650
Title:	**Credentialing and Recredentialing of Practitioners**
Department:	Medical Management
Section:	Quality Improvement
CEO Approval:	*/s/*
Effective Date:	06/01/2017
Revised Date:	08/01/2025
Applicable to:	☐ Administrative ☒ Covered California [Effective 2027] ☒ Medi-Cal ☒ OneCare ☒ PACE

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I. PURPOSE

This policy defines the process by which CalOptima Health evaluates and determines whether practitioners meet the qualifications for participation in CalOptima Health programs.

II. POLICY

A. CalOptima Health shall establish guidelines by which CalOptima Health shall evaluate and select practitioners to participate in CalOptima Health, in accordance with applicable laws, regulations, and regulatory guidance.

B. CalOptima Health may delegate its authority to perform Medi-Cal screening and enrollment activities to a Delegate. If CalOptima Health chooses to delegate this function, the following shall occur:

1. The delegation must be in a written subcontract or agreement, where CalOptima Health remains contractually responsible for the completeness and accuracy of the screening and enrollment activities.

2. CalOptima Health shall evaluate the Delegate's ability to perform these activities, including an initial review to ensure that the Delegate has the administrative capacity, experience, and budgetary resources to fulfill its responsibilities.

3. CalOptima Health shall continuously monitor, evaluate, and approve the delegated functions.

4. CalOptima Health shall notify the Department of Health Care Services (DHCS) sixty (60) calendar days prior to delegating the screening and enrollment to a Delegate and shall submit policies and procedures (P&Ps) that outline the delegation authority, as well as CalOptima Health's monitoring and oversight activities.

C. CalOptima Health may delegate Credentialing and Recredentialing activities to a Delegate, including Health Networks or a Credentialing Verification Organization (CVO), in accordance with CalOptima Health Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities.

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1. Credentialing delegated entities shall perform delegated Credentialing functions that, at minimum, meet the requirements as outlined in this policy.

2. CalOptima Health may accept evidence of NCQA Provider Organization Certification in lieu of a monitoring site visit of delegated physician organization.

D. The Chief Medical Officer (CMO) or Designee shall have direct responsibility over and actively participate in the Credentialing program. The responsibilities include, but are not limited to, chairing the Credentialing and Peer Review Committee (CPRC), reviewing and approving practitioner files, and ensuring Credentialing policies are adhered to.

E. CalOptima Health's CPRC shall be responsible for reviewing a practitioner's Credentialing information and determining such practitioner's participation in CalOptima Health.

F. CalOptima Health and delegated entities shall ensure that any practitioner in its Medi-Cal provider network for whose provider type has an enrollment pathway with DHCS, including ordering, referring and prescribing providers, is screened and enrolled with DHCS in the Medi-Cal Program in accordance with DHCS All Plan Letter (APL) 22-013: Provider Credentialing/Re-credentialing and Screening /Enrollment, including any superseding APL, and Title 42, CFR, Part 455.

1. State-level enrollment pathways are available either through the DHCS' Provider Enrollment Division (PED) or another state department with a recognized enrollment pathway.

2. CalOptima Health may enroll providers through the screening and enrollment process outlined in Section III.G, in compliance with DHCS requirements, or CalOptima Health may direct network providers to enroll through a state-level enrollment pathway.

3. Practitioners that do not have a state level enrollment pathway do not need to be enrolled in Medi-Cal but must comply with CalOptima Health's vetting process.

G. CalOptima Health and its Delegates may allow practitioners in its Medi-Cal provider network to participate in the network for up to one hundred twenty (120) calendar days if the practitioner has a pending enrollment application in review with DHCS' PED or a DHCS approved screening and enrollment process.

1. CalOptima Health and Delegates shall terminate its contract with the practitioner no later than fifteen (15) calendar days of the practitioner receiving notification from DHCS that the practitioner has been denied enrollment of the Medi-Cal program, or upon the expiration of the first one hundred twenty (120) calendar day period.

2. CalOptima Health and Delegates shall not continue to contract with a practitioner during the period in which the practitioner resubmits its enrollment application to DHCS or approved screening and enrollment process and shall only re-initiate a contract upon the practitioner's successful enrollment as a Medi-Cal practitioner.

3. If the practitioner termination impacts Member access, CalOptima Health shall notify DHCS prior to terminating the practitioner and shall submit a plan of action for continuity of services for review and approval before the termination.

H. CalOptima Health and Delegates shall credential, prior to services being rendered, and recredential all contracted practitioners that render services to Members and are:

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1. Licensed, certified, or registered by the state of California to practice independently (without direction or supervision);

    a. CalOptima Health shall not require the licensure of a health professional employed by a tribal health program under the state or local law where the Tribal Health Program is located, if the professional is licensed in another state, in accordance with 25 United States Code (USC) § 1621t.

    b. CalOptima Health and Delegated shall allow out-of-state licensed psychologists, clinical social workers, marriage and family therapists, or professional clinical counselors to provide Specialty Mental Health Services (SMHS) or mental health services under the Medi-Cal program with an approved Professional Licensing Waiver (PLW) from DHCS.

2. Contracted with CalOptima Health to provide care under CalOptima Health's programs (including those practitioners who render care in contracted Federally Qualified Health Centers (FQHC) and community clinics that perform Primary Care and Specialty Care services);

3. In an independent relationship with CalOptima Health;

    a. An independent relationship exists when the CalOptima Health directs its Members to see a specific practitioner or group of practitioners, including all practitioners whom a Member can select as a primary care practitioner; and

4. Providing care to Members under CalOptima Health's programs.

I. CalOptima Health and Delegates shall credential and recredential all contracted practitioners that render services to Members in the following settings:

1. Individual or group practices;

2. Locum Tenens:

    a. CalOptima Health shall provisionally credential the practitioner if the locum tenens works less than sixty (60) calendar days.

    b. CalOptima Health shall fully credential the practitioner if the locum tenens works sixty (60) calendar days or more.

3. Facilities;

4. Telemedicine/telehealth (i.e., virtual care visit); or

5. Rental and preferred provider organization networks.

J. CalOptima Health and Delegates shall credential and recredential the following practitioners including, but not limited to:

1. Medical Doctor (MD).

2. Doctor of Osteopathy (DO).

3. Doctor of Chiropractic Medicine (DC).

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4. Doctor of Dental Surgery (DDS).

5. Doctor of Podiatric Medicine (DPM)

6. Nurse Practitioners (NP).

7. Other medical practitioners who may be within the scope of Credentialing (e.g., Physician Assistant).

    a. Behavioral health practitioners, including but not limited to:

        i. Psychiatrists and other physicians.

        ii. Addiction medicine specialists.

        iii. Doctoral or master's level psychologists.

        iv. Master's-level clinical social workers.

        v. Master's-level clinical nurse specialists or psychiatric nurse practitioners.

        vi. Other behavioral healthcare specialists who may be within the scope of credentialing (e.g., licensed professional counselors, qualified autism services (QAS) providers also known as applied behavior analysis providers, etc.).

K. CalOptima Health and Delegates shall credential and recredential Non-Physician Medical Practitioners (NMP) who meet license and state board requirements for the scope of their practice and who do not have an independent relationship with CalOptima Health.

1. Credentialed and recredentialed NMPs include:

    a. NMPs who provide services under the supervision of a practicing, licensed, and credentialed Physician Practitioner and have executed a signed agreement as required by the applicable state of California board with the NMP;

        i. Physician supervision is not required for services rendered by certain classes of Nurse Practitioners (NPs) pursuant to California Business Professional Code (BPC) §§ 2837.103 and 2837.104.

    b. NMPs who provide services as part of an Organized Health Care System that is credentialed with CalOptima Health and have a signed agreement as required by the applicable state of California board between the NMP and the Organized Health Care System; or

    c. NMPs who are not Physician Assistants (PAs) and who provide services under the employment agreement of a credentialed Physician Practitioner.

2. An NMP shall notify CalOptima Health immediately if the supervising Physician Practitioner no longer meets the CalOptima Health Credentialing requirements, or if there is a change in the supervising Physician Practitioner, or NMP's employment with the entity or Organized Health System.

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L. For practitioners in the Medi-Cal provider network not required to be credentialed and/or who do not have a corresponding state-level enrollment pathway, CalOptima Health shall at minimum verify the qualifications and vet the practitioner for the following:

1. Sufficient experience to provide services similar to the services for which they are contracted to provide within the service area;

2. Business licensing that meets industry standards, if applicable;

3. No history of Fraud, Waste, and/or abuse;

4. No recent history of criminal activity, including a history of criminal activities that endanger Members and/or their families; and

5. No history of liability claims against the practitioner.

M. CalOptima Health does not credential or recredential:

1. Practitioners who practice exclusively within the inpatient setting (*e.g.*, hospitalists) and provide care for a Member only as a result of the Member being directed to the hospital or inpatient setting;

2. Practitioners who practice exclusively within freestanding facilities and provide care for a Member only as a result of the Member being directed to the facility (*e.g.*, diagnostic radiologists, urgent care, emergency medicine);

3. Pharmacists who work for a Pharmacy Benefit Manager (PBM) to which CalOptima Health delegates Utilization Management functions (Credentialing of pharmacies and their professional and technical staff shall be conducted by the PBM, in accordance with CalOptima Health Policy GG.1406: Pharmacy Network Credentialing and Access);

4. Covering practitioners who do not have an independent relationship with CalOptima Health;

5. Practitioners who do not provide care for a Member in a treatment setting (e.g., external physician reviewer);

6. Health care professionals who are permitted to furnish services only under the direct supervision of another practitioner;

7. Students, residents, and fellows, where applicable;

8. Rental network practitioners who provide out-of-area care only, and Members are not required or given an incentive to seek care from them.

9. Health care professionals who are permitted to furnish services as part of a letter of agreement (LOA) or a continuity of care arrangement.

N. CalOptima Health adopts the Credentialing and Recredentialing conducted by Federally Qualified Health Centers (FQHCs) and does not credential or recredential practitioners who practice exclusively within a FQHC and who provide care for a Member only as a result of the Member being directed to the FQHC.

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O. CalOptima Health and Delegates shall recredential a practitioner at least every three (3) years, utilizing a thirty-six (36) month cycle to the month, not to the day.

P. CalOptima Health and Delegates shall ensure that all practitioners maintain current California licensure and shall monitor various state and federal boards, agencies, and databanks for adverse activities in accordance with CalOptima Health Policy GG.1607: Monitoring Adverse Actions.

Q. CalOptima Health and Delegates shall notify the practitioner, in writing, of the Credentialing or Recredentialing decision within thirty (30) calendar days of the date of the approval or denial of the application.

R. CalOptima Health and Delegates shall not discriminate against any practitioner during the Credentialing and Recredentialing process.

1. CalOptima Health and Delegates shall not discriminate, in terms of participation, reimbursement, or indemnification, against any practitioner who is acting within the scope of their license, certification, or registration under federal and state law, solely on the basis of the license, or certification. This prohibition shall not preclude CalOptima Health from:

   a. Refusing to grant participation to a practitioner in excess of the number necessary to meet the needs of Members;

   b. Using different reimbursement amounts for different specialties, or for different practitioners in the same specialty; and

   c. Implementing measures designed to maintain quality and control costs consistent with CalOptima Health's responsibilities.

2. CalOptima Health and Delegates shall not discriminate against a practitioner that serves high-risk populations or specializes in the treatment of costly conditions.

3. CalOptima Health and Delegates shall not base Credentialing and Recredentialing decisions on a practitioner's race, ethnicity, national identity, gender, age, sexual orientation, or the type of procedure, or patient's insurance coverage, in which the practitioner specializes.

S. CalOptima Health and Delegates shall maintain the confidentiality of Credentialing and Recredentialing files, in accordance with CalOptima Health Policy GG.1659: System Controls of Provider Credentialing Information

T. CalOptima Health and Delegates shall ensure that information collected on the application is no more than six (6) months old from the date of the final decision made by the respective Credentialing committee.

1. If CalOptima Health or a Delegate is unable to render a decision within six (6) months, the application shall be considered expired, and Credentialing will re-initialize.

U. Except as provided in CalOptima Health Policy GG.1608: Full Scope Site Reviews, CalOptima Health does not delegate the Facility Site Review (FSR) and Medical Record Review (MRR) processes to a Health Network. CalOptima Health assumes all authority, responsibility, and coordination of FSRs, MRRs, and Physical Accessibility Review Surveys (PARS) and reports its findings to Health Networks to incorporate the documents to support review prior to Credentialing decisions.

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III. PROCEDURE

A. Practitioner Initial Credentialing

1. A practitioner shall initiate the Credentialing process with CalOptima Health or a Delegate.

   a. Upon receipt of interest and/or request from the practitioner, CalOptima Health or Delegate shall send a notification electronically, explaining the expectations for completion and submission of the Credentialing application and required documents.

   b. Practitioners shall meet the Minimum Provider Standards as outlined in CalOptima Health Policy GG.1643: Minimum Provider Credentialing Standards, and CalOptima Health will verify that the Physician Practitioner meets the minimum standards as provided in that policy.

   c. Practitioners shall submit a current, signed, and dated application with attestation to CalOptima Health.

   d. CalOptima Health or its Delegate shall assess and verify the qualifications of a practitioner and make a credentialing decision within one hundred eighty days (180) of the signed attestation date.

   e. CalOptima Health or its Delegate shall assess and verify the qualifications of a Behavioral Health Provider in the Covered California provider network within sixty (60) days after receiving a complete Credentialing application in accordance with California Health & Safety Code § 1374.197.

      i. CalOptima Health or its Delegate shall provide written acknowledgement of receipt and inform the Behavioral Health Provider whether the application is complete and includes all the elements necessary for CalOptima to conduct its credentials verification process, within seven (7) business days of receiving a Credentialing application.

   f. CalOptima Health shall provide written acknowledgement to an Indian Health Care Provider (IHCP) within fifteen (15) days of receiving a complete Credentialing application in accordance with DHCS APL: 24-002 Medi-Cal Managed Care Plan Responsibilities for Indian Health Care Providers and American Indian Members, or a superseding APL.

   g. Practitioners shall attest to:

      i. Any work history gap that exceeds six (6) months and include written clarification;

      ii. The essential functions of the position that the practitioner cannot perform, with or without accommodation (i.e., health status);

      iii. Lack of present illegal drug use that impairs current ability to practice;

      iv. History of criminal convictions;

      v. History of any loss, or limitation, of licensure, or privileges, or disciplinary activity;

      vi. Current malpractice insurance coverage; and

      vii. The correctness and completeness of the application;

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h. Practitioners shall complete an HIV/AIDS Specialist Screening Form, and HIV/AIDS Specialists shall attest to meet the qualifications specified in 28 California Code of Regulations (CCR) § 1300.74.16(e).

i. All Credentialing applications shall be signed. Faxed, digital, electronic, scanned, or photocopied signatures are acceptable; however, signature stamps are not acceptable.

j. A practitioner shall ensure that all information included in a Credentialing application is no more than six (6) months old.

k. CalOptima Health and its Delegate shall return an incomplete application to a practitioner, and such incomplete application will not be processed until the practitioner submits all the required information.

l. If the required information is not received within sixty (60) calendar days of the date of initial receipt of application, CalOptima Health shall consider the application withdrawn.

    i. If an application has been withdrawn and the applicant wishes to apply to be credentialed, a new application must be submitted to CalOptima Health.

m. An NMP, other than a PA, who does not have an independent relationship with CalOptima Health or a Delegate, and is supervised by a Physician Practitioner, must include a signed supervisory agreement or delegation of services agreement indicating the name of supervising Physician Practitioner who is practicing, licensed, and credentialed by CalOptima Health; stating the NMP agrees to follow protocols developed for practice by the supervising Physician Practitioner based on skills and area of specialty or provide a copy of the employment agreement with the credentialed practitioner.

n. A PA who does not have an independent relationship with CalOptima Health or a Delegate and is supervised by Physician Practitioner or has an agreement with an Organized Health Care System, must include:

    i. A delegation of services agreement indicating name of supervising Physician Practitioner who is practicing, licensed, and credentialed by CalOptima Health; statement that the NMP agrees to follow protocols developed for practice by the supervising physician based on skills and area of specialty or provide a copy of the employment agreement with the credentialed Physician Practitioner; or

    ii. A signed Practice Agreement between the NMP and the Organized Health Care System stating that the PA agrees to follow protocols developed for practice by the Organized Health Care System based on skills and area of specialty or provide a copy of the Practice Agreement with the credentialed Organized Health Care System.

2. Upon receipt of a complete Credentialing application, CalOptima Health, its Delegates, or CVO shall verify the information provided through primary source or a contracted agent of the primary source using NCQA-accepted and/or industry-recognized verification sources. This information includes, but is not limited to:

a. A current, valid California license to practice in effect at the time of the Credentialing decision (verification time limit: 120 calendar days);

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b. Board Certification, as applicable, unless exempt from the Board Certification requirement pursuant to CalOptima Health Policy GG.1633: Board Certification Requirements for Physicians (verification time limit: 120 calendar days); and

c. Education and training, including evidence of graduation from an appropriate professional school, continuing education requirements, and if applicable, completion of residency and specialty training.

d. Current (within last three (3) years) full scope FSR/MRR, and PARS for Primary Care practitioners in the Medi-Cal provider network, as applicable, pursuant to CalOptima Health Policy GG.1608: Full Scope Site Reviews;

e. Active enrollment status with Medi-Cal for providers in the Medi-Cal provider network, as required; and

f. Medicare program enrollment opt-out status (i.e. not on the opt-out list).

3. CalOptima Health, its Delegates, or CVO shall collect and verify the following information from each practitioner, as applicable, but need not verify this information through a primary source (see Attachment A). This information includes, but is not limited to:

a. Work history, including all post-graduate activity in the last five (5) years (on initial Credentialing). The practitioner shall provide a written explanation of any gaps of six (6) months or more (verification time limit: 180 calendar days);

b. Confirmation that the practitioner has hospital admitting staff privileges that are in good standing or confirmation that the practitioner refers patients to hospital-based practitioners (hospitalists), as applicable;

i. History of any suspension or curtailment of hospital and clinic privileges.

ii. Any alternative admitting arrangements must be documented in the Credentialing file.

c. A valid Drug Enforcement Administration (DEA) or valid Controlled Dangerous Substances (CDS) certificate, if applicable, in effect at the time of the Credentialing decision; DEA certificate must show an address within the state of California;

i. DEA and CDS-eligible practitioner who do not have a certificate, and for whom prescribing controlled substance is in the scope of their practice shall have in place a designated practitioner to write prescriptions on their behalf;

ii. This requirement is not applicable for practitioner who do not prescribe controlled substances and that in their professional judgment, the patients receiving their care do not require controlled substances; however, such practitioners must provide a written description of their process for handling instances when a patient requires a controlled substance.

d. Current malpractice insurance in the minimum amounts of one million dollars ($1,000,000.00) per occurrence and three million dollars ($3,000,000.00) aggregate per year at the time of the Credentialing decision (verification time limit: 120 calendar days);

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i. For Behavioral Health Service Providers, the minimum amounts shall be no less than one million dollars ($1,000,000.00) per incident and one million dollars ($1,000,000.00) aggregate per year at the time of the Credentialing decision (verification time limit: 120 calendar days).

e. Practitioner information entered in the National Practitioner Data Bank (NPDB), including malpractice history, (verification time limit: 120 calendar days) if applicable;

f. No exclusion or preclusion from participation at any time in federal or state health care programs based on conduct within the last ten (10) years, as set forth in 42 USC § 1320a-7(a), as follows:

i. A conviction of a criminal offense related to the delivery of an item, or service, under federal, or state, health care programs;

ii. A felony conviction related to neglect or abuse of patients in connection with the delivery of a health care item or service;

iii. A felony conviction related to health care fraud; or

iv. A felony conviction related to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

g. No history of professional liability claims that resulted in settlements or judgments paid by, or on behalf of, the practitioner in the last five (5) years;

h. No history of state sanctions, restrictions on licensure, or limitations on scope of practice, which may include accusations, probation, a previously filed 805 and 805.1 report with a licensing board; and

i. HIV/AIDS Specialist Screening Form and Attestation from each practitioner, as applicable.

4. CalOptima Health, a Delegate, or CVO shall verify qualifications for the following practitioner types in the Medi-Cal provider network in accordance with the following CalOptima Health policies:

a. For doulas and comply with the requirements, in accordance with CalOptima Health Policy GG.1707: Doula Services.

b. For Community Health Workers (CHW) and comply with the requirements in accordance with CalOptima Health Policy GG.1213: Community Health Worker Services.

B. Practitioner Recredentialing

1. CalOptima Health or a Delegate shall recredential a practitioner at least every three (3) years after initial Credentialing. At the time of Recredentialing, CalOptima Health, its Delegate, or CVO shall:

a. Collect and/or verify, where applicable, at a minimum, all of the information required for initial Credentialing, as set forth in Section III.A of this policy, including any change in work history, except historical data already verified at the time of the initial Credentialing of the practitioner; and

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b. Include documentation that information from other sources, such as the following data, was incorporated in the decision-making process, which shall have been reviewed no more than one hundred twenty (120) calendar days before the Recredentialing decision is made.

i. Member Grievances and Appeals, including number and type during the past three (3) years;

ii. A review of any Grievances, or quality cases, filed against a practitioner in the last three (3) years;

iii. Information from quality review activities;

iv. Member satisfaction, if applicable; and

v. Compliance with the terms of the practitioner's contract.

c. All Recredentialing applications must include the attestations as contained in the practitioner's initial Credentialing application and shall be signed. Faxed, digital, electronic, scanned, or photocopied signatures are acceptable; however, signature stamps are not acceptable.

2. Current (within the last three (3) years) full scope FSR/MRR and PARS, as applicable, pursuant to CalOptima Health Policy GG.1608: Full Scope Site Reviews.

3. CalOptima Health or its Delegate shall ensure that all practitioners maintain current DEA certification and medical malpractice insurance and shall validate this information at Recredentialing review.

4. CalOptima Health or its Delegate shall ensure that all practitioners maintain current California licensure in the interval between Recredentialing cycles.

a. CalOptima Health or its Delegate documents the license expiration date into the Credentialing files and/or system and monitors all licenses that will expire monthly.

b. CalOptima Health or its Delegate monitors the NPDB and/or the state licensing board for suspensions, restrictions, revocations, surrenders, and disciplinary actions on a monthly basis according to Policy GG.1607 Monitoring Adverse Actions.

C. Practitioner Rights

1. Applicants for Credentialing will receive practitioner rights included in the Credentialing application, as follows:

a. Right to review information:

i. Practitioners will be notified of their right to review information that CalOptima Health or its Delegate has obtained to evaluate the practitioner's Credentialing application, attestation, or curriculum vitae. This includes non-privileged information obtained from any outside source (*e.g.*, malpractice insurance carriers, state licensing boards), but does not extend to review of information, references, or recommendations protected by law from disclosure (*i.e.*, peer-review protected information).

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b. Right to correct erroneous information:

i. All practitioners will be notified by email or certified mail when Credentialing information obtained from other sources during Credentialing varies from that provided by the practitioner in the Credentialing application;

ii. All practitioners have the right to correct erroneous information, as follows:

a) The practitioner has forty-eight (48) hours, excluding weekends, from date of notification to correct erroneous information;

b) Requests for correction of erroneous information must be submitted by email or certified mail on the practitioner's letterhead with a detailed explanation regarding the erroneous information, as well as copy(ies) of corrected information; and

c) For practitioners credentialed directly CalOptima Health, mailed submissions must be sent to CalOptima Health's Quality Improvement (QI) Department using the following address or email:

Attn Quality Improvement Department – Credentialing
CalOptima Health
505 City Parkway West
Orange CA 92868

Email: mycredentialingupdates@caloptima.org

d) For practitioners credentialed by a Delegate, the practitioner shall contact their Delegate directly to address any erroneous information.

iii. CalOptima Health is not required to reveal the source of information, if the information is not obtained to meet CalOptima Health's Credentialing verification requirements, or if federal or state law prohibits disclosure.

iv. Documentation of receipt of corrections:

a) CalOptima Health or its Delegate shall document receipt of corrected information in the practitioner's Credentialing file.

b) A practitioner shall be notified via fax, email, or certified letter to document receipt of the identified erroneous information.

v. Right to be notified of application status

a) Practitioners may receive the status of their Credentialing or Recredentialing application, upon request.

b) Practitioners can contact the QI Department by phone or e-mail requesting the status of their application. The QI Department will aim to respond within seven (7) business day of the status of the practitioner's application with respect to outstanding information required to complete the application process.

D. Credentialing Committee

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1. CalOptima Health or Delegates shall designate a Credentialing committee that uses a peer-review process to make recommendations and decisions regarding credentialing and recredentialing.

2. CalOptima Health shall designate the Credentialing and Peer Review Committee (CPRC) that uses a peer-review process to make recommendations and decisions regarding Credentialing and Recredentialing for practitioners in CalOptima Health Community Network, CalOptima Direct, or Program of All-Inclusive Care for the Elderly.

3. CPRC shall include representation from a range of practitioners participating in the organization's network and shall be responsible for reviewing a practitioner's Credentialing and Recredentialing files and determining the practitioner's participation in CalOptima Health programs.

4. Completed Credentialing and Recredentialing files will either be presented to the CMO or Designee on a clean file list for signature or will be presented at CPRC for review and approval.

    a. A clean file consists of a complete application with a signed attestation and consent form, supporting documents, and verification of no more than one (1) professional review or malpractice claim(s) that resulted in settlements or judgments greater than twenty-five thousand dollars ($25,000) paid by, or on behalf of, the practitioner within the last seven (7) years from the date of the Credentialing or Recredentialing review.

        i. A clean file shall be considered approved and effective on the date that the CMO or Designee reviews and approves a practitioner's Credentialing, or Recredentialing, file, and deems the file clean.

        ii. Clean file lists approved by the CMO or Designee shall be presented at the CPRC for final approval and be reflected in the meeting minutes.

    b. Files that do not meet the clean file review process and that require further review by CPRC include, but are not limited to, those files that include more than one (1) malpractice claim that resulted in a settlement or judgment greater than twenty-five thousand dollars ($25,000), or NPDB query identifying medical board investigations, or other actions.

        i. Non-clean list files will be reviewed by CPRC for determination to accept, or deny, the application.

        ii. CPRC shall give thoughtful consideration to the information presented in the Credentialing file, which consideration shall be reflected in the minutes of the CPRC meeting.

        iii. CPRC meetings and decisions may take place in real-time, or as a virtual meeting via telephone or video conference but may not be conducted through e-mail.

5. Practitioner files identified as not meeting Credentialing criteria with exceptions or potential exceptions, which may include serious quality deficiencies that result in the suspension or termination of a practitioner, shall be referred to the CMO or designee for review.

    a. The CMO or Designee shall review each file for practitioners who do not meet Credentialing criteria and make recommendations regarding approving or denying Credentialing of the practitioner to the CPRC. For practitioner files not meeting criteria on an administrative basis only, the file may be approved or denied by the CMO or Designee.

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6. The CPRC shall make a final determination based on the practitioners' ability to deliver care based on the Credentialing information collected from the file review process and that is verified prior to making a Credentialing decision.

    a. The QI Department shall send the practitioner a decision letter within thirty (30) calendar days of the decision indicating:

        i. Acceptance;

        ii. Acceptance with restrictions along with appeal rights information, in accordance with CalOptima Health Policy GG.1616: Fair Hearing Plan for Practitioners; or

        iii. Denial of the application along with appeal rights information, in accordance with CalOptima Health Policy GG.1616: Fair Hearing Plan for Practitioners, with a letter of explanation forwarded to the applicant.

    b. CalOptima Health shall render a final Credentialing decision within one hundred eighty (180) calendar days from the date of the signed attestation that confirms the correctness and completeness of the application.

        i. If CalOptima Health is unable to render a decision within one hundred eighty (180) calendar days from the date of the signed attestation for any practitioner, during the practitioner's Credentialing or Recredentialing process, the practitioner must attest that the information on the application remains correct and complete, by resigning and redating the attestation.

7. If CalOptima Health terminates a practitioner during the Recredentialing process for administrative reasons (*i.e.*, the practitioner failed to provide complete Credentialing information) and not for quality reasons (*i.e.,* medical disciplinary cause or reason), CalOptima Health may reinstate the practitioner within thirty (30) calendar days of termination and is not required to perform initial Credentialing. However, CalOptima Health must re-verify credentials that are no longer within the verification time limit. If the reinstatement would be more than thirty (30) calendar days after termination, CalOptima Health must perform initial Credentialing of such practitioner.

    a. Termination of privileges includes failure or refusal to renew a contract or to renew, extend, or reestablish any staff privileges, if the action is based on medical disciplinary cause or reason.

E. CalOptima Health and Delegates shall monitor and prevent discriminatory practices. Activities, including, but are not limited to:

1. Monitoring:

    a. Conduct periodic audits of Credentialing files (in-process, denied, and approved files) to ensure that practitioners are not discriminated against as set forth in Section II.Q.;

    b. Review practitioner complaints to determine if there are complaints alleging discrimination; and

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c. On a quarterly basis, the QI Department shall review Grievances, Appeals, and potential quality-of-care issues for complaints alleging discrimination and will report outcomes to the CPRC for review and determination.

2. Prevention:

a. The QI Department shall maintain a heterogeneous CPRC and will require those responsible for Credentialing decisions to sign a statement affirming that they do not discriminate.

b. QI Department staff shall remove identifying information, such as name and affiliation, from the practitioner and provider files when presenting cases to CPRC to remove bias and prevent discrimination.

F. Upon acceptance and approval of a Credentialing application, the QI Department shall share the credentialing profile with Contracting, Provider Relations, and Provider Data Management Service (PDMS) Departments. This practitioner profile shall be generated from the Credentialing database to ensure that the information is consistent with data verified during the Credentialing process (*i.e.*, education, training, Board Certification, and specialty). The PDMS Department will enter the contract and Credentialing data into CalOptima Health's core business system and/or will verify the Credentialing data in the system, which updates pertinent information into the online provider directory.

G. Practitioner Screening and Enrollment (Medi-Cal Providers Only)

1. CalOptima Health shall access the California Health and Human Services' (CHHS) Open Data Portal to obtain a list of currently enrolled Medi-Cal fee-for-service (FFS) practitioners or obtain a PED approval letter as an acceptable form of initial enrollment verification conducted by DHCS.

2. If a practitioner is already enrolled with DHCS as a Medi-Cal FFS practitioner, then the practitioner screening and enrollment process does not need to be completed by CalOptima Health.

3. If a practitioner is not already enrolled with DHCS as a Medi-Cal FFS practitioner, then CalOptima Health may complete screening and enrollment established by CalOptima Health.

a. CalOptima Health shall notify DHCS and submit its P&Ps for approval prior to implementation. The P&Ps must define the scope of their enrollment process if CalOptima Health does not enroll all provider types.

b. CalOptima Health shall complete the process and provide the applicant with a written determination on CalOptima Health letterhead within one hundred twenty (120) calendar days of its receipt of a practitioner application.

c. CalOptima Health shall submit a list of its newly enrolled practitioners every six months to CalOptima Health's DHCS Managed Care Operations Division (MCOD) contract manager.

d. CalOptima Health shall collect all the appropriate information, data elements, and supporting documentation required for each provider type and ensure that the application is reviewed for both accuracy and completeness.

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i. CalOptima Health shall inform practitioners seeking to enroll with CalOptima Health of the differences between CalOptima Health's and DHCS's provider enrollment processes, including the practitioner's right to enroll through DHCS, at the time of application. CalOptima Health will provide required disclosures that include, but are not limited to, the following elements:

a) A statement that certain enrollment functions will not be performed by CalOptima Health but will continue to be performed by DHCS, including fingerprinting, criminal background checks, and decisions to deny or terminate enrollment.

b) A notice that some of the enrollment requirements and rights found in the state enrollment process may not be applicable when a practitioner chooses to enroll through CalOptima Health, including provisional practitioner status with Medi-Cal FFS, processing timelines of the enrollment application, and the ability to appeal CalOptima Health's decision to suspend the enrollment process.

c) A provision informing the practitioner that if CalOptima Health receives any information that impacts the practitioner's eligibility for enrollment, CalOptima Health will suspend processing of the practitioner's enrollment application and make the practitioner aware of the option to apply through DHCS' Medi-Cal FFS practitioner enrollment process.

d) A statement clarifying that in order for the practitioner to participate in the Medi-Cal FFS program, the practitioner must enroll through DHCS, and that enrolling through DHCS will also make the practitioner eligible to contract with CalOptima Health.

ii. CalOptima Health may collect an application fee, not to exceed the Medi-Cal FFS enrollment application fee amount.

iii. CalOptima Health shall obtain the practitioner's consent in order to share information relating to the practitioner's application and eligibility with DHCS.

iv. CalOptima Health shall collect and maintain the original signed Medi-Cal Provider Agreement and Network Provider Agreement for each practitioner.

v. CalOptima Health shall maintain all practitioner enrollment documentation in a secure manner to ensure confidentiality of the practitioner's personal information.

vi. Enrollment records shall be made available upon request to DHCS, CMS or other authorized governmental agencies.

e. Practitioners that apply as a partnership, corporation, governmental entity, or nonprofit organization must disclose ownership or control information as required by 42 CFR § 455.104.

i. Practitioners who are unincorporated sole proprietors are not required to disclose the ownership or control information.

ii. Upon CalOptima Health's request, a practitioner must submit within thirty-five (35) calendar days:

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a) Full and complete information about the ownership of any subcontractor with whom the practitioner has had business transactions totaling more than twenty-five thousand dollars ($25,000) during the twelve (12) month period ending on the date of the request; and,

b) Any significant business transactions between the practitioner and any wholly owned supplier, or between the practitioner and any subcontractor, during the five (5)-year period ending on the date of the request.

f. CalOptima Health shall screen initial practitioner applications, including applications for a new practice location, and any applications received in response to a practitioner's reenrollment or revalidation request to determine the practitioner's categorical risk level as limited, moderate, or high.

i. If a practitioner fits within more than one risk level, CalOptima Health must screen the practitioner at the highest risk level.

ii. A practitioner's designated risk level is also affected by findings of license verification, site reviews, checks of suspended and terminated practitioner lists, and criminal background checks.

iii. CalOptima Health shall not enroll a practitioner who fails to comply with the screening criteria for that practitioner's assigned level of risk.

g. Practitioners are subject to screening based on verification of the following requirements:

i. Limited-Risk Practitioners:

a) Meet state and federal requirements;

b) Hold a license certified for practice in the state and has no limitations from other states; and

c) Have no suspensions or terminations on state and federal databases.

ii. Medium-Risk Practitioners:

a) Screening requirements of limited-risk practitioners; and

b) Pre-enrollment and post-enrollment onsite visits to verify that the information submitted to CalOptima Health and DHCS is accurate and to determine compliance with state and federal enrollment requirements.

iii. High-Risk Practitioners:

a) Screening requirements of medium-risk practitioners; and

b) Criminal background checks based in part on a set of fingerprints.

h. CalOptima Health and DHCS shall adjust the categorical risk level when any of the following circumstances occur:

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i. The state imposes a payment suspension on a practitioner based on a credible allegation(s) of Fraud, Waste, or abuse.

ii. The practitioner has an existing Medicaid overpayment based on Fraud, Waste, or abuse.

iii. The practitioner has been excluded by the Office of Inspector General or another state's Medicaid program within the previous ten (10) years, or when a state or federal moratorium on a provider type has been lifted.

iv. The practitioner would have been prevented from applying for enrollment due to a moratorium and the moratorium was lifted in the past six (6) months.

i. Additional criteria for high-risk practitioners

i. Any person with a five percent (5%) or more direct or indirect ownership and is a high-risk applicant or where information discovered in the onsite or data analysis may lead to this type of request.

ii. CalOptima Health shall direct practitioners to fill out Form BCIA 8016 on the California Department of Justice (DOJ) website and ensure that practitioners include the correct agency information on the Live Scan form when submitting their application. The agency-specific information shall include the following information:

Applicant Submission

Field	**Entry**
ORI (Code assigned by DOJ)	CA0341600
Authorized Applicant Type	High Risk Medi-Cal Provider
Type of License/Certification/Permit OR Working Title	MCMC

Contributing Agency Information

Field	**Entry**
Agency Authorized to Receive Criminal Record Information	Department of Health Care Services
Mail Code (Five-digit code assigned by DOJ)	19509
Street Address or PO Box	1700 K Street; MS 2200
Contact Name	MCMC
City	Sacramento
State	CA
ZIP Code	95811
Contact Telephone Number	(916) 750-1509

iii. When fingerprinting is required, CalOptima Health must furnish the practitioners with the Live Scan form and instructions on where to deliver the completed form.

iv. The practitioner must deliver the completed Live Scan form to the California DOJ and is responsible for paying for any Live Scan processing fees.

v. CalOptima Health shall notify DHCS upon initiation of each criminal background check for a practitioner that has been designated as high risk.

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vi. CalOptima Health shall maintain the security and confidentiality of all of the information it receives from DHCS relating to the practitioner's high-risk designation and the results of the criminal background checks.

j. Site Visits

i. CalOptima Health shall conduct pre- and post-enrollment site visits of medium-risk and high-risk practitioners to verify that the information submitted to CalOptima Health and DHCS is accurate and to determine the applicant's compliance with state and federal enrollment requirements.

ii. CalOptima Health shall conduct post-enrollment site visits for medium-risk practitioners at least every five (5) years and their high-risk practitioners every three (3) years or as necessary to verify that the information submitted to CalOptima Health and DHCS is accurate and determine if practitioners are in compliance with state and federal enrollment requirements.

iii. Onsite visits may be conducted for many reasons, including, but not limited to, the following:

a) The practitioner was temporarily suspended from the Medi-Cal program;

b) The practitioner's license was previously suspended;

c) There is conflicting information in the practitioner's enrollment application;

d) There is conflicting information in the practitioner's supporting enrollment documentation; and

e) As part of the practitioner enrollment process, CalOptima Health receives information that raises a suspicion of fraud.

k. Federal and State Database Checks

i. CalOptima Health shall check the following databases to verify the identity and determine the exclusion and/or enrollment status of all practitioners:

a) Social Security Administration's Death Master File;

b) National Plan and Provider Enumeration System (NPPES);

c) List of Excluded Individuals/Entities (LEIE);

d) System for Award Management (SAM);

e) CMS' Medicare Exclusion Database (MED);

f) DHCS' Suspended and Ineligible Provider List;

g) Restricted Provider Database (RPD); and

h) CHHS Open Data Portal.

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ii. CalOptima Health shall also review the SAM, LEIE, and RPD databases on a regular basis, and at least monthly, to ensure that contracted practitioners continue to meet enrollment criteria and take appropriate action in connection with the exclusion.

iii. Any practitioners terminated from the Medicare or Medicaid/Medi-Cal program may not participate in CalOptima Health's practitioner network.

l. If CalOptima Health declines to enroll a practitioner, it must refer the practitioner to DHCS for further enrollment options.

m. If CalOptima Health acquires information, either before or after enrollment, that may impact the practitioner's eligibility to participate in the Medi-Cal program, or a practitioner refuses to submit to the required screening activities, CalOptima Health may decline to accept that practitioner's application.

n. If at any time CalOptima Health determines that it does not want to contract with a prospective practitioner, and/or that the prospective practitioner will not meet enrollment requirements, CalOptima Health must immediately suspend the enrollment process of that practitioner.

o. CalOptima Health is not obligated to establish an appeal process for screening and enrollment decisions. Practitioners may only appeal a suspension or termination to DHCS when the suspension or termination occurs as part of DHCS' denial of the Medi-Cal FFS enrollment application.

p. All practitioners must resubmit and recertify the accuracy of their enrollment information as part of the revalidation process at least every five (5) years to ensure that all enrollment information is accurate and up-to-date.

q. CalOptima Health shall retain all practitioner screening and enrollment materials and documents for ten (10) years.

r. CalOptima Health shall make all screening and enrollment documents and materials promptly available to DHCS, CMS, and any other authorized governmental entities upon request.

IV. ATTACHMENT(S)

A. CalOptima Health Primary Source Verification Table

V. REFERENCE(S)

A. California Business and Professions Code §§ 805, 2837.103, 2837.104 and 3500-3502.3
B. California Evidence Code § 1157
C. California Health & Safety Code § 1374.197
D. CalOptima Health Contract for Health Care Services
E. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
F. CalOptima Health Contract with Covered California
G. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
H. CalOptima Health PACE Program Agreements
I. CalOptima Health Policy GG.1213: Community Health Worker Services

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J. CalOptima Health Policy GG.1406: Pharmacy Network: Credentialing and Access
K. CalOptima Health Policy GG.1602: Non-Physician Medical Practitioner (NMP) Scope of Practice
L. CalOptima Health Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities
M. CalOptima Health Policy GG.1607: Monitoring Adverse Actions
N. CalOptima Health Policy GG.1608: Full Scope Site Reviews
O. CalOptima Health Policy GG.1616: Fair Hearing Plan for Practitioners
P. CalOptima Health Policy GG.1619: Delegation Oversight
Q. CalOptima Health Policy GG.1633: Board Certification Requirements for Physicians
R. CalOptima Health Policy GG.1643: Minimum Provider Credentialing Standards
S. CalOptima Health Policy GG.1651: Assessment and Re-Assessment of Organizational Providers
T. CalOptima Health Policy GG.1659: System Controls of Provider Credentialing Information
U. CalOptima Health Policy GG.1707: Doula Services
V. CalOptima Health Policy HH.1101: CalOptima Health Provider Complaint
W. CalOptima Health Policy MA.9006: Provider Complaint Process
X. Department of Health Care Services (DHCS) All Plan Letter (APL) 16-009: Adult Immunizations as a Pharmacy Benefit (Revised 12/23/2016)
U. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-013: Provider Credentialing / Recredentialing and Screening / Enrollment (Revised 08/24/2022)
V. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-024: Doula Services (Supersedes APL 22-031) (Revised 11/03/2023)
W. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-002: Medi-Cal Managed Care Plan Responsibilities for Indian health Care Providers and American Indian Members
X. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-006: Community Health Worker Services Benefit (Supersedes APL 22-016)
Y. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-015: California Children's Services Whole Child Model Program (Supersedes APL 23-034)
U. Medicare Managed Care Manual, Chapter 6: Relationships with Providers
V. National Committee for Quality Assurance (NCQA) Standards and Guidelines
W. Title 42, Code of Federal Regulations (CFR), §§ 422.204(a), 422.205, 438.12, 438.214, 460.64, 460.71, and Part 455, Subpart E
X. Title 42, United States Code (USC), §1320a-7(a)
Y. Title XVIII and XIV of the Social Security Act

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
04/28/2015	Department of Health Care Services (DHCS)	Approved as Submitted
09/20/2018	Department of Health Care Services (DHCS)	Approved as Submitted
10/13/2020	Department of Health Care Services (DHCS)	No Reply 60 Days
05/05/2022	Department of Health Care Services (DHCS)	Approved as Submitted
10/26/2022	Department of Health Care Services (DHCS)	Approved as Submitted
01/09/2023	Department of Health Care Services (DHCS)	Approved as Submitted
07/11/2023	Department of Health Care Services (DHCS)	Approved as Submitted
06/13/2024	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

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Date	Meeting
06/01/2017	Regular Meeting of the CalOptima Board of Directors
09/06/2018	Regular Meeting of the CalOptima Board of Directors
10/01/2020	Regular Meeting of the CalOptima Board of Directors
04/07/2022	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	06/01/2017	GG.1650	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	01/01/2018	GG.1650	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	09/06/2018	GG.1650	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	02/01/2019	GG.1650	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	10/01/2020	GG.1650	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	04/07/2022	GG.1650	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	GG.1650	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare PACE
Revised	04/01/2023	GG.1650	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare PACE
Revised	05/01/2024	GG.1650	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare PACE
Revised	04/01/2025	GG.1650	Credentialing and Recredentialing of Practitioners	Covered California Medi-Cal OneCare PACE

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Action	Date	Policy	Policy Title	Program(s)
Revised	05/01/2025	GG.1650	Credentialing and Recredentialing of Practitioners	Covered California Medi-Cal OneCare PACE
Revised	08/01/2025	GG.1650	Credentialing and Recredentialing of Practitioners	Covered California Medi-Cal OneCare PACE

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IX. GLOSSARY

Term	Definition
Abuse	Covered California: Excessive, or improper use of something, or the use of something in a manner contrary to the natural or legal rules for its use; the intentional destruction, diversion, manipulation, misapplication, maltreatment, or misuse of resources; or extravagant or excessive use to abuse one's position or authority. Often, the terms fraud and abuse are used simultaneously with the primary distinction is the intent. Inappropriate practices that begin as abuse can quickly evolve into fraud. Abuse can occur in financial or non-financial settings. Examples of abuse include excessive charges, improper billing practices, payment for services that do not meet recognized standards of care and payment for medically unnecessary services. Medi-Cal: Practices that are inconsistent with sound fiscal and business practices or medical standards, and result in an unnecessary cost to the Medi-Cal program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to the Medi-Cal program. OneCare: A Provider practice that is inconsistent with sound fiscal, business, or medical practice, and results in an unnecessary cost to CalOptima Health and the OneCare program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to CalOptima Health and the OneCare program.
Appeal (Member)	Covered California: A review by CalOptima Health of an adverse benefit determination, which includes one of the following actions: 1. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a service; 4. Failure to provide services in a timely manner; or 5. Failure to act within the required timeframes for standard and expedited resolution of grievances and appeals in accordance with Health & Safety Code § 1368. Medi-Cal: A review by CalOptima Health of an adverse benefit determination, which includes one of the following actions: 1. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a service;

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Term	Definition
	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. PACE: A Member's action taken with respect to the PACE organization's noncoverage of, modification of, or nonpayment for, a service including denials, reductions or termination of services, as defined by federal PACE regulation 42 CFR § 460.122.
Behavioral Health Provider	A licensed practitioner including, but not limited to, physicians, nurse specialists, psychiatric nurse practitioners, licensed psychologists (PhD or PsyD), licensed clinical social worker (LCSW), marriage and family therapist (MFT or MFCC), professional clinical counselors and qualified autism service providers, furnishing covered services.
Board Certification/Certified	Certification of a physician by one (1) of the boards recognized by the American Board of Medical Specialties (ABMS), or American Osteopathic Association (AOA), as meeting the requirements of that board for certification.
Covered California: *Effective 01/01/2027 for CalOptima Health*	The California Health Benefit Exchange, doing business as Covered California and an independent entity within the Government of the State.
Credentialing	Covered California: The initial process by which the qualifications of a Provider is verified in order to make a determination relating to the Provider's eligibility for participation in CalOptima Health's programs. Medi-Cal: The process of determining a Provider or an entity's professional or technical competence, and may include registration, certification, licensure and professional association membership. OneCare: The process of obtaining, verifying, assessing, and monitoring the qualifications of a Provider to provide quality and safe patient care services. PACE: The recognition of professional or technical competence. The process involved may include registration, certification, licensure, and professional association membership.
Credentialing and Peer Review Committee (CPRC)	The Credentialing and Peer Review (CPRC) Committee makes decisions, provides guidance, and provides peer input into the CalOptima provider selection process and determines corrective action necessary to ensure that all practitioners and providers who provide services to CalOptima Members meet generally accepted standards for their profession in the industry. The CPRC

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Term	Definition
	meets at least quarterly and reports to the CalOptima Quality Improvement (QI) Committee.
Credentialing Verification Organization (CVO)	For purposes of this policy, an organization that collects and verifies Credentialing information.
Delegate	An organization or entity granted authority to perform an activity on behalf of CalOptima within agreed-upon parameters. Any party that enters into an acceptable written arrangement below the level of the arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Facility Site Review (FSR)	A DHCS tool utilized to assess the quality, safety and accessibility of primary care physicians (PCPs) and high-volume specialist physician offices.
Federally Qualified Health Center (FQHC)	A type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. An FQHC must be a public entity or a private non-profit organization. FQHCs must provide primary care services for all age groups.
Fraud	An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law, in accordance with Title 42 CFR § 455.2, Welfare and Institutions Code § 14043.1(i).
Grievance	Covered California: A written or oral expression of dissatisfaction regarding CalOptima Health, a Health Network, or a Provider, including quality of care concerns, Member's complaint about a delay or denial of payment on a claim, and shall include a complaint, dispute, request for reconsideration or Appeal made by a Member or the Member's representative. A complaint is the same as a Grievance. An inquiry is a request for more information that does not include an expression of dissatisfaction, including, but not limited to, questions pertaining to eligibility, benefits, or other CalOptima Health processes. If CalOptima Health is unable to distinguish between a Grievance and an inquiry, it must be considered a Grievance. Medi-Cal: 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. OneCare: An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken.

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Term	Definition
	PACE: A complaint, either written or oral, expressing dissatisfaction with service delivery or the quality of care furnished, as defined by the federal PACE regulation 42 CFR § 460.120.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, health care service plan, such as a Health Maintenance Organization (HMO), Subcontractor, or First Tier Entity, that contracts with CalOptima Health to provide Covered Services to Members.
HIV/AIDS Specialist	A physician who holds a valid, unrevoked and unsuspended certificate to practice medicine in the state of California who meets any one of the following four (4) criteria: 1. Is credentialed as an "HIV Specialist" by the American Academy of HIV Medicine; 2. Is board certified, or has earned a Certificate of Added Qualification, in the field of HIV medicine granted by a member board of the American Board of Medical Specialties, should a member board of that organization establish board certification, or a Certificate of Added Qualification, in the field of HIV medicine; 3. Is board certified in the field of infectious diseases by a member board of the American Board of Medical Specialties and meets the following qualifications: (A) In the immediately preceding 12 months has clinically managed medical care to a minimum of 25 patients who are infected with HIV; and (B) In the immediately preceding 12 months has successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients, including a minimum of 5 hours related to antiretroviral therapy per year; or 4. Meets the following qualifications: (A) In the immediately preceding 24 months has clinically managed medical care to a minimum of 20 patients who are infected with HIV; and (B) Has completed any of the following: 1. In the immediately preceding 12 months has obtained board certification or recertification in the field of infectious diseases from a member board of the American Board of Medical Specialties; or 2. In the immediately preceding 12 months has successfully completed a minimum of 30 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients; or 3. In the immediately preceding 12 months has successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients and has successfully completed the HIV Medicine Competency Maintenance Examination administered by the American Academy of HIV medicine.
Indian Health Care Provider (IHCP)	A health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (IHCIA) at 25 USC § 1603.
Medical Record Review (MRR)	A DHCS tool utilized to audit PCP medical records for format, legal protocols, and documented evidence of the provision of preventive care and coordination and continuity of care services.
Member	An individual enrolled in a CalOptima program.

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Term	Definition
Minimum Physician Standards	Minimum standards that must be met in order for a Physician to be credentialed and contracted for participation in CalOptima programs.
Non-Physician Medical Practitioner (NMP)	A licensed practitioner, including but not limited to, a Nurse Practitioner (NP), Certified Nurse Midwife (CNM), Licensed Midwife (LM), Certified Nurse Specialists (CNS), Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), Speech Therapist (ST), or Audiologist furnishing covered services.
Organized Health Care System	Includes a licensed clinic as described in Chapter 1 (commencing with Section 1200) of Division 2 of the Health and Safety Code, an outpatient setting as described in Chapter 1.3 (commencing with Section 1248) of Division 2 of the Health and Safety Code, a health facility as described in Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code, a county medical facility as described in Chapter 2.5 (commencing with Section 1440) of Division 2 of the Health and Safety Code, an accountable care organization, a home health agency, a physician's office, a professional medical corporation, a medical partnership, a medical foundation, and any other entity that lawfully provides medical services and is in compliance with Article 18 (commencing with Section 2400) of Chapter 5.
Pharmacy Benefit Manager (PBM)	The entity that performs certain functions and tasks including, but not limited to, pharmacy Credentialing, contracting, and claims processing in accordance with the terms and conditions of the PBM Services Agreement.
Physical Accessibility Review Survey (PARS)	A DHCS tool used to assess the level of physical accessibility of provider sites, including specialist and ancillary service providers.
Physician Practitioner	A licensed practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), furnishing covered services.
Practice Agreement	The writing, developed through collaboration among one or more physicians and surgeons and one or more physician assistants, that defines the medical services the physician assistant is authorized to perform pursuant to BPC § 3502 and that grants approval for physicians and surgeons on the staff of an Organized Health Care System to supervise one or more physician assistants in the Organized Health Care System. Any reference to a delegation of services agreement relating to physician assistants in any other law shall have the same meaning as a Practice Agreement.
Primary Care	For purposes of this policy, a basic level of health care usually rendered in an ambulatory setting by a PCP.
Recredentialing	The process by which the qualifications of practitioners is verified in order to make determinations relating to their continued eligibility for participation in the CalOptima program.
Specialty Care	For purposes of this policy, specialty care given to Members by referral by other than a PCP.
Telehealth	The mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management and self-management of a Member's health care while the Member is at the originating site, and the health care provider is at a distant site. Telehealth facilitates Member self-management and caregiver support for Members and includes synchronous interactions and asynchronous store and forward transfers.

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Term	Definition
Utilization Management (UM)	Requirements or limits on coverage. UM may include, but is not limited to, prior authorization, quantity limit, or step therapy restrictions.
Waste	Covered California: Intentional or unintentional, extravagant careless or needless expenditures, consumption, mismanagement, use, or squandering of resources, to the detriment or potential detriment of entities, but without an intent to deceive or misrepresent. Waste includes incurring unnecessary costs because of inefficient or ineffective practices, systems, decisions, or controls. Medi-Cal: The overutilization or inappropriate utilization of services and misuse of resources, and typically is not a criminal or intentional act, as stated in CMS' Fraud, Waste, and Abuse Toolkit. OneCare: The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Health Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

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CalOptima Health Primary Source Verification Table

Primary Source Verification – Licensure

Licensure	Source of Verification	Method of Verification
MD – Medical Board of California	https://search.dca.ca.gov/ https://www.mbc.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
DO- Osteopathic Board of California	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
DC- California Board of Chiropractic	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
DDS- Dental Board of California	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
DPM- California Board of Podiatric Medicine	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
California Board of Psychology	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
California Board of Behavioral Sciences	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.

CalOptima Health Primary Source Verification Table

Department of Consumer Affairs Acupuncture Board	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
Department of Consumer Affairs CA State Board of Optometry	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
California Board of Registered Nursing	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
California Department of Consumer Affairs. Physician Assistant Board	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
Physical Therapy Board of California	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
Department of Consumer Affairs California Board of Occupational Therapy	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.

Department of Consumer affairs Speech-Language Pathology & Audiology & Hearing Aid Dispensers Board	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.

CalOptima Health Primary Source Verification Table

Primary Source Verification – DEA

	Source of Verification	Method of Verification
DEA	https://apps.deadiversion.usdoj.gov/RDA/ **Login and Password required	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	Copy of current DEA certificate	Visual inspection of certificate and stored in Credentialing database.

Primary Source Verification – Board Certification

Certification	Source of Verification	Method of Verification
Board Certification	American Board of Medical Specialties https://certifacts.abms.org/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	American Osteopathic Association (AOA) https://osteopathic.org/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	American Board of Professional Psychology https://www.abpp.org/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated

CalOptima Health Primary Source Verification Table

	American Board of Foot and Ankle Surgery (ABFAS) https://www.abfas.org/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	American Board of Oral and Maxillofacial Surgery (ABOMS) https://www.aboms.org/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
Nursing Board	Nursing Board Certification for Nurse Practitioners/Advance Practice Nurses American Academy of Nurse Practitioners Certification Board (AANPCB) www.aanpcert.org/ American Nursing Credentialing Center (ANCC) https://www.nursingworld.org/ancc/ National Certification Corporation (NCC) www.nccwebsite.org	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	Pediatric Nursing Certification Board (PNCB) www.pncb.org American Association of Critical Care Nurses (AACN) www.aacn.org	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
Midwifery	American Midwifery Certification Board (AMCB) http://www.amcbmidwife.org/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.

CalOptima Health Primary Source Verification Table

Physician Assistant	National Commission on Certification of PA's (NCCPA) https://portal.nccpa.net/verifypac	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.

Primary Source Verification – Education & Training

Education	Source of Verification	Method of Verification
Education & Training	Board certification by ABMS or AOIA in practicing specialty	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	American Board of Multiple Specialties in Podiatry. http://abmsp.org/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	AMA Physician Master File https://www.ama-assn.org/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	AOIA Official Osteopathic Physician Profile Report https://www.aoaprofiles.org/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	Contact the training institution to verify the highest level of training; or State Licensing Agency, as applicable	Letter from institution is reviewed and stored in Credentialing database. All sources are electronically tracked and dated.

CalOptima Health Primary Source Verification Table

	National Student Clearing House http://nscverifications.org/welcome-toverification-serives/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	National Board of Physicians and Surgeons (NBPAS) https://nbpas.org/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.

Primary Source Verification – Malpractice History

Malpractice Information	Source of Verification	Method of Verification
Malpractice History	National Practitioner Data Bank (NPDB) https://www.npdb.hrsa.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.

Primary Source Verification –Sanctions and other sources

Sanction Information	Source of Verification	Method of Verification
State & Federal Sanctions and Other Sources	National Practitioner Data Bank (NPDB) https://www.npdb.hrsa.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	System for Award Management-SAM https://sam.gov/search/?index=_all&page=1&sort=modifiedDate&sfm%5Bstatus%5D%5Bis_active%5D=true	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	Office of Inspector General https://exclusions.oig.hhs.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.

CalOptima Health Primary Source Verification Table

State & Federal Sanctions and Other Sources	Medi-Cal Suspended & Ineligible List https://files.medi Provider Suspended and Ineligible List (S&I List) - Provider Suspended and Ineligible List (S&I List) - California Open Data	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	CMS Preclusion List https://portal.cms.gov/wps/portal/unauthportal/home/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	Drug Code Limitation Listing of practitioners and/or medical groups placed on P/DCL sanction, https://files.medi-cal.ca.gov/pubsdoco/pdcl_home.aspx	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	Department of Health Care Service (DHCS)- Restricted Provider Database	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	CMS.gov Centers for Medicare & Medicaid Services – Medicare Opt-Out Physicians https://www.cms.gov/Medicare/ Provider-EnrollmentandCertification/MedicareProviderSupEnroll/OptOutAffidavits.html	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	For a listing of all physicians and practitioners that are currently opted out of Medicare: https://data.cms.gov/tools/provideropt-out-affidavits-look-up-tool https://data.cms.gov/provider-characteristics/medicare-provider-supplier-enrollment/opt-out-affidavits/data	

CalOptima Health Primary Source Verification Table

Other Sanction Sources	AMA Physician Master File	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	AOIA Physician Profile report	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.

Screening and Enrollment

Sanction Information	Source of Verification	Method of Verification
Social Security Death Master File (DMF). National Technical Information Services (NTIS) is the only authorized official distributor of the Death Master file on the web.	**Social Security Death Master File (DMF) Website** https://evoconportal.com/dmfportal/login.php **National Technical Information Services (NTIS)** https://classic.ntis.gov/products/ssa-dmf/#	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
National Plan and Provider Enumeration System (NPPES)	https://nppes.cms.hhs.gov/NPPES/Welcome.do Search NPI Records https://npiregistry.cms.hhs.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.

CalOptima Health Primary Source Verification Table

List of Excluded Individuals/Entities (LEIE)	Office of Inspector General https://exclusions.oig.hhs.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.

System for Award Management (SAM)	System for Award Management-SAM https://sam.gov/search/?index= all&page= 1&sort=modifiedDate&sfm%5Bstatus%5D% 5Bis active%5D=true	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
CMS' Medicare Exclusion Database (MED)	CMS Preclusion List https://portal.cms.gov/wps/portal/unauthpo rtal/home/ Receive from IS Dept	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
DHCS' Suspended and Ineligible Provider List	Medi-Cal Suspended & Ineligible List - c Provider Suspended and Ineligible List (S&I List) - Provider Suspended and Ineligible List (S&I List) - California Open Data	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
Restricted Provider Database (RPD)	Department of Health Care Service (DHCS)- Restricted Provider Database Receive from IS Dept	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.

CalOptima Health Primary Source Verification Table

CHHS Open Data Portal (Medical Enrollment)	Medi Cal FFS Provider Listing | Medi Cal FFS Provider Listing | DHCS GIS Data Hub (arcgis.com)	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.

Ordering, referring, and prescribing (ORP)	https://mcweb.apps.prd.cammis.medi-cal.ca.gov/orp	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.

Policy:	GG.1651
Title:	**Assessment and Reassessment of Organizational Providers**
Department:	Medical Management
Section:	Quality Improvement
CEO Approval:	*/s/*
Effective Date:	06/01/2017
Revised Date:	08/01/2025
Applicable to:	☐ Administrative ☒ Covered California [Effective 2027] ☒ Medi-Cal ☒ OneCare ☒ PACE

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I. PURPOSE

This policy describes the process by which CalOptima Health evaluates and determines a Provider, including an Organizational Provider (OP), rendering consolidated, facility-based services and/or billing for health care services not directly rendered and billed by a professional Provider, eligibility to participate in CalOptima Health programs.

II. POLICY

A. CalOptima Health shall establish guidelines for evaluation of OPs participation eligibility in CalOptima Health programs, in accordance with applicable laws, regulations, and regulatory guidance.

B. CalOptima Health may delegate authority to perform Medi-Cal screening and enrollment activities to a Health Network or Delegate. If CalOptima Health chooses to delegate this function, the follow shall occur:

1. The delegation shall be in a written subcontract or agreement, where CalOptima Health remains contractually responsible for the completeness and accuracy of the screening and enrollment activities.

2. CalOptima Health shall evaluate the Health Network or Delegate's ability to perform these activities, including an initial review to ensure that the Health Network or Delegate has the administrative capacity, experience, and budgetary resources to fulfill its responsibilities.

3. CalOptima Health shall continuously monitor, evaluate, and approve the delegated functions.

4. CalOptima Health shall notify the Department of Health Care Services (DHCS) sixty (60) calendar days prior to delegating the screening and enrollment to a Health Network or Delegate and shall submit policies and procedures (P&Ps) that outline the delegation authority, as well as CalOptima Health's monitoring and oversight activities.

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C. CalOptima Health may delegate the Assessment and Reassessment of OPs to a Delegate or Credentialing Verification Organization, in accordance with CalOptima Health Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities.

1. Credentialing Delegate shall perform delegated Credentialing functions that, at minimum, meet the requirements as outlined in this policy.

D. The Chief Medical Officer (CMO) or Designee shall have direct responsibility over and shall actively participate in the assessment and Reassessment of an OP.

E. The CalOptima Health Credentialing and Peer Review Committee (CPRC) shall be responsible for reviewing an OP's application information and CalOptima Health's findings for determining an OP's participation in CalOptima Health's Provider network.

F. CalOptima Health shall assess or reassess ~~Ops~~OPs, including, but not limited to, the following:

1. Acute Rehabilitation Facilities;
2. Behavioral Health Facility/Substance Abuse Providers (Inpatient, Residential or Ambulatory);
3. Birthing Centers;
4. Certified Hospice Providers;
5. Chronic Dialysis Clinic;
6. Clinical/Medical Laboratory;
7. Community Based Adult Services (CBAS) Providers;
8. Community Clinic;
9. Dialysis (End-Stage Renal Disease) Center/Facility;
10. Customized/Durable Medical Equipment (DME) Providers;
11. Federally Qualified Health Clinic;
12. Free Clinic;
13. Health Access Program;
14. Home Health Agencies;
15. Hospice and Palliative Care Providers;
16. Hospitals;
17. Indian Health Care Providers or Facilities;
18. Intermediate Care Facilities for the Developmentally Disabled (ICF/DD);
19. Emergency/Non-Emergency and Medical/Non-Medical Ground Transportation;

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i. For Transportation Network Companies (TNC), CalOptima Health is not responsible for Credentialing drivers, in accordance with DHCS All Plan Letter (APL) 22-008: Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses.

20. Non-Emergency Medical Transportation;

21. Prosthetics and Orthotics;

22. Qualified Autism Services (QAS) also known as Applied Behavior Analysis (ABA) Groups;

~~22.~~23. Radiology Center (Free Standing);

~~23.~~24. Rehabilitation Center/Clinic (Outpatient for Physical Therapy, Occupational Therapy, and Speech Pathology);

~~24.~~25. Religious Non-Medical Health Care Institution;

~~25.~~26. Residential Care Facilities for the Elderly;

~~26.~~27. Rural Health Clinic;

~~27.~~28. Skilled Nursing Facilities/Long Term Care Facility;

~~28.~~29. Surgical Center (Free Standing);

~~29.~~30. Transplant Programs (Organ Procurement Organization); and

~~30.~~31. Urgent Care Center (Free Standing).

G. CalOptima Health and Delegates shall ensure that any Provider in its Medi-Cal provider network for whose provider type has an enrollment pathway with DHCS, including ordering, referring and prescribing Providers, is screened and enrolled with DHCS in the Medi-Cal program in accordance with DHCS APL 22-013: Provider Credentialing/Recredentialing and Screening/Enrollment, including any superseding APL, and Title 42, CFR, Part 455, and as described in Sections III.A. and III.B. of this Policy.

1. State-level enrollment pathways are available either through the DHCS Provider Enrollment Division (PED) or another state department with a recognized enrollment pathway.

2. CalOptima Health may enroll providers through the screening and enrollment process outlined in Section III.E, in compliance with DHCS requirements, or CalOptima Health may direct network Providers to enroll through a state-level enrollment pathway.

3. Providers that do not have a state-level enrollment pathway do not need to be enrolled with Medi-Cal but must comply with CalOptima Health's vetting process.

4. Provider enrollment requirements shall be waived for Letters of Agreement (LOA), or single-case agreements with out-of-state transplant programs.

H. Providers in the Medi-Cal provider network not having a corresponding state-level enrollment pathway, including but not limited to Community Supports Providers (*e.g.*, housing agencies, medically tailored meal programs), ~~Applied Behavioral Analysis Providers,~~ and certain Enhanced Care Management (ECM) Providers, are not required to enroll in the Medi-Cal program and

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CalOptima Health shall vet the qualifications of the Provider or Provider organization to ensure Providers have:

1. Sufficient experience to provide services similar to the specific service for which they are contracted to provide within the service area;

2. Business licensing that meets industry standards;

3. History of fraud, waste, and/or abuse;

4. Recent history of criminal activity, including a history of criminal activities that endanger Members and/or their families; and

5. History of liability claims against the Provider.

I. CalOptima Health and Delegates may allow Providers in its Medi-Cal provider network to participate in the network for up to one hundred twenty (120) calendar days if the Provider has a pending enrollment application in review with DHCS' PED or a DHCS approved screening and enrollment process.

1. CalOptima Health and Delegates shall terminate its contract with the Provider no later than fifteen (15) calendar days of the Provider receiving notification from DHCS that the Provider has been denied enrollment of the Medi-Cal program, or upon the expiration of the first one hundred twenty (120) calendar day period.

2. CalOptima Health and Delegates shall not continue to contract with a Provider during the period in which the Provider resubmits its enrollment application to DHCS or approved screening and enrollment process and shall only re-initiate a contract upon the Provider's successful enrollment as a Medi-Cal Provider.

3. If the Provider termination impacts Member access, CalOptima Health shall notify DHCS prior to terminating the Provider and shall submit a plan of action for continuity of services for review and approval before the termination.

J. CalOptima Health and Delegates shall require that the OP be successfully assessed prior to contracting and every three (3) years thereafter, except as otherwise specified in this policy.

1. CalOptima Health and Delegates shall confirm that the OP is in good standing with state and federal regulatory agencies,

2. CalOptima Health and Delegates shall require OPs to be reviewed and approved by an accrediting body or have received an on-site quality assessment consistent with the provisions of this policy if the Provider is not accredited, as applicable.

K. Upon initial assessment, Reassessment, and on a monthly basis if required, CalOptima Health and Delegates shall confirm ~~the Medi-Cal and Medicare participation status of the OP.~~ :

1. Medi-Cal participation status of the OP and

2. Medicare participation status for the following OPs:

a. Hospitals;

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b. Home Health Agencies (HHAs);

c. Hospices;

d. Clinical Laboratories;

e. Skilled Nursing Facilities (SNFs);

f. Comprehensive Outpatient Rehabilitation Facilities (CORFs);

g. Outpatient Physical Therapy and Speech Pathology Providers;

h. Ambulatory Surgical Centers (ASCs);

i. Providers of end-stage renal disease services;

j. Providers of outpatient diabetes self-management training;

k. Portable x-ray suppliers;

l. Rural health Clinic (RHCs); and

m. Federally Qualified Health Center (FQHCs).

L. If an OP is denied approval to participate in the CalOptima Health Provider network, CalOptima Health or Delegates shall notify, in writing, such OP within thirty (30) calendar days of the reason for its decision. An OP shall have the right to file a complaint about the decision in accordance with CalOptima Health Policies HH.1101: CalOptima Health Provider Complaint and MA.9006: Contracted Provider Complaint Process, as applicable.

M. CalOptima Health and Delegates shall maintain the confidentiality of Credentialing files, in accordance with CalOptima Health Policy GG.1659: System Controls of Provider Credentialing.

III. PROCEDURE

A. OP Initial Assessment

1. Upon notification of an intent to contract, CalOptima Health and Delegates shall confirm the OP is in good standing with state and/or federal regulatory agencies based on an examination of the sources listed in Section III.A.2. of this policy.

2. The OP shall submit an application, signed, and dated by an authorized official of the OP, along with the following supplemental documentation:

a. OPs shall include a roster listing the Practitioners associated with the OP, where applicable, as part of the application;

b. OPs shall ensure that all information included in the assessment application is no more than six (6) months old;

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i. CalOptima Health and Delegates shall return an incomplete application to an OP, and such incomplete application will not be processed until the OP submits all the required information.

ii. If the required information is not received within sixty (60) calendar days of the date of initial receipt of application, CalOptima Health shall consider the application withdrawn and will close the Credentialing file, if applicable.

iii. If an application has been withdrawn and the applicant wishes to apply to be credentialed, a new application must be submitted to CalOptima Health.

c. Confirmation that the OP is compliant with any other applicable state or federal requirements and possesses a business license (or business tax certificate), as applicable.

d. Accreditation and/or government-issued certification from the following entities, as applicable:

i. The Joint Commission certificate of accreditation, or another Centers for Medicare & Medicaid Services (CMS)-deemed accreditation organization for hospitals, ambulatory surgery centers, skilled nursing facilities, and home health agencies;

ii. Accreditation Association for Ambulatory Health Care (AAAHC) for outpatient settings, including ambulatory surgery centers, office-based surgery facilities, endoscopy centers, medical and dental group practices, community health centers, and retail clinics;

iii. Commission on Accreditation of Rehabilitation Facilities (CARF) for aging services, behavioral health, child and youth services, vision rehabilitation services, medical rehabilitation, Durable Medical Equipment, prosthetics and orthotics supplies, and opioid treatment programs;

iv. Community Health Accreditation Program (CHAP) for home health agencies, hospice Providers, pharmacies, home medical equipment suppliers, private duty nursing, palliative care, and infusion therapy nursing;

v. American Board for Certification (ABC) for prosthetists, orthotists, and pedorthists;

vi. American Speech-Language-Hearing Association (ASHA) for speech, language, hearing, and audiology certification;

vii. DME or Durable Medical Equipment Prosthetics Orthotics Supplier (DMEPOS) Accreditation Commission for Health Care, Inc. (ACHC);

viii. Commission on Accreditation of Ambulance Services (CAAS) for ambulance organizations;

ix. College of American Pathologist (CAP) for laboratories, biorepositories, and reproductive laboratories;

x. Healthcare Quality Association on Accreditation (HQAA) for home medical equipment suppliers, DMEPOS, and pharmacies;

xi. Inter-Societal Accreditation Commission (IAC) for radiology or diagnostic imaging Providers, and procedure-based modalities;

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xii. Det Norske Veritas Germanischer Lloyd (DNV GL)-Health Care for hospitals;

xiii. National Dialysis Accreditation Commission (NDAC) for the accreditation of end state renal disease facilities; and

xiv. The California Department of Public Health (CDPH) for hospitals, ambulatory surgery centers, home health agencies, hospices, dialysis centers, Community Based Adult Services centers, skilled nursing facilities, Federal Qualified Health Centers verifications.

e. If an OP is not accredited, CalOptima Health shall conduct an on-site quality review with criteria for each type of Provider used for the assessment, and the process for ensuring that the Providers credential their Practitioners;

i. The Provider may submit evidence of a CMS or state quality review in lieu of a site visit.

a) The CMS or state quality review must be no more than three (3) years old. If the review is older than three (3) years, then CalOptima Health shall conduct its own onsite quality review.

ii. If a Provider has satellite facilities that follow the same policies and procedures as the Provider, the site visits may be limited to a main facility.

f. Certificate of current professional liability insurance of at least the minimum amounts required by provider type per the Contract for Health Care Services, as applicable;

g. A copy of any history of sanctions, preclusions, exclusions, suspensions, or terminations from Medicare and/or Medi-Cal, as applicable;

h. A copy of the PED certificate validating active enrollment in Medi-Cal, if applicable;

i. Active panels with the California Children's Services Program, if applicable;

j. Staff roster and copy of all staff certifications, or licensure, if applicable;

k. A valid Type 2 National Provider Identifier (NPI) number; and

l. All contracted laboratory-testing sites must have either a Clinical Laboratory Improvement Act (CLIA) certificate or waiver of a certificate of registration along with a CLIA identification number.

3. CalOptima Health shall conduct and communicate the results of a Facility Site Review (FSR) for community clinics and free-standing urgent care centers in providing services to Members in CalOptima Health's Medi-Cal provider network pursuant to CalOptima Health Policy GG.1608: Full Scope Site Reviews to incorporate the documents to support review prior to approval decisions.

4. All participation applications shall be signed. Faxed, digital, electronic, scanned, or photocopied signatures are acceptable; however, signature stamps are not acceptable.

5. CalOptima Health or Delegates shall review the history of professional liability claims that resulted in settlements or judgements paid by, or on behalf of, the OP in the last five (5) years.

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B. Intermediate Care Facility for the Developmentally Disabled (ICF/DD) Assessment

1. Requirements for an Intermediate Care Facility for the Developmentally Disabled (ICF/DD) seeking to participate in CalOptima Health's Medi-Cal program:

   a. A CalOptima Health Ancillary Facility Network Provider Application, also known as the OP application, in accordance with Section III.A.2. of this policy.

   b. An ICF/DD Attestation, in accordance with DHCS APL 24-011: Intermediate Care Facilities for Individuals with Developmental Disabilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care, or superseding APL, signed under penalty of perjury attesting that the following Credentialing requirements are satisfied:

      i. Completion of the CalOptima Health Provider training within the last two (2) years;

      ii. A facility site audit from a state agency;

      iii. No change in five percent (5%) ownership disclosure;

      iv. Possession of an active CDPH license and CMS certification; and

      v. In good standing as a Regional Center vendor.

   c. W-9 request for taxpayer identification number and certification.

   d. City or county business license (excluding ICF/DD-H and N homes with six (6) or less residents)

   e. Certificate of insurance for professional and general liability of at least the minimum amounts required by Provider type, in accordance with the DHCS contract for Medi-Cal, as applicable.

C. OP Reassessment

1. CalOptima Health or Delegates shall reassess an OP at least every three (3) years after initial assessment. At the time of Reassessment, CalOptima Health shall:

   a. Collect and/or verify, at a minimum, all of the information required for initial assessment as set forth in Section III.A. of this Policy;

   b. Incorporate the following data in the decision-making process:

      i. Quality review activities, including but not limited to:

         a) Enrollment and other information from DHCS, CMS, or another agency, as applicable;

         b) CalOptima Health quality review results, including, but not limited to, Grievances, Appeals, potential quality issue cases, and compliance cases, as applicable;

         c) Review of FSR or Physical Accessibility Review Survey (PARS) results for provider in the Medi-Cal provider network, as applicable; and

         d) Review of medical records, as applicable.

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ii. Member experience, if applicable;

iii. Liability claims history, if applicable; and

iv. Compliance with the terms of the Provider's contract.

c. ICF/DDs will be reassessed every two (2) years through re-submission of the requirements in Section III.B. of this policy.

i. If an ICF/DD has a change to any requirement attested to between the years ICF/DDs are reassessed, an ICF/DD must report that change to CalOptima Health along with any required documentation within ninety (90) days of when the change occurred.

2. CalOptima Health or Delegates shall ensure that an OP has current appropriate licensure, accreditation (if applicable), and insurance at all times during such OP's participation in CalOptima Health.

C. Upon initial assessment, Reassessment, and on a monthly basis, CalOptima Health or Delegates shall monitor the Medicare and Medi-Cal Sanction Lists, which include Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE), System for Award Management (SAM), CMS Preclusion List, Medi-Cal Suspended & Ineligible (S&I), and DHCS Restricted Provider Database. CalOptima Health shall immediately suspend any OP identified on the sanction lists in accordance with CalOptima Health Policy GG.1607: Monitoring Adverse Actions.

D. Credentialing Committee

1. CalOptima Health or Delegates shall designate a Credentialing committee that uses a peer-review process to make recommendations and decisions regarding Assessment and Reassessment.

2. CalOptima Health's Credentialing and Peer Review Committee (CPRC) shall make recommendations and decisions regarding an OP's eligibility to participate in CalOptima Health Community Network, CalOptima Direct, or Program of All-Inclusive Care for the Elderly.

3. Completed OP files will either be presented to the CMO or Designee, on a clean file list for signature, or will be presented at CPRC for review and approval.

a. A clean file consists of a complete signed application, required supporting documents that are current and valid, and verification that there have been no liability claim(s) that resulted in settlements or judgments paid by, or on behalf of, the OP within the last seven (7) years from the date of the assessment, and confirmation that the OP is in good standing with state and federal regulatory agencies.

i. A clean file shall be considered approved and effective on the date that the CMO or Designee, reviews and approves an OP's assessment and Reassessment file, and deems the file clean.

ii. Clean file lists approved by the CMO or Designee shall be presented at the CPRC for final approval and reflected in the meeting minutes.

b. Files that do not meet the clean file review process and require further review by CPRC include but are not limited to those files that include a history of liability claim(s) that resulted in settlements, or judgments, paid by or on behalf of the OP.

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i. Non-clean list files will be reviewed by CPRC for determination to accept, or deny, the application. Files that are incomplete will not be processed until the Provider submits all the required information.

ii. CPRC minutes shall reflect thoughtful consideration by the CPRC of the information presented in the file.

iii. CPRC meetings and decisions may take place in real-time, as a virtual meeting via telephone or video conferencing, but may not be conducted through e-mail.

4. Provider files identified as not meeting Credentialing criteria with exceptions or potential exceptions shall be referred to the CMO or Designee for review.

a. The CMO or Designee shall review each file for Providers who do not meet Credentialing criteria and make recommendations regarding approving or denying Credentialing of the Provider to the CPRC. For Provider files not meeting criteria on an administrative basis only, the file may be approved or denied by the CMO or Designee.

5. The CPRC shall make a final determination on the OP's ability to participate in CalOptima Health programs based on the information reviewed as specified in this policy.

a. The CalOptima Health Quality Improvement Department shall send the OP, or applicant, a decision letter within thirty (30) calendar days of the decision indicating:

i. Acceptance; or

ii. Denial of the application, along with information regarding the right to file a complaint, with a letter of explanation forwarded to the applicant.

5. Upon acceptance of the participation application, the CalOptima Health Quality Improvement Department shall generate a Provider profile and forward the Provider profile to the Contracting, Provider Relations, and Provider Data Management Service (PDMS) Departments. The PDMS Department will enter the contract and Provider data into CalOptima Health's core business system, which updates pertinent information into the online Provider Directory.

E. Provider Screening and Enrollment (Medi-Cal Providers Only)

1. CalOptima Health shall access the California Health and Human Services' (CHHS) Open Data Portal to obtain a list of currently enrolled Medi-Cal fee-for-service (FFS) Providers or obtain a PED approval letter as an acceptable form of initial enrollment verification conducted by DHCS.

2. If a Provider is already enrolled with DHCS as a Medi-Cal FFS Provider, then the Provider screening and enrollment process does not need to be completed by CalOptima Health.

3. If a Provider is not already enrolled with DHCS as a Medi-Cal FFS Provider, then the CalOptima Health may complete screening and enrollment established by CalOptima Health.

a. CalOptima Health shall notify DHCS and submit its P&Ps for approval prior to implementation. The P&Ps must define the scope of their enrollment process if CalOptima Health does not enroll all Provider types.

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b. CalOptima Health shall complete the process and provide the applicant with a written determination on CalOptima Health letterhead within one hundred twenty (120) calendar days of its receipt of a Provider application.

c. CalOptima Health shall submit a list of its newly enrolled Providers every six months to CalOptima Health's DHCS Managed Care Operations Division (MCOD) contract manager.

d. CalOptima Health shall collect all the appropriate information, data elements, and supporting documentation required for each Provider type and ensure that the application is reviewed for both accuracy and completeness.

i. CalOptima Health shall inform Providers seeking to enroll with CalOptima Health, of the differences between CalOptima Health's and DHCS' Provider enrollment processes, including the Provider's right to enroll through DHCS, at the time of application. CalOptima Health will provide required disclosures that include, but are not limited to, the following elements:

a) A statement that certain enrollment functions will not be performed by CalOptima Health but will continue to be performed by DHCS, including fingerprinting, criminal background checks, and decisions to deny or terminate enrollment.

b) A notice that some of the enrollment requirements and rights found in the state enrollment process may not be applicable when a Provider chooses to enroll through CalOptima Health, including provisional Provider status with Medi-Cal FFS, processing timelines of the enrollment application, and the ability to appeal CalOptima Health's decision to suspend the enrollment process.

c) A provision informing the Provider that if CalOptima Health receives any information that impacts the Provider's eligibility for enrollment, CalOptima Health will suspend processing of the Provider's enrollment application and make the Provider aware of the option to apply through DHCS' Medi-Cal FFS Provider enrollment process.

d) A statement clarifying that in order for the Provider to participate in the Medi-Cal FFS program, the Provider must enroll through DHCS, and that enrolling through DHCS will also make the Provider eligible to contract with CalOptima Health.

ii. CalOptima Health may collect an application fee, not to exceed the Medi-Cal FFS enrollment application fee amount.

iii. CalOptima Health shall obtain the Provider's consent in order to share information relating to the Provider's application and eligibility with DHCS.

iv. CalOptima Health shall collect and maintain the original signed Medi-Cal Provider Agreement and Network Provider Agreement for each Provider.

v. CalOptima Health shall maintain all Provider enrollment documentation in a secure manner to ensure confidentiality of the Provider's personal information.

vi. Enrollment records shall be made available upon request to DHCS, CMS or other authorized governmental agencies.

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e. Providers that apply as a partnership, corporation, governmental entity, or nonprofit organization must disclose ownership or control information as required by 42 CFR § 455.104.

i. Providers who are unincorporated sole proprietors are not required to disclose the ownership or control information.

ii. Upon CalOptima Health's request, a Provider must submit within thirty-five (35) calendar days:

a) Full and complete information about the ownership of any subcontractor with whom the Provider has had business transactions totaling more than twenty-five thousand dollars ($25,000) during the twelve (12)-month period ending on the date of the request; and,

b) Any significant business transactions between the Provider and any wholly owned supplier, or between the Provider and any subcontractor, during the five (5)-year period ending on the date of the request.

f. CalOptima Health shall screen initial Provider applications, including applications for a new practice location, and any applications received in response to a Provider's reenrollment or revalidation request to determine the Provider's categorical risk level as limited, moderate, or high.

i. If a Provider fits within more than one risk level, CalOptima Health must screen the Provider at the highest risk level.

ii. A Provider's designated risk level is also affected by findings of license verification, site reviews, checks of suspended and terminated Provider lists, and criminal background checks.

iii. CalOptima Health shall not enroll a Provider who fails to comply with the screening criteria for that Provider's assigned level of risk.

g. Providers are subject to screening based on verification of the following requirements:

i. Limited-Risk Providers:

a) Meet state and federal requirements;

b) Hold a license certified for practice in the state and has no limitations from other states; and

c) Have no suspensions or terminations on state and federal databases.

ii. Medium-Risk Providers

a) Screening requirements of limited-risk Providers; and

b) Pre-enrollment and post-enrollment onsite visits to verify that the information submitted to CalOptima Health and DHCS is accurate, and to determine compliance with state and federal enrollment requirements.

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iii. High-Risk Providers:

a) Screening requirements of medium-risk Providers; and

b) Criminal background checks based in part on a set of fingerprints

h. CalOptima Health and DHCS shall adjust the categorical risk level when any of the following circumstances occur:

i. The state imposes a payment suspension on a Provider based on a credible allegation(s) of fraud, waste, or abuse.

ii. The Provider has an existing Medicaid overpayment based on fraud, waste, or abuse.

iii. The Provider has been excluded by the Office of Inspector General or another state's Medicaid program within the previous ten (10) years, or when a state or federal moratorium on a provider type has been lifted.

iv. The Provider would have been prevented from applying for enrollment due to a moratorium and the moratorium was lifted in the past six months.

i. Additional criteria for high-risk Providers

i. Any person with a five percent (5%) or more direct or indirect ownership in a high-risk applicant or where information discovered in the onsite or data analysis may lead to this type of request.

ii. CalOptima Health shall direct Providers to fill out Form BCIA 8016 on the California Department of Justice (DOJ) website and ensure that Providers include the correct agency information on the Live Scan form when submitting their application. The agency-specific information shall include the following information:

Applicant Submission

Field	**Entry**
ORI (Code assigned by DOJ)	CA0341600
Authorized Applicant Type	High-Risk Medi-Cal Provider
Type of License/Certification/Permit OR Working Title	MCMC

Contributing Agency Information

Field	**Entry**
Agency Authorized to Receive Criminal Record Information	Department of Health Care Services
Mail Code (Five-digit code assigned by DOJ)	19509
Street Address or PO Box	1700 K Street MS 2200
Contact Name	MCMC
City	Sacramento
State	CA
ZIP Code	95811
Contact Telephone Number	(916) 750-1509

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iii. When fingerprinting is required, CalOptima Health must furnish the Provider with the Live Scan form and instructions on where to deliver the completed form.

iv. The Provider must deliver the completed Live Scan form to the California DOJ and is responsible for paying for any Live Scan processing fees.

v. CalOptima Health shall notify DHCS upon initiation of each criminal background check for a Provider that has been designated as high-risk.

vi. CalOptima Health shall maintain the security and confidentiality of all of the information it receives from DHCS relating to the Provider's high-risk designation and the results of the criminal background checks.

j. Site Visits

i. CalOptima Health shall conduct pre- and post-enrollment site visits of medium-risk and high-risk Providers to verify that the information submitted to CalOptima Health and DHCS is accurate, and to determine the applicant's compliance with state and federal enrollment requirements.

ii. CalOptima Health shall conduct post-enrollment site visits for medium-risk Providers at least every five (5) years, and their high-risk Providers every three (3) years or as necessary to verify that the information submitted to CalOptima Health and DHCS is accurate and determine if Providers are in compliance with state and federal enrollment requirements.

iii. Onsite visits may be conducted for many reasons, including, but not limited to, the following:

a) The Provider was temporarily suspended from the Medi-Cal program;

b) The Provider's license was previously suspended;

c) There is conflicting information in the Provider's enrollment application;

d) There is conflicting information in the Provider's supporting enrollment documentation; and

e) As part of the Provider enrollment process, CalOptima Health receives information that raises a suspicion of fraud.

k. Federal and State Database Checks

i. CalOptima Health shall check the following databases to verify the identity and determine the exclusion and/or enrollment status of all Providers:

a) Social Security Administration's Death Master File;

b) National Plan and Provider Enumeration System (NPPES);

c) List of Excluded Individuals/Entities (LEIE);

d) System for Award Management (SAM);

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e) CMS' Medicare Exclusion Database (MED);

f) DHCS' Suspended and Ineligible Provider List;

g) Restricted Provider Database (RPD); and

h) CHHS Open Data Portal.

ii. CalOptima Health shall also review the SAM, LEIE, and RPD databases on a regular basis, and at least monthly, to ensure that contracted Providers continue to meet enrollment criteria and take appropriate action in connection with the exclusion.

iii. Any Provider terminated from the Medicare or Medicaid/Medi-Cal program may not participate in CalOptima Health's Provider network.

l. If CalOptima Health declines to enroll a Provider, it must refer the Provider to DHCS for further enrollment options.

m. If the CalOptima Health acquires information, either before or after enrollment that may impact the Provider's eligibility to participate in the Medi-Cal program, or a Provider refuses to submit to the required screening activities, CalOptima Health may decline to accept that Provider's application.

n. If at any time CalOptima Health determines that it does not want to contract with a prospective Provider, and/or that the prospective Provider will not meet enrollment requirements, CalOptima Health must immediately suspend the enrollment process.

o. CalOptima Health is not obligated to establish an appeal process for screening and enrollment decisions. Providers may only appeal a suspension or termination to DHCS when the suspension or termination occurs as part of DHCS' denial of the Medi-Cal FFS enrollment application.

p. All Providers must resubmit and recertify the accuracy of their enrollment information as part of the revalidation process at least every five (5) years to ensure that all enrollment information is accurate and up to date.

q. CalOptima Health shall retain all Provider screening and enrollment materials and documents for ten (10) years.

r. CalOptima Health shall make all screening and enrollment documents and materials promptly available to DHCS, CMS, and any other authorized governmental entities upon request.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. California Evidence Code, §1157
B. CalOptima Health Contract for Health Care Services
C. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage

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D. CalOptima Health Contract with Covered California
E. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
F. CalOptima Health PACE Program Agreement
G. CalOptima Health Policy GG.1355: CalAIM Community Supports
H. CalOptima Health Policy GG.1659: System Controls of Provider Credentialing Information
I. CalOptima Health Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities
J. CalOptima Health Policy GG.1607: Monitoring Adverse Actions
K. CalOptima Health Policy GG.1608: Full Scope Site Reviews
L. CalOptima Health Policy HH.1101: CalOptima Health Provider Complaint
M. CalOptima Health Policy MA.9006: Contracted Provider Complaint Process
N. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-015: Benefit Standardization and Mandatory Managed Care Enrollment Provisions of the California Advancing and Innovating Medi-Cal Initiative (Revised: 10/14/2022)
O. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-008: Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses (Supersedes APL 17-010)
O. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-013: Provider Credentialing/Recredentialing and Screening/Enrollment (Supersedes APL 19-004) (Revised: 08/24/2022)
P. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-002: Medi-Cal Managed Care Plan Responsibilities for Indian Health Care Providers and American Indian Members (Supersedes APL 09-009)
Q. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-011: Intermediate Care Facilities for Individuals With Developmental Disabilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care (Supersedes APL 23-023)
R. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-015: California Children's Services Whole Child Model Program (Supersedes APL 23-034)
S. Title 42, Code of Federal Regulations, §§422.204(a), 422.205, 455.450 and Parts 424 and 431
T. Title 42, United States Code, §1320a-7(a)
U. Title 45, Code of Federal Regulations, Part 455
V. Title XVIII and XIV of the Social Security Act
W. Medicare Managed Care Manual Chapter 6-70 Institutional Provider and Supplier Certification
X. National Committee of Quality Assurance (NCQA) Standards CR7 – Assessment of Organizational Providers

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
07/15/2020	Department of Health Care Services (DHCS)	Approved as Submitted
04/20/2022	Department of Health Care Services (DHCS)	File and Use
01/09/2023	Department of Health Care Services (DHCS)	Approved as Submitted
08/14/2023	Department of Health Care Services (DHCS)	File and Use
05/02/2024	Department of Health Care Services (DHCS)	Approved as Submitted
10/16/2024	Department of Health Care Services (DHCS)	File and Use

VII. BOARD ACTION(S)

Date	Meeting
06/01/2017	Regular Meeting of the CalOptima Board of Directors

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Date	Meeting
06/04/2020	Regular Meeting of the CalOptima Board of Directors
04/07/2022	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	06/01/2017	GG.1651	Credentialing and Recredentialing of Healthcare Delivery Organizations	Medi-Cal OneCare OneCare Connect PACE
Revised	01/01/2018	GG.1651	Credentialing and Recredentialing of Healthcare Delivery Organizations	Medi-Cal OneCare OneCare Connect PACE
Revised	06/04/2020	GG.1651	Assessment and Re-Assessment of Organizational Providers	Medi-Cal OneCare OneCare Connect PACE
Revised	04/07/2022	GG.1651	Assessment and Re-Assessment of Organizational Providers	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	GG.1651	Assessment and Re-Assessment of Organizational Providers	Medi-Cal OneCare PACE
Revised	03/01/2023	GG.1651	Assessment and Re-Assessment of Organizational Providers	Medi-Cal OneCare PACE
Revised	08/01/2023	GG.1651	Assessment and Re-Assessment of Organizational Providers	Medi-Cal OneCare PACE
Revised	02/01/2024	GG.1651	Assessment and Reassessment of Organizational Providers	Medi-Cal OneCare PACE
Revised	04/01/2024	GG.1651	Assessment and Reassessment of Organizational Providers	Medi-Cal OneCare PACE
Revised	10/01/2024	GG.1651	Assessment and Reassessment of Organizational Providers	Medi-Cal OneCare PACE
Revised	04/01/2025	GG.1651	Assessment and Reassessment of Organizational Providers	Medi-Cal OneCare PACE
Revised	05/01/2025	GG.1651	Assessment and Reassessment of Organizational Providers	Covered California Medi-Cal OneCare PACE

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Action	Date	Policy	Policy Title	Program(s)
Revised	08/01/2025	GG.1651	Assessment and Reassessment of Organizational Providers	Covered California Medi-Cal OneCare PACE

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IX. GLOSSARY

Term	Definition
Appeal	Covered California: A review by CalOptima Health of an adverse benefit determination, which includes one of the following actions: 1. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a service; 4. Failure to provide services in a timely manner; or 5. Failure to act within the required timeframes for standard and expedited resolution of grievances and appeals in accordance with Health & Safety Code § 1368. Medi-Cal: A review by CalOptima Health of an adverse benefit determination, which includes one of the following actions: 1. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a 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: As defined at 42 CFR §§ 422.561 and 423.560, the procedures that deal with the review of adverse initial determinations made by the plan on health care services or benefits under Part C or D the enrollee believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the enrollee) or on any amounts the enrollee must pay for a service or drug as defined in 42 CFR §§ 422.566(b) and 423.566(b). These appeal procedures include a plan reconsideration or redetermination (also referred to as a level 1 appeal), a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (Council), and judicial review. PACE: A Member's action taken with respect to the PACE organization's noncoverage of, modification of, or nonpayment for, a service including denials, reductions or termination of services, as defined by federal PACE regulation 42 CFR § 460.122.
Community Supports	Substitute services or settings to those required under the California Medicaid State Plan that CalOptima Health may select and offer to their Members pursuant to 42 CFR § 438.3(e)(2) when the substitute service or setting is medically appropriate and more cost-effective than the service or setting listed in the California Medicaid State Plan.

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Term	Definition
Covered California: *Effective 01/01/2027 for CalOptima Health*	The California Health Benefit Exchange, doing business as Covered California and an independent entity within the Government of the State.
Credentialing	Covered California: The initial process by which the qualifications of a Provider is verified in order to make a determination relating to the Provider's eligibility for participation in CalOptima Health's programs. Medi-Cal: The process of determining a Provider or an entity's professional or technical competence, and may include registration, certification, licensure and professional association membership. OneCare: The process of obtaining, verifying, assessing, and monitoring the qualifications of a Provider to provide quality and safe patient care services. PACE: The recognition of professional or technical competence. The process involved may include registration, certification, licensure, and professional association membership.
Credentialing Peer Review Committee	Peer review body who reviews Provider information and files and makes recommendations and decisions regarding Credentialing and Recredentialing
Credentialing Verification Organization (CVO)	For purposes of this policy, an organization that collects and verifies Credentialing information.
Delegate	An organization or entity granted authority to perform an activity on behalf of CalOptima within agreed-upon parameters. Any party that enters into an acceptable written arrangement below the level of the arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.

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Term	Definition
Durable Medical Equipment (DME) and Durable Medical Equipment Prosthetics Orthotics Supplier (DMEPOS)	Covered California: An item that is intended for repeated use, primarily and customarily used to serve a medical purpose, generally not useful to a person who is not ill or injured, and appropriate for use outside an institutional setting and includes: Mobility devices, including walkers and manual and power wheelchairs and scooters; augmented communications devices, such as speech generating devices, communications boards, and apps; continuous positive airway pressure (CPAP) machines; portable oxygen; hospital beds; for diabetes blood testing, blood glucose monitors and their supplies (such as blood glucose monitor test strips, lancets, and lancet devices); infusion pumps (such as insulin pumps) and supplies to operate the pump (but not including insulin or any other Drugs); standard curved handle or quad canes and replacement supplies; standard or forearm crutches and replacement supplies; dry pressure pads for a mattress; nebulizers and supplies; peak flow meters; and IV pole. Medi-Cal: Medically Necessary medical equipment as defined by 22 CCR section 51160 that a Provider prescribes for a Member that the Member uses in the home, in the community, or in a facility that is used as a home. OneCare: M~~Durable m~~edical ~~equipment means~~ equipment prescribed by a licensed Practitioner to meet medical equipment needs of the Member that: 1. Can withstand repeated use. 2. Is used to serve a medical purpose. 3. Is not useful to an individual in the absence of an illness, injury, functional impairment, or congenital anomaly. 4. Is appropriate for use in or out of the patient's home.
Facility Site Review	A DHCS tool utilized to assess the quality, safety and accessibility of primary care physicians (PCPs) and high-volume specialty care provider offices.
Grievance	Covered California: A written or oral expression of dissatisfaction regarding CalOptima Health, a Health Network, or a Provider, including quality of care concerns, Member's complaint about a delay or denial of payment on a claim, and shall include a complaint, dispute, request for reconsideration or Appeal made by a Member or the Member's representative. A complaint is the same as a Grievance. An inquiry is a request for more information that does not include an expression of dissatisfaction, including, but not limited to, questions pertaining to eligibility, benefits, or other CalOptima Health processes. If CalOptima Health is unable to distinguish between a Grievance and an inquiry, it must be considered a Grievance. Medi-Cal: Any expression of dissatisfaction about any matter other than an Adverse Benefit Determination (ABD), and may include, but is not limited to the Quality of Care or services provided, aspects of interpersonal relationships with a Provider or CalOptima Health's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by CalOptima Health to make an authorization decision. A complaint is the same as Grievance. An inquiry is a request for more information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other CalOptima Health processes. If CalOptima Health is unable to distinguish between a Grievance and an inquiry, it must be considered a Grievance.

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Term	Definition
	OneCare: An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. PACE: A complaint, either written or oral, expressing dissatisfaction with service delivery or the quality of 17 care furnished, regardless of whether remedial action is requested, as defined by the federal PACE regulation 42 CFR § 460.120.
Health Network	A ~~physician hospital consortium~~Physician Hospital Consortium (PHC), physician group under a shared risk contract, ~~or~~ health care service plan, such as a ~~health maintenance organization~~Health Maintenance Organization (HMO~~)~~), Subcontractor, or First Tier Entity, that contracts with CalOptima Health to provide Covered Services to Members ~~assigned to that health network~~.
Member	An individual enrolled in a CalOptima Health program.
Organizational Provider (OP)	For purposes of this policy, organizations or institutions that are contracted to provide medical services such as, but not limited to: hospitals, home health agencies, nursing facilities (includes skilled nursing, long term care, and sub-acute), free standing ambulatory surgical centers, hospice services, community clinics including Federally Qualified Health Centers, urgent care centers, End-Stage renal disease services (dialysis centers), Residential Care Facility for the Elderly (RCFE), Community Based Adult Services (CBAS), Managed Long Term Services and Supports (MLTSS), durable medical equipment suppliers, radiology centers, clinical laboratories, outpatient rehabilitation facilities, outpatient physical therapy and speech pathology providers, diabetes centers, portable x-ray suppliers and methadone clinics, non-emergency medical transportation (NEMT), mobile blood bank, community home support services for housing, non-medical service practitioners.
Physical Accessibility Review Survey (PARS)	A DHCS tool used to assess the level of physical accessibility of provider sites, including PCPs, high volume specialists and ancillary service providers, and CBAS centers.
Practitioner	A licensed independent practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.

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Term	Definition
Provider	Covered California: A licensed health care facility or as stipulated by local or international jurisdictions, a program, agency or health professional that delivers Covered Services. Medi-Cal: Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so. OneCare: Any Medicare Provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician Provider, laboratory, supplier) 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.
Reassessment	The process by which Provider status is verified in order to make determinations relating to their continued eligibility for participation in the CalOptima Health program.
Regional Center (RC)	A non-profit, community-based entity that is contracted by Department of Developmental Services (DDS) and develops, purchases and manages services for Members with developmental disabilities and their families.

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Policy:	GG.1651
Title:	**Assessment and Reassessment of Organizational Providers**
Department:	Medical Management
Section:	Quality Improvement
CEO Approval:	*/s/*
Effective Date:	06/01/2017
Revised Date:	08/01/2025
Applicable to:	☐ Administrative ☒ Covered California [Effective 2027] ☒ Medi-Cal ☒ OneCare ☒ PACE

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I. PURPOSE

This policy describes the process by which CalOptima Health evaluates and determines a Provider, including an Organizational Provider (OP), rendering consolidated, facility-based services and/or billing for health care services not directly rendered and billed by a professional Provider, eligibility to participate in CalOptima Health programs.

II. POLICY

A. CalOptima Health shall establish guidelines for evaluation of OPs participation eligibility in CalOptima Health programs, in accordance with applicable laws, regulations, and regulatory guidance.

B. CalOptima Health may delegate authority to perform Medi-Cal screening and enrollment activities to a Health Network or Delegate. If CalOptima Health chooses to delegate this function, the follow shall occur:

1. The delegation shall be in a written subcontract or agreement, where CalOptima Health remains contractually responsible for the completeness and accuracy of the screening and enrollment activities.

2. CalOptima Health shall evaluate the Health Network or Delegate's ability to perform these activities, including an initial review to ensure that the Health Network or Delegate has the administrative capacity, experience, and budgetary resources to fulfill its responsibilities.

3. CalOptima Health shall continuously monitor, evaluate, and approve the delegated functions.

4. CalOptima Health shall notify the Department of Health Care Services (DHCS) sixty (60) calendar days prior to delegating the screening and enrollment to a Health Network or Delegate and shall submit policies and procedures (P&Ps) that outline the delegation authority, as well as CalOptima Health's monitoring and oversight activities.

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C. CalOptima Health may delegate the Assessment and Reassessment of OPs to a Delegate or Credentialing Verification Organization, in accordance with CalOptima Health Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities.

1. Credentialing Delegate shall perform delegated Credentialing functions that, at minimum, meet the requirements as outlined in this policy.

D. The Chief Medical Officer (CMO) or Designee shall have direct responsibility over and shall actively participate in the assessment and Reassessment of an OP.

E. The CalOptima Health Credentialing and Peer Review Committee (CPRC) shall be responsible for reviewing an OP's application information and CalOptima Health's findings for determining an OP's participation in CalOptima Health's Provider network.

F. CalOptima Health shall assess or reassess OPs, including, but not limited to, the following:

1. Acute Rehabilitation Facilities;
2. Behavioral Health Facility/Substance Abuse Providers (Inpatient, Residential or Ambulatory);
3. Birthing Centers;
4. Certified Hospice Providers;
5. Chronic Dialysis Clinic;
6. Clinical/Medical Laboratory;
7. Community Based Adult Services (CBAS) Providers;
8. Community Clinic;
9. Dialysis (End-Stage Renal Disease) Center/Facility;
10. Customized/Durable Medical Equipment (DME) Providers;
11. Federally Qualified Health Clinic;
12. Free Clinic;
13. Health Access Program;
14. Home Health Agencies;
15. Hospice and Palliative Care Providers;
16. Hospitals;
17. Indian Health Care Providers or Facilities;
18. Intermediate Care Facilities for the Developmentally Disabled (ICF/DD);
19. Emergency/Non-Emergency and Medical/Non-Medical Ground Transportation;

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i. For Transportation Network Companies (TNC), CalOptima Health is not responsible for Credentialing drivers, in accordance with DHCS All Plan Letter (APL) 22-008: Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses.

20. Non-Emergency Medical Transportation;

21. Prosthetics and Orthotics;

22. Qualified Autism Services (QAS) also known as Applied Behavior Analysis (ABA) Groups;

23. Radiology Center (Free Standing);

24. Rehabilitation Center/Clinic (Outpatient for Physical Therapy, Occupational Therapy, and Speech Pathology);

25. Religious Non-Medical Health Care Institution;

26. Residential Care Facilities for the Elderly;

27. Rural Health Clinic;

28. Skilled Nursing Facilities/Long Term Care Facility;

29. Surgical Center (Free Standing);

30. Transplant Programs (Organ Procurement Organization); and

31. Urgent Care Center (Free Standing).

G. CalOptima Health and Delegates shall ensure that any Provider in its Medi-Cal provider network for whose provider type has an enrollment pathway with DHCS, including ordering, referring and prescribing Providers, is screened and enrolled with DHCS in the Medi-Cal program in accordance with DHCS APL 22-013: Provider Credentialing/Recredentialing and Screening/Enrollment, including any superseding APL, and Title 42, CFR, Part 455, and as described in Sections III.A. and III.B. of this Policy.

1. State-level enrollment pathways are available either through the DHCS Provider Enrollment Division (PED) or another state department with a recognized enrollment pathway.

2. CalOptima Health may enroll providers through the screening and enrollment process outlined in Section III.E, in compliance with DHCS requirements, or CalOptima Health may direct network Providers to enroll through a state-level enrollment pathway.

3. Providers that do not have a state-level enrollment pathway do not need to be enrolled with Medi-Cal but must comply with CalOptima Health's vetting process.

4. Provider enrollment requirements shall be waived for Letters of Agreement (LOA), or single-case agreements with out-of-state transplant programs.

H. Providers in the Medi-Cal provider network not having a corresponding state-level enrollment pathway, including but not limited to Community Supports Providers (*e.g.*, housing agencies, medically tailored meal programs), and certain Enhanced Care Management (ECM) Providers, are not

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required to enroll in the Medi-Cal program and CalOptima Health shall vet the qualifications of the Provider or Provider organization to ensure Providers have:

1. Sufficient experience to provide services similar to the specific service for which they are contracted to provide within the service area;

2. Business licensing that meets industry standards;

3. History of fraud, waste, and/or abuse;

4. Recent history of criminal activity, including a history of criminal activities that endanger Members and/or their families; and

5. History of liability claims against the Provider.

I. CalOptima Health and Delegates may allow Providers in its Medi-Cal provider network to participate in the network for up to one hundred twenty (120) calendar days if the Provider has a pending enrollment application in review with DHCS' PED or a DHCS approved screening and enrollment process.

1. CalOptima Health and Delegates shall terminate its contract with the Provider no later than fifteen (15) calendar days of the Provider receiving notification from DHCS that the Provider has been denied enrollment of the Medi-Cal program, or upon the expiration of the first one hundred twenty (120) calendar day period.

2. CalOptima Health and Delegates shall not continue to contract with a Provider during the period in which the Provider resubmits its enrollment application to DHCS or approved screening and enrollment process and shall only re-initiate a contract upon the Provider's successful enrollment as a Medi-Cal Provider.

3. If the Provider termination impacts Member access, CalOptima Health shall notify DHCS prior to terminating the Provider and shall submit a plan of action for continuity of services for review and approval before the termination.

J. CalOptima Health and Delegates shall require that the OP be successfully assessed prior to contracting and every three (3) years thereafter, except as otherwise specified in this policy.

1. CalOptima Health and Delegates shall confirm that the OP is in good standing with state and federal regulatory agencies,

2. CalOptima Health and Delegates shall require OPs to be reviewed and approved by an accrediting body or have received an on-site quality assessment consistent with the provisions of this policy if the Provider is not accredited, as applicable.

K. Upon initial assessment, Reassessment, and on a monthly basis if required, CalOptima Health and Delegates shall confirm:

1. Medi-Cal participation status of the OP and

2. Medicare participation status for the following OPs:

   a. Hospitals;

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b. Home Health Agencies (HHAs);

c. Hospices;

d. Clinical Laboratories;

e. Skilled Nursing Facilities (SNFs);

f. Comprehensive Outpatient Rehabilitation Facilities (CORFs);

g. Outpatient Physical Therapy and Speech Pathology Providers;

h. Ambulatory Surgical Centers (ASCs);

i. Providers of end-stage renal disease services;

j. Providers of outpatient diabetes self-management training;

k. Portable x-ray suppliers;

l. Rural health Clinic (RHCs); and

m. Federally Qualified Health Center (FQHCs).

L. If an OP is denied approval to participate in the CalOptima Health Provider network, CalOptima Health or Delegates shall notify, in writing, such OP within thirty (30) calendar days of the reason for its decision. An OP shall have the right to file a complaint about the decision in accordance with CalOptima Health Policies HH.1101: CalOptima Health Provider Complaint and MA.9006: Contracted Provider Complaint Process, as applicable.

M. CalOptima Health and Delegates shall maintain the confidentiality of Credentialing files, in accordance with CalOptima Health Policy GG.1659: System Controls of Provider Credentialing.

III. PROCEDURE

A. OP Initial Assessment

1. Upon notification of an intent to contract, CalOptima Health and Delegates shall confirm the OP is in good standing with state and/or federal regulatory agencies based on an examination of the sources listed in Section III.A.2. of this policy.

2. The OP shall submit an application, signed, and dated by an authorized official of the OP, along with the following supplemental documentation:

a. OPs shall include a roster listing the Practitioners associated with the OP, where applicable, as part of the application;

b. OPs shall ensure that all information included in the assessment application is no more than six (6) months old;

i. CalOptima Health and Delegates shall return an incomplete application to an OP, and such incomplete application will not be processed until the OP submits all the required information.

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ii. If the required information is not received within sixty (60) calendar days of the date of initial receipt of application, CalOptima Health shall consider the application withdrawn and will close the Credentialing file, if applicable.

iii. If an application has been withdrawn and the applicant wishes to apply to be credentialed, a new application must be submitted to CalOptima Health.

c. Confirmation that the OP is compliant with any other applicable state or federal requirements and possesses a business license (or business tax certificate), as applicable.

d. Accreditation and/or government-issued certification from the following entities, as applicable:

i. The Joint Commission certificate of accreditation, or another Centers for Medicare & Medicaid Services (CMS)-deemed accreditation organization for hospitals, ambulatory surgery centers, skilled nursing facilities, and home health agencies;

ii. Accreditation Association for Ambulatory Health Care (AAAHC) for outpatient settings, including ambulatory surgery centers, office-based surgery facilities, endoscopy centers, medical and dental group practices, community health centers, and retail clinics;

iii. Commission on Accreditation of Rehabilitation Facilities (CARF) for aging services, behavioral health, child and youth services, vision rehabilitation services, medical rehabilitation, Durable Medical Equipment, prosthetics and orthotics supplies, and opioid treatment programs;

iv. Community Health Accreditation Program (CHAP) for home health agencies, hospice Providers, pharmacies, home medical equipment suppliers, private duty nursing, palliative care, and infusion therapy nursing;

v. American Board for Certification (ABC) for prosthetists, orthotists, and pedorthists;

vi. American Speech-Language-Hearing Association (ASHA) for speech, language, hearing, and audiology certification;

vii. DME or Durable Medical Equipment Prosthetics Orthotics Supplier (DMEPOS) Accreditation Commission for Health Care, Inc. (ACHC);

viii. Commission on Accreditation of Ambulance Services (CAAS) for ambulance organizations;

ix. College of American Pathologist (CAP) for laboratories, biorepositories, and reproductive laboratories;

x. Healthcare Quality Association on Accreditation (HQAA) for home medical equipment suppliers, DMEPOS, and pharmacies;

xi. Inter-Societal Accreditation Commission (IAC) for radiology or diagnostic imaging Providers, and procedure-based modalities;

xii. Det Norske Veritas Germanischer Lloyd (DNV GL)-Health Care for hospitals;

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xiii. National Dialysis Accreditation Commission (NDAC) for the accreditation of end state renal disease facilities; and

xiv. The California Department of Public Health (CDPH) for hospitals, ambulatory surgery centers, home health agencies, hospices, dialysis centers, Community Based Adult Services centers, skilled nursing facilities, Federal Qualified Health Centers verifications.

e. If an OP is not accredited, CalOptima Health shall conduct an on-site quality review with criteria for each type of Provider used for the assessment, and the process for ensuring that the Providers credential their Practitioners;

i. The Provider may submit evidence of a CMS or state quality review in lieu of a site visit.

a) The CMS or state quality review must be no more than three (3) years old. If the review is older than three (3) years, then CalOptima Health shall conduct its own onsite quality review.

ii. If a Provider has satellite facilities that follow the same policies and procedures as the Provider, the site visits may be limited to a main facility.

f. Certificate of current professional liability insurance of at least the minimum amounts required by provider type per the Contract for Health Care Services, as applicable;

g. A copy of any history of sanctions, preclusions, exclusions, suspensions, or terminations from Medicare and/or Medi-Cal, as applicable;

h. A copy of the PED certificate validating active enrollment in Medi-Cal, if applicable;

i. Active panels with the California Children's Services Program, if applicable;

j. Staff roster and copy of all staff certifications, or licensure, if applicable;

k. A valid Type 2 National Provider Identifier (NPI) number; and

l. All contracted laboratory-testing sites must have either a Clinical Laboratory Improvement Act (CLIA) certificate or waiver of a certificate of registration along with a CLIA identification number.

3. CalOptima Health shall conduct and communicate the results of a Facility Site Review (FSR) for community clinics and free-standing urgent care centers in providing services to Members in CalOptima Health's Medi-Cal provider network pursuant to CalOptima Health Policy GG.1608: Full Scope Site Reviews to incorporate the documents to support review prior to approval decisions.

4. All participation applications shall be signed. Faxed, digital, electronic, scanned, or photocopied signatures are acceptable; however, signature stamps are not acceptable.

5. CalOptima Health or Delegates shall review the history of professional liability claims that resulted in settlements or judgements paid by, or on behalf of, the OP in the last five (5) years.

B. Intermediate Care Facility for the Developmentally Disabled (ICF/DD) Assessment

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1. Requirements for an Intermediate Care Facility for the Developmentally Disabled (ICF/DD) seeking to participate in CalOptima Health's Medi-Cal program:

    a. A CalOptima Health Ancillary Facility Network Provider Application, also known as the OP application, in accordance with Section III.A.2. of this policy.

    b. An ICF/DD Attestation, in accordance with DHCS APL 24-011: Intermediate Care Facilities for Individuals with Developmental Disabilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care, or superseding APL, signed under penalty of perjury attesting that the following Credentialing requirements are satisfied:

        i. Completion of the CalOptima Health Provider training within the last two (2) years;

        ii. A facility site audit from a state agency;

        iii. No change in five percent (5%) ownership disclosure;

        iv. Possession of an active CDPH license and CMS certification; and

        v. In good standing as a Regional Center vendor.

    c. W-9 request for taxpayer identification number and certification.

    d. City or county business license (excluding ICF/DD-H and N homes with six (6) or less residents)

    e. Certificate of insurance for professional and general liability of at least the minimum amounts required by Provider type, in accordance with the DHCS contract for Medi-Cal, as applicable.

C. OP Reassessment

1. CalOptima Health or Delegates shall reassess an OP at least every three (3) years after initial assessment. At the time of Reassessment, CalOptima Health shall:

    a. Collect and/or verify, at a minimum, all of the information required for initial assessment as set forth in Section III.A. of this Policy;

    b. Incorporate the following data in the decision-making process:

        i. Quality review activities, including but not limited to:

            a) Enrollment and other information from DHCS, CMS, or another agency, as applicable;

            b) CalOptima Health quality review results, including, but not limited to, Grievances, Appeals, potential quality issue cases, and compliance cases, as applicable;

            c) Review of FSR or Physical Accessibility Review Survey (PARS) results for provider in the Medi-Cal provider network, as applicable; and

            d) Review of medical records, as applicable.

        ii. Member experience, if applicable;

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iii. Liability claims history, if applicable; and

iv. Compliance with the terms of the Provider's contract.

c. ICF/DDs will be reassessed every two (2) years through re-submission of the requirements in Section III.B. of this policy.

i. If an ICF/DD has a change to any requirement attested to between the years ICF/DDs are reassessed, an ICF/DD must report that change to CalOptima Health along with any required documentation within ninety (90) days of when the change occurred.

2. CalOptima Health or Delegates shall ensure that an OP has current appropriate licensure, accreditation (if applicable), and insurance at all times during such OP's participation in CalOptima Health.

C. Upon initial assessment, Reassessment, and on a monthly basis, CalOptima Health or Delegates shall monitor the Medicare and Medi-Cal Sanction Lists, which include Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE), System for Award Management (SAM), CMS Preclusion List, Medi-Cal Suspended & Ineligible (S&I), and DHCS Restricted Provider Database. CalOptima Health shall immediately suspend any OP identified on the sanction lists in accordance with CalOptima Health Policy GG.1607: Monitoring Adverse Actions.

D. Credentialing Committee

1. CalOptima Health or Delegates shall designate a Credentialing committee that uses a peer-review process to make recommendations and decisions regarding Assessment and Reassessment.

2. CalOptima Health's Credentialing and Peer Review Committee (CPRC) shall make recommendations and decisions regarding an OP's eligibility to participate in CalOptima Health Community Network, CalOptima Direct, or Program of All-Inclusive Care for the Elderly.

3. Completed OP files will either be presented to the CMO or Designee, on a clean file list for signature, or will be presented at CPRC for review and approval.

a. A clean file consists of a complete signed application, required supporting documents that are current and valid, and verification that there have been no liability claim(s) that resulted in settlements or judgments paid by, or on behalf of, the OP within the last seven (7) years from the date of the assessment, and confirmation that the OP is in good standing with state and federal regulatory agencies.

i. A clean file shall be considered approved and effective on the date that the CMO or Designee, reviews and approves an OP's assessment and Reassessment file, and deems the file clean.

ii. Clean file lists approved by the CMO or Designee shall be presented at the CPRC for final approval and reflected in the meeting minutes.

b. Files that do not meet the clean file review process and require further review by CPRC include but are not limited to those files that include a history of liability claim(s) that resulted in settlements, or judgments, paid by or on behalf of the OP.

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i. Non-clean list files will be reviewed by CPRC for determination to accept, or deny, the application. Files that are incomplete will not be processed until the Provider submits all the required information.

ii. CPRC minutes shall reflect thoughtful consideration by the CPRC of the information presented in the file.

iii. CPRC meetings and decisions may take place in real-time, as a virtual meeting via telephone or video conferencing, but may not be conducted through e-mail.

4. Provider files identified as not meeting Credentialing criteria with exceptions or potential exceptions shall be referred to the CMO or Designee for review.

   a. The CMO or Designee shall review each file for Providers who do not meet Credentialing criteria and make recommendations regarding approving or denying Credentialing of the Provider to the CPRC. For Provider files not meeting criteria on an administrative basis only, the file may be approved or denied by the CMO or Designee.

5. The CPRC shall make a final determination on the OP's ability to participate in CalOptima Health programs based on the information reviewed as specified in this policy.

   a. The CalOptima Health Quality Improvement Department shall send the OP, or applicant, a decision letter within thirty (30) calendar days of the decision indicating:

      i. Acceptance; or

      ii. Denial of the application, along with information regarding the right to file a complaint, with a letter of explanation forwarded to the applicant.

5. Upon acceptance of the participation application, the CalOptima Health Quality Improvement Department shall generate a Provider profile and forward the Provider profile to the Contracting, Provider Relations, and Provider Data Management Service (PDMS) Departments. The PDMS Department will enter the contract and Provider data into CalOptima Health's core business system, which updates pertinent information into the online Provider Directory.

E. Provider Screening and Enrollment (Medi-Cal Providers Only)

1. CalOptima Health shall access the California Health and Human Services' (CHHS) Open Data Portal to obtain a list of currently enrolled Medi-Cal fee-for-service (FFS) Providers or obtain a PED approval letter as an acceptable form of initial enrollment verification conducted by DHCS.

2. If a Provider is already enrolled with DHCS as a Medi-Cal FFS Provider, then the Provider screening and enrollment process does not need to be completed by CalOptima Health.

3. If a Provider is not already enrolled with DHCS as a Medi-Cal FFS Provider, then the CalOptima Health may complete screening and enrollment established by CalOptima Health.

   a. CalOptima Health shall notify DHCS and submit its P&Ps for approval prior to implementation. The P&Ps must define the scope of their enrollment process if CalOptima Health does not enroll all Provider types.

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b. CalOptima Health shall complete the process and provide the applicant with a written determination on CalOptima Health letterhead within one hundred twenty (120) calendar days of its receipt of a Provider application.

c. CalOptima Health shall submit a list of its newly enrolled Providers every six months to CalOptima Health's DHCS Managed Care Operations Division (MCOD) contract manager.

d. CalOptima Health shall collect all the appropriate information, data elements, and supporting documentation required for each Provider type and ensure that the application is reviewed for both accuracy and completeness.

i. CalOptima Health shall inform Providers seeking to enroll with CalOptima Health, of the differences between CalOptima Health's and DHCS' Provider enrollment processes, including the Provider's right to enroll through DHCS, at the time of application. CalOptima Health will provide required disclosures that include, but are not limited to, the following elements:

a) A statement that certain enrollment functions will not be performed by CalOptima Health but will continue to be performed by DHCS, including fingerprinting, criminal background checks, and decisions to deny or terminate enrollment.

b) A notice that some of the enrollment requirements and rights found in the state enrollment process may not be applicable when a Provider chooses to enroll through CalOptima Health, including provisional Provider status with Medi-Cal FFS, processing timelines of the enrollment application, and the ability to appeal CalOptima Health's decision to suspend the enrollment process.

c) A provision informing the Provider that if CalOptima Health receives any information that impacts the Provider's eligibility for enrollment, CalOptima Health will suspend processing of the Provider's enrollment application and make the Provider aware of the option to apply through DHCS' Medi-Cal FFS Provider enrollment process.

d) A statement clarifying that in order for the Provider to participate in the Medi-Cal FFS program, the Provider must enroll through DHCS, and that enrolling through DHCS will also make the Provider eligible to contract with CalOptima Health.

ii. CalOptima Health may collect an application fee, not to exceed the Medi-Cal FFS enrollment application fee amount.

iii. CalOptima Health shall obtain the Provider's consent in order to share information relating to the Provider's application and eligibility with DHCS.

iv. CalOptima Health shall collect and maintain the original signed Medi-Cal Provider Agreement and Network Provider Agreement for each Provider.

v. CalOptima Health shall maintain all Provider enrollment documentation in a secure manner to ensure confidentiality of the Provider's personal information.

vi. Enrollment records shall be made available upon request to DHCS, CMS or other authorized governmental agencies.

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e. Providers that apply as a partnership, corporation, governmental entity, or nonprofit organization must disclose ownership or control information as required by 42 CFR § 455.104.

i. Providers who are unincorporated sole proprietors are not required to disclose the ownership or control information.

ii. Upon CalOptima Health's request, a Provider must submit within thirty-five (35) calendar days:

a) Full and complete information about the ownership of any subcontractor with whom the Provider has had business transactions totaling more than twenty-five thousand dollars ($25,000) during the twelve (12)-month period ending on the date of the request; and,

b) Any significant business transactions between the Provider and any wholly owned supplier, or between the Provider and any subcontractor, during the five (5)-year period ending on the date of the request.

f. CalOptima Health shall screen initial Provider applications, including applications for a new practice location, and any applications received in response to a Provider's reenrollment or revalidation request to determine the Provider's categorical risk level as limited, moderate, or high.

i. If a Provider fits within more than one risk level, CalOptima Health must screen the Provider at the highest risk level.

ii. A Provider's designated risk level is also affected by findings of license verification, site reviews, checks of suspended and terminated Provider lists, and criminal background checks.

iii. CalOptima Health shall not enroll a Provider who fails to comply with the screening criteria for that Provider's assigned level of risk.

g. Providers are subject to screening based on verification of the following requirements:

i. Limited-Risk Providers:

a) Meet state and federal requirements;

b) Hold a license certified for practice in the state and has no limitations from other states; and

c) Have no suspensions or terminations on state and federal databases.

ii. Medium-Risk Providers

a) Screening requirements of limited-risk Providers; and

b) Pre-enrollment and post-enrollment onsite visits to verify that the information submitted to CalOptima Health and DHCS is accurate, and to determine compliance with state and federal enrollment requirements.

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iii. High-Risk Providers:

a) Screening requirements of medium-risk Providers; and

b) Criminal background checks based in part on a set of fingerprints

h. CalOptima Health and DHCS shall adjust the categorical risk level when any of the following circumstances occur:

i. The state imposes a payment suspension on a Provider based on a credible allegation(s) of fraud, waste, or abuse.

ii. The Provider has an existing Medicaid overpayment based on fraud, waste, or abuse.

iii. The Provider has been excluded by the Office of Inspector General or another state's Medicaid program within the previous ten (10) years, or when a state or federal moratorium on a provider type has been lifted.

iv. The Provider would have been prevented from applying for enrollment due to a moratorium and the moratorium was lifted in the past six months.

i. Additional criteria for high-risk Providers

i. Any person with a five percent (5%) or more direct or indirect ownership in a high-risk applicant or where information discovered in the onsite or data analysis may lead to this type of request.

ii. CalOptima Health shall direct Providers to fill out Form BCIA 8016 on the California Department of Justice (DOJ) website and ensure that Providers include the correct agency information on the Live Scan form when submitting their application. The agency-specific information shall include the following information:

Applicant Submission

Field	**Entry**
ORI (Code assigned by DOJ)	CA0341600
Authorized Applicant Type	High-Risk Medi-Cal Provider
Type of License/Certification/Permit OR Working Title	MCMC

Contributing Agency Information

Field	**Entry**
Agency Authorized to Receive Criminal Record Information	Department of Health Care Services
Mail Code (Five-digit code assigned by DOJ)	19509
Street Address or PO Box	1700 K Street MS 2200
Contact Name	MCMC
City	Sacramento
State	CA
ZIP Code	95811
Contact Telephone Number	(916) 750-1509

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iii. When fingerprinting is required, CalOptima Health must furnish the Provider with the Live Scan form and instructions on where to deliver the completed form.

iv. The Provider must deliver the completed Live Scan form to the California DOJ and is responsible for paying for any Live Scan processing fees.

v. CalOptima Health shall notify DHCS upon initiation of each criminal background check for a Provider that has been designated as high-risk.

vi. CalOptima Health shall maintain the security and confidentiality of all of the information it receives from DHCS relating to the Provider's high-risk designation and the results of the criminal background checks.

j. Site Visits

i. CalOptima Health shall conduct pre- and post-enrollment site visits of medium-risk and high-risk Providers to verify that the information submitted to CalOptima Health and DHCS is accurate, and to determine the applicant's compliance with state and federal enrollment requirements.

ii. CalOptima Health shall conduct post-enrollment site visits for medium-risk Providers at least every five (5) years, and their high-risk Providers every three (3) years or as necessary to verify that the information submitted to CalOptima Health and DHCS is accurate and determine if Providers are in compliance with state and federal enrollment requirements.

iii. Onsite visits may be conducted for many reasons, including, but not limited to, the following:

a) The Provider was temporarily suspended from the Medi-Cal program;

b) The Provider's license was previously suspended;

c) There is conflicting information in the Provider's enrollment application;

d) There is conflicting information in the Provider's supporting enrollment documentation; and

e) As part of the Provider enrollment process, CalOptima Health receives information that raises a suspicion of fraud.

k. Federal and State Database Checks

i. CalOptima Health shall check the following databases to verify the identity and determine the exclusion and/or enrollment status of all Providers:

a) Social Security Administration's Death Master File;

b) National Plan and Provider Enumeration System (NPPES);

c) List of Excluded Individuals/Entities (LEIE);

d) System for Award Management (SAM);

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e) CMS' Medicare Exclusion Database (MED);

f) DHCS' Suspended and Ineligible Provider List;

g) Restricted Provider Database (RPD); and

h) CHHS Open Data Portal.

ii. CalOptima Health shall also review the SAM, LEIE, and RPD databases on a regular basis, and at least monthly, to ensure that contracted Providers continue to meet enrollment criteria and take appropriate action in connection with the exclusion.

iii. Any Provider terminated from the Medicare or Medicaid/Medi-Cal program may not participate in CalOptima Health's Provider network.

l. If CalOptima Health declines to enroll a Provider, it must refer the Provider to DHCS for further enrollment options.

m. If the CalOptima Health acquires information, either before or after enrollment that may impact the Provider's eligibility to participate in the Medi-Cal program, or a Provider refuses to submit to the required screening activities, CalOptima Health may decline to accept that Provider's application.

n. If at any time CalOptima Health determines that it does not want to contract with a prospective Provider, and/or that the prospective Provider will not meet enrollment requirements, CalOptima Health must immediately suspend the enrollment process.

o. CalOptima Health is not obligated to establish an appeal process for screening and enrollment decisions. Providers may only appeal a suspension or termination to DHCS when the suspension or termination occurs as part of DHCS' denial of the Medi-Cal FFS enrollment application.

p. All Providers must resubmit and recertify the accuracy of their enrollment information as part of the revalidation process at least every five (5) years to ensure that all enrollment information is accurate and up to date.

q. CalOptima Health shall retain all Provider screening and enrollment materials and documents for ten (10) years.

r. CalOptima Health shall make all screening and enrollment documents and materials promptly available to DHCS, CMS, and any other authorized governmental entities upon request.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. California Evidence Code, §1157
B. CalOptima Health Contract for Health Care Services
C. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
D. CalOptima Health Contract with Covered California

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E. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
F. CalOptima Health PACE Program Agreement
G. CalOptima Health Policy GG.1355: CalAIM Community Supports
H. CalOptima Health Policy GG.1659: System Controls of Provider Credentialing Information
I. CalOptima Health Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities
J. CalOptima Health Policy GG.1607: Monitoring Adverse Actions
K. CalOptima Health Policy GG.1608: Full Scope Site Reviews
L. CalOptima Health Policy HH.1101: CalOptima Health Provider Complaint
M. CalOptima Health Policy MA.9006: Contracted Provider Complaint Process
N. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-015: Benefit Standardization and Mandatory Managed Care Enrollment Provisions of the California Advancing and Innovating Medi-Cal Initiative (Revised: 10/14/2022)
O. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-008: Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses (Supersedes APL 17-010)
O. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-013: Provider Credentialing/Recredentialing and Screening/Enrollment (Supersedes APL 19-004) (Revised: 08/24/2022)
P. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-002: Medi-Cal Managed Care Plan Responsibilities for Indian Health Care Providers and American Indian Members (Supersedes APL 09-009)
Q. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-011: Intermediate Care Facilities for Individuals With Developmental Disabilities – Long Term Care Benefit Standardization and Transition of Members to Managed Care (Supersedes APL 23-023)
R. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-015: California Children's Services Whole Child Model Program (Supersedes APL 23-034)
S. Title 42, Code of Federal Regulations, §§422.204(a), 422.205, 455.450 and Parts 424 and 431
T. Title 42, United States Code, §1320a-7(a)
U. Title 45, Code of Federal Regulations, Part 455
V. Title XVIII and XIV of the Social Security Act
W. Medicare Managed Care Manual Chapter 6-70 Institutional Provider and Supplier Certification
X. National Committee of Quality Assurance (NCQA) Standards CR7 – Assessment of Organizational Providers

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
07/15/2020	Department of Health Care Services (DHCS)	Approved as Submitted
04/20/2022	Department of Health Care Services (DHCS)	File and Use
01/09/2023	Department of Health Care Services (DHCS)	Approved as Submitted
08/14/2023	Department of Health Care Services (DHCS)	File and Use
05/02/2024	Department of Health Care Services (DHCS)	Approved as Submitted
10/16/2024	Department of Health Care Services (DHCS)	File and Use

VII. BOARD ACTION(S)

Date	Meeting
06/01/2017	Regular Meeting of the CalOptima Board of Directors
06/04/2020	Regular Meeting of the CalOptima Board of Directors
04/07/2022	Regular Meeting of the CalOptima Board of Directors
	Regular Meeting of the CalOptima Board of Directors

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VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	06/01/2017	GG.1651	Credentialing and Recredentialing of Healthcare Delivery Organizations	Medi-Cal OneCare OneCare Connect PACE
Revised	01/01/2018	GG.1651	Credentialing and Recredentialing of Healthcare Delivery Organizations	Medi-Cal OneCare OneCare Connect PACE
Revised	06/04/2020	GG.1651	Assessment and Re-Assessment of Organizational Providers	Medi-Cal OneCare OneCare Connect PACE
Revised	04/07/2022	GG.1651	Assessment and Re-Assessment of Organizational Providers	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	GG.1651	Assessment and Re-Assessment of Organizational Providers	Medi-Cal OneCare PACE
Revised	03/01/2023	GG.1651	Assessment and Re-Assessment of Organizational Providers	Medi-Cal OneCare PACE
Revised	08/01/2023	GG.1651	Assessment and Re-Assessment of Organizational Providers	Medi-Cal OneCare PACE
Revised	02/01/2024	GG.1651	Assessment and Reassessment of Organizational Providers	Medi-Cal OneCare PACE
Revised	04/01/2024	GG.1651	Assessment and Reassessment of Organizational Providers	Medi-Cal OneCare PACE
Revised	10/01/2024	GG.1651	Assessment and Reassessment of Organizational Providers	Medi-Cal OneCare PACE
Revised	04/01/2025	GG.1651	Assessment and Reassessment of Organizational Providers	Medi-Cal OneCare PACE
Revised	05/01/2025	GG.1651	Assessment and Reassessment of Organizational Providers	Covered California Medi-Cal OneCare PACE
Revised	08/01/2025	GG.1651	Assessment and Reassessment of Organizational Providers	Covered California Medi-Cal OneCare PACE

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IX. GLOSSARY

Term	Definition
Appeal	Covered California: A review by CalOptima Health of an adverse benefit determination, which includes one of the following actions: 1. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a service; 4. Failure to provide services in a timely manner; or 5. Failure to act within the required timeframes for standard and expedited resolution of grievances and appeals in accordance with Health & Safety Code § 1368. Medi-Cal: A review by CalOptima Health of an adverse benefit determination, which includes one of the following actions: 1. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a 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: As defined at 42 CFR §§ 422.561 and 423.560, the procedures that deal with the review of adverse initial determinations made by the plan on health care services or benefits under Part C or D the enrollee believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the enrollee) or on any amounts the enrollee must pay for a service or drug as defined in 42 CFR §§ 422.566(b) and 423.566(b). These appeal procedures include a plan reconsideration or redetermination (also referred to as a level 1 appeal), a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (Council), and judicial review. PACE: A Member's action taken with respect to the PACE organization's noncoverage of, modification of, or nonpayment for, a service including denials, reductions or termination of services, as defined by federal PACE regulation 42 CFR § 460.122.
Community Supports	Substitute services or settings to those required under the California Medicaid State Plan that CalOptima Health may select and offer to their Members pursuant to 42 CFR § 438.3(e)(2) when the substitute service or setting is medically appropriate and more cost-effective than the service or setting listed in the California Medicaid State Plan.

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Term	Definition
Covered California: *Effective 01/01/2027 for CalOptima Health*	The California Health Benefit Exchange, doing business as Covered California and an independent entity within the Government of the State.
Credentialing	Covered California: The initial process by which the qualifications of a Provider is verified in order to make a determination relating to the Provider's eligibility for participation in CalOptima Health's programs. Medi-Cal: The process of determining a Provider or an entity's professional or technical competence, and may include registration, certification, licensure and professional association membership. OneCare: The process of obtaining, verifying, assessing, and monitoring the qualifications of a Provider to provide quality and safe patient care services. PACE: The recognition of professional or technical competence. The process involved may include registration, certification, licensure, and professional association membership.
Credentialing Peer Review Committee	Peer review body who reviews Provider information and files and makes recommendations and decisions regarding Credentialing and Recredentialing
Credentialing Verification Organization (CVO)	For purposes of this policy, an organization that collects and verifies Credentialing information.
Delegate	An organization or entity granted authority to perform an activity on behalf of CalOptima within agreed-upon parameters. Any party that enters into an acceptable written arrangement below the level of the arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.

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Term	Definition
Durable Medical Equipment (DME) and Durable Medical Equipment Prosthetics Orthotics Supplier (DMEPOS)	Covered California: An item that is intended for repeated use, primarily and customarily used to serve a medical purpose, generally not useful to a person who is not ill or injured, and appropriate for use outside an institutional setting and includes: Mobility devices, including walkers and manual and power wheelchairs and scooters; augmented communications devices, such as speech generating devices, communications boards, and apps; continuous positive airway pressure (CPAP) machines; portable oxygen; hospital beds; for diabetes blood testing, blood glucose monitors and their supplies (such as blood glucose monitor test strips, lancets, and lancet devices); infusion pumps (such as insulin pumps) and supplies to operate the pump (but not including insulin or any other Drugs); standard curved handle or quad canes and replacement supplies; standard or forearm crutches and replacement supplies; dry pressure pads for a mattress; nebulizers and supplies; peak flow meters; and IV pole. Medi-Cal: Medically Necessary medical equipment as defined by 22 CCR section 51160 that a Provider prescribes for a Member that the Member uses in the home, in the community, or in a facility that is used as a home. OneCare: Medical equipment prescribed by a licensed Practitioner to meet medical equipment needs of the Member that: 1. Can withstand repeated use. 2. Is used to serve a medical purpose. 3. Is not useful to an individual in the absence of an illness, injury, functional impairment, or congenital anomaly. 4. Is appropriate for use in or out of the patient's home.
Facility Site Review	A DHCS tool utilized to assess the quality, safety and accessibility of primary care physicians (PCPs) and high-volume specialty care provider offices.
Grievance	Covered California: A written or oral expression of dissatisfaction regarding CalOptima Health, a Health Network, or a Provider, including quality of care concerns, Member's complaint about a delay or denial of payment on a claim, and shall include a complaint, dispute, request for reconsideration or Appeal made by a Member or the Member's representative. A complaint is the same as a Grievance. An inquiry is a request for more information that does not include an expression of dissatisfaction, including, but not limited to, questions pertaining to eligibility, benefits, or other CalOptima Health processes. If CalOptima Health is unable to distinguish between a Grievance and an inquiry, it must be considered a Grievance. Medi-Cal: Any expression of dissatisfaction about any matter other than an Adverse Benefit Determination (ABD), and may include, but is not limited to the Quality of Care or services provided, aspects of interpersonal relationships with a Provider or CalOptima Health's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by CalOptima Health to make an authorization decision. A complaint is the same as Grievance. An inquiry is a request for more information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other CalOptima Health processes. If CalOptima Health is unable to distinguish between a Grievance and an inquiry, it must be considered a Grievance.

For 20251106 BOD Review Only

Term	Definition
	OneCare: An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. PACE: A complaint, either written or oral, expressing dissatisfaction with service delivery or the quality of 17 care furnished, regardless of whether remedial action is requested, as defined by the federal PACE regulation 42 CFR § 460.120.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, health care service plan, such as a Health Maintenance Organization (HMO), Subcontractor, or First Tier Entity, that contracts with CalOptima Health to provide Covered Services to Members.
Member	An individual enrolled in a CalOptima Health program.
Organizational Provider (OP)	For purposes of this policy, organizations or institutions that are contracted to provide medical services such as, but not limited to: hospitals, home health agencies, nursing facilities (includes skilled nursing, long term care, and sub-acute), free standing ambulatory surgical centers, hospice services, community clinics including Federally Qualified Health Centers, urgent care centers, End-Stage renal disease services (dialysis centers), Residential Care Facility for the Elderly (RCFE), Community Based Adult Services (CBAS), Managed Long Term Services and Supports (MLTSS), durable medical equipment suppliers, radiology centers, clinical laboratories, outpatient rehabilitation facilities, outpatient physical therapy and speech pathology providers, diabetes centers, portable x-ray suppliers and methadone clinics, non-emergency medical transportation (NEMT), mobile blood bank, community home support services for housing, non-medical service practitioners.
Physical Accessibility Review Survey (PARS)	A DHCS tool used to assess the level of physical accessibility of provider sites, including PCPs, high volume specialists and ancillary service providers, and CBAS centers.
Practitioner	A licensed independent practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.

For 2025 10/6 BOD Review Only

Term	Definition
Provider	Covered California: A licensed health care facility or as stipulated by local or international jurisdictions, a program, agency or health professional that delivers Covered Services. Medi-Cal: Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so. OneCare: Any Medicare Provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician Provider, laboratory, supplier) 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.
Reassessment	The process by which Provider status is verified in order to make determinations relating to their continued eligibility for participation in the CalOptima Health program.
Regional Center (RC)	A non-profit, community-based entity that is contracted by Department of Developmental Services (DDS) and develops, purchases and manages services for Members with developmental disabilities and their families.

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For 20251106 BOD Review Only

CalOptima Health Board Action Agenda Referral

Action To Be Taken November 6, 2025
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

7. Approve CalOptima Health's Calendar Year 2026 Member Health Rewards

Contacts

Richard Pitts, D.O., Ph.D., Chief Medical Officer, (714) 246-8491
Linda Lee, Executive Director, Quality Improvement, (657) 900-1069

Recommended Action

1. Approve CalOptima Health's Calendar Year 2026 Member Health Rewards for Medi-Cal and OneCare.

Background

In Calendar Year (CY) 2025, CalOptima Health offers health rewards to eligible members through physical gift cards for Medi-Cal and &more flex card rewards for OneCare, to enhance member health and quality outcomes. CalOptima Health provides Medi-Cal and OneCare members with health rewards for preventive services, including annual wellness visit, blood lead test(s), breast cancer screening, cervical cancer screening, colorectal cancer screening, diabetes tests, postpartum care, osteoporosis testing, and follow-up care for children prescribed ADHD medication.

Medi-Cal

The Medi-Cal member health rewards program has both provider attestation and automated claims-based rewarding. Annual wellness visits, health risk assessment, and diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications have historically been automated reward incentives. The remaining member incentives require provider attestations.

OneCare

The OneCare member health rewards program has both self-attestation and automated claims-based rewards. Annual wellness visits and health risk assessment are automated rewards. The remaining member incentives require a self-attestation form. In CY 2025, the OneCare &more flex benefit card is being used as the vehicle for member health rewards, which can be used for any purchases permissible through the &more card. The transition to digital self-attestation forms and automated rewards in CY 2025 has increased health reward processing efficiency and minimized turnaround time for members to receive their rewards.

Discussion

Health rewards may motivate members to establish primary care relationships and get recommended preventive care and screenings. Rewards may encourage members to receive important tests, reinforce health behaviors, and positively impact member experience. Health rewards were selected based on clinical areas with the largest opportunity for improvement and those measures where CalOptima Health has performed below established benchmarks.

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Staff recommend maintaining the following health rewards from CY 2025 for CY 2026 as detailed in the table below:

Proposed CY2026 Member Incentives		
Medi-Cal		**OneCare**
Automated Reward		**Automated Reward**
Annual Wellness Visit- $50		Health Risk Assessment- $25
Blood Lead Test 12 Months of Age- $25		
Blood Lead Test 24 Months of Age- $25		
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications- $25		
Provider Attestation Reward		**Self-Attestation Reward**
Breast Cancer Screening- $25		Annual Wellness Visit- $50
Cervical Cancer Screening- $25		Breast Cancer Screening- $25
Colorectal Cancer Screening- $50*		Colorectal Cancer Screening- $50*
Diabetes A1c Test- $25		Diabetes A1c Test- $25
Diabetes Eye Exam- $25		Diabetes Eye Exam- $25
Postpartum Checkup- $25		Osteoporosis Screening- $25

*The reward amount will vary based on the type of colon cancer screening test completed: $15 for fecal occult blood test (FOBT) or fecal immunochemical test (sDNA FIT), $25 for CT colonography or flexible sigmoidoscopy, or $50 for colonoscopy.

Staff recommends the following revisions to the health rewards program for CY 2026. To align with the US Preventive Services Task Force (USPSTF) recommendations, the Colorectal Cancer Screening health reward will be expanded to include four types of colon cancer screening tests: FOBT, sDNA FIT, CT colonography, and flexible sigmoidoscopy.

Additionally, in accordance with USPSTF guidelines, the Medi-Cal member health rewards will recognize screenings, tests, or exams completed outside the standard age criteria. This adjustment acknowledges that members may require these screenings, tests, or exams at different intervals and may not adhere strictly to the recommended age criteria.

Staff recommend Osteoporosis Screening be revised to reward members who get a bone mineral density test or additionally those who fill a prescription for a drug to treat osteoporosis. This addition is in alignment with clinical practice guidelines which aim to reduce fracture risk by encouraging early intervention rather than waiting for adverse events such as falls.

Staff recommends revising the OneCare Annual Wellness Visit Member Health Reward from an automated, claims-based reward to self-attestation. In 2025, OneCare Member Health Rewards were upgraded to digital form submission, eliminating the need for members to bring a physical form to the provider's office and either mail or fax it to CalOptima Health. This proactive, streamlined approach is designed to enhance member engagement, reduce barriers, minimize inquiries and grievances, and increase member ownership of their health. The Annual Wellness Visit Health Reward has shown a

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strong correlation as a gateway to complete other screenings such as breast cancer screening, colorectal cancer screening, and retinal eye exams for members with diabetes. By implementing self-attestation, members will not only become more aware of other health offerings but also learn how to access their rewards through the &more flex card. This change is expected to further improve member satisfaction and health outcomes.

Program Changes		
Medi-Cal		**OneCare**
Breast Cancer Screening - Update age criteria to 40-74 years old		Osteoporosis Screening - Expand criteria to allow medication treatment as a qualifying event
Colorectal Cancer Screening - Update to allow other colon cancer screening methods		Colorectal Cancer Screening - Update to allow other colon cancer screening methods
		Annual Wellness Visit - Change process for rewarding to self-attestation

For CY 2026, the Behavioral Health Department recommends discontinuing the Follow-Up Care for Children Prescribed ADHD Medication (ADD) health reward due to the low participation rate (fewer than 5 participants in CY 2024) and the unique qualifications required. In its place, the Behavioral Health Department has developed an ADD text campaign to remind members who qualify for the ADD measure to follow up with their provider within 30 days of filling their first prescription.

Retire		
Medi-Cal		**OneCare**
Follow-up Care for Children Prescribed ADHD Medication		N/A

Members will receive a health reward upon completing the qualifying event. At the time of budgeting, staff assumed a member participation rate of 15-20%* based on historical participation rates and an anticipated increase in member participation. Should the participation rates exceed these assumptions and budgeted amounts, staff will return to the Board of Directors for additional funding requests at future meetings. Other participation rate assumptions are as follows:

** **Automated Health Rewards:***

- *Annual Wellness Visit (OneCare): Participation rate is assumed at 45%, consistent with past participation.*
- *Blood Lead Test at 12 and 24 Months (Medi-Cal): Participation rate is assumed at 71.11% (75th percentile), which is the next benchmark following achievement of the DHCS minimum performance level for Measurement Year (MY) 2024.*
- *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications (Medi-Cal): Participation rate is assumed at 84.63% (75th percentile), supporting alignment with Behavioral Health initiatives.*
- *Health Risk Assessment (OneCare): Participation rate is assumed at 76%, in line with the current CMS 4-star rating.*

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**** Self-Attestation Rewards:***

- *Annual Wellness Visit (Medi-Cal): Participation rate is assumed at 25%, based on past participation.*
- *All other member health rewards participation rate is assumed at 15% for Medi-Cal and 20% for OneCare.*

Program Funding

Staff recommends utilizing unearned MY 2024 Pay for Value Performance Program (P4V Program) dollars to fund the member health reward program. MY 2024 Medi-Cal P4V rewards have been preliminarily calculated. The total Medi-Cal P4V pool was $101 million (based on 10% of professional capitation for Fiscal Year 2024-25) with $31 million earned and $70 million unearned. The MY 2024 OneCare P4V will be calculated in November 2025 pending results from member satisfaction surveys. Staff expects OneCare performance similar to Medi-Cal with 30% earned and 70% unearned.

Fiscal Impact

Medi-Cal:

The recommended action has no additional fiscal impact on the operating budget. The estimated cost for the CY 2026 Medi-Cal Member Health Rewards program is $6.3 million. Staff anticipates that unearned funds from the MY 2024 Medi-Cal P4V Program will be sufficient to fund the program.

OneCare:

The recommended action has no additional fiscal impact on the operating budget. The estimated cost for the CY 2026 OneCare Member Health Rewards program is $1.0 million. Staff anticipates that unearned funds from the MY 2024 OneCare P4V Program will be sufficient to fund the program.

Rationale for Recommendation

A member health reward program will strengthen the primary care provider-patient relationship, improve the quality of care delivered to CalOptima Health members by promoting preventive care, early identification, chronic care management, and identify opportunities to coordinate care based on an annual wellness visit.

Concurrence

Troy R. Szabo, Outside General Counsel, Kennaday Leavitt
Board of Directors' Quality Assurance Committee

Attachment

1. Calendar Year 2026 Member Health Rewards for Medi-Cal and OneCare Presentation

/s/ Michael Hunn *10/30/2025*
Authorized Signature **Date**

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Calendar Year 2026 Member Health Rewards for Medi-Cal and OneCare

Quality Assurance Committee Meeting

October 8, 2025

Linda Lee, Executive Director, Quality Improvement

Our Mission

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

Our Vision

Provide all members with access to care and supports to achieve optimal health and well-being through an equitable and high-quality health care system.

Current 2025 Member Health Rewards Program

- CalOptima Health provides health rewards and incentives to members for completing preventive services
- 11 Medi-Cal Health Rewards
  - Rewards are through physical cards
  - Provider attestation and passive reward mechanism
- 7 OneCare Health Rewards
  - Rewards are through the flex benefit card
  - Self attestation and passive reward mechanism

CalOptima Health

2026 Medi-Cal Program and Proposed Changes

Mechanism	Medi-Cal Health Reward	Reward Amount	Proposed Changes
Passive	Annual Wellness Visit	$50	
	Blood Lead Test 12 Months of Age	$25	
	Blood Lead Test 24 Months of Age	$25	
	Diabetes Screening for People with Schizophrenia or Bipolar…*	$25	
Provider Attestation	Breast Cancer Screening	$25	Update age criteria to 40-74 years old
	Cervical Cancer Screening	$25	
	Colorectal Cancer Screening	$15-50**	Expand to include other screening options
	Diabetes A1c Test	$25	
	Diabetes Eye Exam	$25	
	Postpartum Checkup	$25	

*Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications. **Reward varies: $15 for FIT or FOBT, $25 for CT colonography or flexible sigmoidoscopy, or $50 for colonoscopy .

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2026 OneCare Program and Proposed Changes

Mechanism	OneCare Health Reward	Reward Amount	Proposed Changes
Passive	Health Risk Assessment	$25	
Self Attestation	Annual Wellness Visit	$50	Change reward process to self-attestation
	Breast Cancer Screening	$25	
	Colorectal Cancer Screening	$15-50**	Expand to include other screening options
	Diabetes A1c Test	$25	
	Diabetes Eye Exam	$25	
	Osteoporosis Screening	$25	Expand criteria to allow medication treatment

**Reward varies: $15 for FIT or FOBT, $25 for CT colonography or flexible sigmoidoscopy, or $50 for colonoscopy .

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2026 Proposed Revisions

- Breast Cancer Screening, Medi-Cal:
  - Update age criteria to 40-74 years
- Osteoporosis Screening, OneCare:
  - Expand criteria to allow medication treatment
- Annual Wellness Visit, OneCare:
  - Change rewarding process to self-attestation

2026 Proposed Revisions

- Colorectal Cancer Screening, Medi-Cal and OneCare:
  - Expand eligible screening options:
    - Health Reward 1:
      - $15 fecal occult blood test (FOBT), or
      - $15 fecal immunochemical test (sDNA FIT), or
      - $25 for CT colonography, or
      - $25 flexible sigmoidoscopy
    - Health Reward 2:
      - $50 for colonoscopy

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Retire

- Medi-Cal, Follow-up Care for Children Prescribed ADHD Medication

Summary of Fiscal Impact

- Estimated Cost at 15-20% Response Rate
  - Medi-Cal: approximately $6.25 million
  - OneCare: approximately $1.03 million

	2025	2026	Budget Difference
Medi-Cal	$4,865,244	$6,250,382	$1,385,138
OneCare	$656,130	$1,026,665	$370,535

Passive health rewards were calculated based on Quality Compass Benchmarks or Star goals.

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Appendix

Medi-Cal 2026 Projected Cost

Member Health Rewards	Reward Value	2026 Projected Expenditure
Annual Wellness Visit (AWV)	$50.00	$3,125,000.00
Blood Lead Test at 12 Months of Age (BLT12)	$25.00	$175,161.71
Blood Lead Test at 24 Months of Age (BLT24)	$25.00	$175,161.71
Breast Cancer Screening (BCS)	$25.00	$254,250.00
Cervical Cancer Screening (CCS)	$25.00	$756,255.00
Colorectal Cancer Screening (COL)	$50.00	$1,292,520.00
Diabetes A1C Test (GSD)	$25.00	$172,875.00
Diabetes Eye Exam (EED)	$25.00	$172,875.00
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications (SSD)	$25.00	$105,152.78
Postpartum Checkup (PPC)	$25.00	$21,131.25
	Total	$6,250,382.44

AWV projected at 25% participation rate. BLT 12, BLT 24 and SSD projected at the 75th percentile. All other health rewards projected at 15% participation rate.

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OneCare 2026 Projected Cost

Member Health Rewards	Reward Value	2026 Projected Expenditure
Annual Wellness Visit (AWV)	$50.00	$450,000.00
Breast Cancer Screening (BCS)	$25.00	$27,680.00
Colorectal Cancer Screening (COL)	$50.00	$109,580.00
Diabetes A1C Test (GSD)	$25.00	$21,380.00
Diabetes Eye Exam (EED)	$25.00	$21,380.00
Health Risk Assessment (HRA)	$25.00	$380,000.00
Osteoporosis Screening (OSW, OMW)	$25.00	$16,645.00
		$1,026,665.00

AWV projected at 45% participation rate. HRA projected at 4 Stars Goal. All other health rewards projected at 20% participation rate.

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CalOptima Health Board Action Agenda Referral

Action To Be Taken November 6, 2025
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

8. Ratify Amendments to CalOptima Health's Primary Agreement and Secondary Agreement with the California Department of Health Care Services

Contact

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

Recommended Action

Ratify Calendar Year 2025 – A Contract Amendment to the Primary Agreement and CY 2024 Contract Amendment to the Secondary Agreement between the California Department of Health Care Services and CalOptima Health.

Background

The purpose of this COBAR is to request that the CalOptima Health Board of Directors ratify the finalized CY 2025 – A contract amendment to the Primary Agreement and CY 2024 contract amendment to the Secondary Agreement, which were signed by the CalOptima Health Board of Directors Chair in September 2025 and July 2025, respectively, to meet Department of Health Care Services (DHCS) deadlines.

As a county organized health system, CalOptima Health contracts with DHCS to provide health care services to Medi-Cal members in Orange County. CalOptima Health has a Primary and Secondary Agreement with DHCS.

- The Primary Agreement contains, among other terms and conditions, the payment rates CalOptima Health receives from DHCS to provide health care services.
- The Secondary Agreement is a companion agreement to CalOptima Health's Primary Agreement and covers specific Medi-Cal state-supported services for CalOptima Health's members enrolled under the Primary Agreement.

In January 2024, CalOptima Health entered into new Primary and Secondary Agreements with DHCS. The new Primary Agreement is Agreement 23-30235, and the new Secondary Agreement is Agreement 23-30267. The amendments to the new agreements are summarized in Attachment 1. Annual amendments for the DHCS Primary and Secondary agreements are a routine occurrence. The main changes in the current amendments to the Primary Agreement and Secondary Agreement are the finalization of CY 2025 language and benefit changes and extending the terms of the Primary and Secondary Agreement to December 31, 2026.

Discussion

Calendar Year (CY) 2025 – A Contract Amendment to the Primary Agreement

Overview

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The CalOptima Health Board of Directors Chair signed the finalized CY 2025 – A Contract Amendment in September 2025 to meet the DHCS deadline of September 30, 2025. Staff requests the CalOptima Health Board of Directors ratify the Chair's execution of the amendment with DHCS.

Detailed Discussion
This amendment will bring CalOptima Health's agreement with DHCS into alignment with requirements effective January 1, 2025. *See* Attachment 4 for further information regarding the changes contained within this amendment.

The CY 2025 – A Contract Amendment contains notable language changes, which DHCS has generally already implemented by issuing sub-regulatory guidance such as All-Plan Letters. The requirements in DHCS' agreements with MCPs, including CalOptima Health, require Centers for Medicare & Medicaid Services (CMS) approval. DHCS' implementation of these requirements via sub-regulatory guidance prior to their formal inclusion in the MCP agreements is largely due to the lengthy CMS review process. While the contractual requirements are being formalized, CalOptima Health staff has implemented the required operational changes and other contractual requirements by following the sub-regulatory guidance issued by DHCS. The amendment extends the term of CalOptima Health's Primary Agreement with DHCS to December 31, 2026. The Amendment also extends the term of CalOptima Health's Secondary Agreement to December 31, 2026, based on a provision within the Secondary Agreement stating that the agreement will continue in full force and effect through the term of the Primary Agreement.

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

CY 2024 Contract Amendment to the Secondary Agreement
Overview
The CalOptima Health Board of Directors Chair signed the finalized CY 2024 Contract Amendment in July 2025 to meet the DHCS deadline of July 10, 2025. Staff requests the CalOptima Health Board of Directors ratify the Chair's execution of the amendment with DHCS.

Detailed Discussion
This amendment incorporates changes to the Unsatisfactory Immigration Status (UIS) Member definition and the Change Order Process to align with the Primary Agreement.

Fiscal Impact
The provisions in the contract amendments are operational in nature. There is no additional direct fiscal impact on the CalOptima Health Fiscal Year (FY) 2025-26 Operating Budget.

Rationale for Recommendation
CalOptima Health's execution of the CY 2025 – A Contract Amendment to its Primary Agreement and CY 2024 Contract Amendment to its Secondary Agreement with DHCS is necessary for the continued operation of CalOptima Health's Medi-Cal program.

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Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Appendix Summary of Amendments to Primary and Secondary Agreements with DHCS
2. CalOptima Health_2024 MCP Primary Contract + Amendments
3. CalOptima Health_2024 MCP Secondary Contract + Amendments
4. Additional CY 2025-A Contract Amendment Detail

/s/ Michael Hunn *10/30/2025*
Authorized Signature **Date**

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APPENDIX TO AGENDA ITEM 8

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

Amendments to Primary Agreement	Board Approval
Primary Agreement 23-30235 provides language and benefit changes effective January 1, 2024.	December 7, 2023
A-01 incorporates Calendar Year (CY) 2024 capitation rates.	March 7, 2024
A-02 incorporates language and benefit changes effective January 1, 2024.	August 1, 2024
A-03 extends the term of the Primary Agreement and Secondary Agreement (23 – 30267) (by default) to December 31, 2025.	November 7, 2024
A-04 incorporates updated final Calendar Year (CY) 2024 capitation rates.	April 3, 2025
A-05 incorporates final Calendar Year (CY) 2025 capitation rates and extends the Enhanced Care Management (ECM) risk corridor rating period through December 31, 2025.	April 3, 2025
A-06 incorporates language and benefit changes effective January 1, 2024.	June 5, 2025
A-07 incorporates language and benefit changes effective July 1, 2024.	August 7, 2025
A-08 incorporates language and benefit changes effective January 1, 2025, and extends the term of the Primary Agreement and Secondary Agreement (by default) to December 31, 2026.	November 6, 2025

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

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

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

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

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

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

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

Amendments to Secondary Agreement	Board Approval
Agreement 23 – 30267 covers specific state – supported services to CalOptima Health's members enrolled under CalOptima Health's Primary Agreement (23 – 30235).	December 7, 2023
A-01 incorporates Calendar Year (CY) 2024 capitation rates.	March 7, 2024
A-02 incorporates updated final Calendar Year (CY) 2024 capitation rates.	April 3, 2025
A-03 incorporates final Calendar Year (CY) 2025 capitation rates.	April 3, 2025
A-04 incorporates changes to the Unsatisfactory Immigration Status (UIS) Member definition and Change Order Process.	November 6, 2025

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

Amendments to Secondary Agreement	Board Approval
A-01 implemented rate amendments to conform to rate amendments contained in the Primary Agreement with DHCS (08-85214).	July 8, 2010

A-02 implemented rate adjustments to reflect a decrease in the statewide average cost for Sensitive Services for the rate period July 1, 2010 through June 30, 2011.	August 4, 2011
A-03 extended the term of the Secondary Agreement to December 31, 2014.	June 6, 2013
A-04 incorporates rates for the periods July 1, 2011 through June 30, 2012, and July 1, 2012 through June 30, 2013 as well as extends the current term of the Secondary Agreement to December 31, 2015	January 5, 2012 (FY 11-12 and FY 12-13 rates) May 1, 2014 (term extension)
A-05 incorporates rates for the periods July 1, 2013 through June 30, 2014, and July 1, 2014 through June 30, 2015. For the period July 1, 2014 through June 30, 2015, Amendment A-05 also adds funding for the Medi-Cal expansion population for services provided through the Secondary Agreement.	December 4, 2014
A-06 incorporates rates for the period July 1, 2015 onward. A-06 also extends the term of the Secondary Agreement to December 31, 2016.	May 7, 2015 (term extension) Ratification of rates requested April 7, 2016
A-07 extends the Secondary Agreement with the DHCS to December 31, 2020.	December 1, 2016
A–08 incorporates Adult & Family/Optional Targeted Low–Income Child and Adult Expansion rates for July 2016 to June 2017 and July 2017 to June 2018.	December 6, 2018
A-09 incorporates updated Calendar Year (CY) 2022 Public Health Emergency (PHE) capitation rates.	November 2, 2023
A-10 extends the Secondary Agreement with DHCS to December 31, 2021	November 5, 2020
A-12 extends the Secondary Agreement with DHCS to December 31, 2022.	October 7, 2021

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

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

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

Amendments to Agreement 16-93274	Board Approval
A-01 extends the Agreement 16-93274 with DHCS to December 31, 2018.	August 3, 2017
A–02 extends the Agreement 16–93274 with DHCS to December 31, 2019	June 7, 2018
A–03 extends the Agreement 16–93274 with DHCS to December 31, 2020	May 2, 2019
A–04 extends the Agreement 16–93274 with DHCS to December 31, 2021	June 4, 2020
A–05 extends the Agreement 16–93274 with DHCS to December 31, 2022.	June 3, 2021
A-06 extends Agreement 16 – 93274 with DHCS to December 31, 2023.	May 5, 2022
A-07 extends Agreement 16 – 93274 with DHCS to December 31, 2023.	October 6, 2022
A-08 extends Agreement 16 – 93274 with DHCS to December 31, 2023.	Not applicable due to non – substantive changes.
A-09 extends Agreement 16 – 93274 with DHCS to December 31, 2024.	May 4, 2023
A-10 extends Agreement 16 – 93274 with DHCS to December 31, 2025.	May 2, 2024

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

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

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

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

Exhibit A
SCOPE OF WORK

I. Service Overview

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

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

II. Service Location

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

III. Service Hours

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

IV. Contract Representatives

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

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

B. Direct all inquiries to:

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Exhibit A
SCOPE OF WORK

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

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

V. Americans with Disabilities Act

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

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

Exhibit A, ATTACHMENT I

1.0 Definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Behavioral Health Services means Specialty Mental Health Services (SMHS), Non-**S**~~s~~pecialty Mental Health Services (NSMHS), and Substance Use Disorders (SUD) treatment.

Behavioral Health Treatment (BHT) means services and treatment programs ~~for the treatment of Autism Spectrum Disorder (ASD), as specified in the California Medicaid State Plan~~, including applied behavioral analysis and other evidence-based intervention programs**,** that ~~develop or restore~~**prevent or minimize the adverse effects of symptoms and behaviors that may interfere with learning and social interaction and promote,** to the maximum extent practicable, the functioning of a Member ~~less than~~**under** 21 years of age**,** ~~who has been diagnosed with~~ **including those diagnosed with Autism Spectrum Disorder (**ASD**)**, ~~or for whom~~**as determined to be medically necessary for the child by** a licensed physician~~, surgeon,~~ or psychologist**.** ~~has determined BHT is Medically Necessary.~~

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

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

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

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

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

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B. Any associated Medicaid waivers as approved by CMS pursuant to 42 USC section 1396n, including but not limited to the CalAIM Section 1915(b) Waiver Control Number CA 17.R10, that are necessary to implement a CalAIM component, including for any applicable extension period, or for any period otherwise specified in the CalAIM Terms and Conditions.

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

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

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

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

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

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

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

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

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

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

A. Services the Member receives by Contractor;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Complex Care Needs means the multifaceted health and social support requirements of Members who face significant barriers to achieving and maintaining health and stability. This includes individuals with multiple chronic conditions, functional impairments, behavioral health challenges, or those requiring extensive care coordination due to social determinants of health.

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

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

Contract means this written agreement between DHCS and Contractor.

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

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

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

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

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

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

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

Covered Services do not include:

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

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

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

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

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

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

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

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

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

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

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

L. State Supported Services;

M. Targeted Case Management (TCM) services as set forth in 42 USC section 1396n(g), W&I sections 14132.48 and 14021.3, 22 CCR sections 51185 and 51351, and as described in Exhibit A, Attachment III, Subsection 4.3.11

(*Targeted Case Management Services*). However, if Members less than 21 years of age are not eligible for or accepted by a Regional Center (RC) or a local government health program for TCM services, Contractor must ensure access to comparable services under the EPSDT benefit in accordance with APL 23-005;

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

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

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

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

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

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

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

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

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

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

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

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

Director means the Director of DHCS.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

B. Serious impairment to bodily functions;

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

D. Death.

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

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

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

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

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

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

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

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

ECM Streamlined Authorization policy means that select ECM Providers as defined in Exhibit A, Attachment III, Subsection 4.4.7 (*Authorizing Members for Enhanced Care Management*) may initiate ECM services and must be reimbursed for those services for a period of up to 30 calendar days – while the ECM Provider refers the Member to the Contractor and awaits the Contractors' ECM authorization decision.

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

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

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

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

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

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

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

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

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

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

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

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

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

Financial Statements means reports prepared by Contractor to present its financial performance and position at a point in time, and include a balance sheet, income statement, statement of cash flows, statement of equity and accompanying footnotes prepared in accordance with Generally Accepted Accounting Principles (GAAP).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Intermediate Care Facility (ICF) means a **health**~~residential~~ facility **that**~~certified and licensed by the State to provide medical services at a lower level of care than is provided at Skilled Nursing Facilities (SNFs), and~~ meets the standards specified in 22 CCR section 51212 **and provides inpatient care to ambulatory or non-ambulatory patients who have recurring need for skilled nursing supervision and need supportive care, but who do not require availability of continuous skilled nursing care**~~. An Intermediate Care Facility for the Developmentally Disabled (ICF/DD) includes the following types:~~

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

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

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

Intermediate Care Facility/Developmentally Disabled (ICF/DD) means a facility that provides 24-hour personal care, habilitation, developmental, and supportive health services to persons with developmental disabilities whose primary need is for developmental services and who have a recurring but intermittent need for skilled nursing services. An Intermediate Care Facility/Developmentally Disabled (ICF/DD) includes the following types:

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

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

C. ICF/DD for purposes of this contract does not include the ICF/DD-Continuous Nursing Care Program.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Member Information means documents that are vital, or critical to obtaining benefits or services, and includes, but is not limited to: the Member Handbook, Provider Directory, welcome packets, Marketing information, form letters including Notice of Actions (NOA),

notices related to Grievances or Appeals, including Grievance and Appeal acknowledgement and resolution letters, Contractor's preventive health reminders, Member surveys, notices advising of the availability of free language assistance, and newsletters.

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

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

Minor Consent Services means those Covered Services of a sensitive nature which minors **Members under 18 years of age** may, without parental or guardian consent, receive**, if the minor, in the opinion of the attending professional person, is mature enough to participate intelligently in the outpatient services**. Minor Consent Services include, but are not limited to the following situations:

Under Age 12

A. Pregnancy and pregnancy related services

B. Family planning services

C. Sexual assault services

Age 12 and Older

D. Pregnancy and pregnancy related services

E. Family planning services

F. Sexual assault services

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

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

I. Drug and alcohol abuse treatment and counseling

J. Outpatient mental health treatment and counseling **if in the opinion of the attending professional person determines that the minor is mature enough to participate intelligently in their health care pursuant to Family Code section 6924.**

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

K. Intimate partner violence services

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

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

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

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

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

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

Network Provider Data means information concerning all Network Providers in a Network, regardless of location, which render Covered Services to Members in a Contractor's Service Area and the provider groups, Subcontractors, and/or Downstream Subcontractors, if any, under which a Network Provider renders those services. This includes, but is not limited to, information about the contractual relationship between Network Providers, provider groups, Subcontractors, and Downstream Subcontractors within the Network, information regarding the facilities where services are rendered, and information about a Network Provider's area(s) of specialization.

No Wrong Door means Members receive timely Behavioral Health Services without delay, regardless of delivery system where they seek care and are able to maintain

treatment relationships with trusted Providers without interruption. This includes concurrent service provision, whereby Contractor must cover Medically Necessary Non-**S**~~s~~pecialty Mental Health Services (NSMHS) for a Member concurrently receiving Specialty Mental Health Services (SMHS) covered by the county Mental Health Plan (MHP), and ensure those services are coordinated and not duplicative. Contractor must ensure compliance with No Wrong Door pursuant to W&I section 14184.402.

Non-Emergency Medical Transportation (NEMT) means ambulance, litter van, wheelchair van, and air medical transportation services. NEMT is used when the Member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated, and transportation is required for the purpose of obtaining needed medical care, and pursuant to 22 CCR sections 51323, 51231.1, and 51231.2, is rendered by licensed Providers.

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

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

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

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

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

D. Psychiatric consultation; and

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

Operations Period means the period of time between the effective date of the first month of operations and continues on through the last month of Contractor’s capitation and provision of services to Members. The Operations Period commences at the

conclusion of the Implementation Period upon DHCS' acceptance of Contractor's completion of any readiness requirements required by DHCS.

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

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

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

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

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

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

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

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

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

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

Potential Member or **Potential Enrollee** means a Medi-Cal beneficiary who resides in Contractor's Service Area and is subject to mandatory Enrollment, or who may voluntarily elect to enroll, but is not yet enrolled, in a Medi-Cal managed care health plan, and is **in one of the aid codes found within Exhibit L, Article 1.0 (*Definitions*).** ~~in one of the following aid codes:~~

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

	~~66, 6A, 6C, 6E, 6G, 6H, 6J, 6N, 6P, 6V, 6X, L6~~	
~~SPD~~	~~10, 14, 16, 1E, 1H, 20, 24, 26, 2E, 2H, 36, 60, 64, 66, 6A, 6C, 6E, 6G, 6H, 6J, 6N, 6P, 6V, L6~~	
~~Adult Expansion~~	~~L1, M1, 7U~~	
~~Breast and Cervical Cancer Treatment Program (BCCTP)~~	~~0M, 0N, 0P, 0R, 0T, 0U, 0W~~	
~~Long-Term Care~~	~~13, 23, 53, 63~~	
~~Long-Term Care Dual~~	~~13, 23, 53, 63~~	

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

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

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

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

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

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

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

Provider Directory means Contractor's listing of all Network Providers and that includes the Providers' contact information, whether the Provider is accepting new Members, the hours of operation, what languages are available in the Provider's office

and whether the Provider's office has accommodations, including offices, exam rooms and equipment, for people with physical disabilities.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

State means the State of California.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Tribal Health Program means an American Indian tribe or tribal organization that operates any health program, service, function, activity, or facility funded, in whole or part, by the Indian Health Service through, or provided for in, a contract or compact with the Indian Health Service under the Indian Health Service under the Indian Self-Determination and Education Assistance Act and is defined in 25 USC section 1603(25).

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

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

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

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

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

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

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

Working Capital Ratio means a liquidity ratio, calculated as current assets divided by current liabilities, that measures Contractor’s ability to pay its current liabilities with

current assets. Working Capital Ratio is computed in accordance with Generally Accepted Accounting Principles (GAAP).

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

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

2.0 Acronyms

Medi-Cal Managed Care Contract Acronyms List

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

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

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

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

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

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

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

Exhibit A, ATTACHMENT II

1.0 Operational Readiness Deliverables and Requirements

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

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

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

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

Dual Special Needs Plan

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

EXHIBIT A, ATTACHMENT I – 1.0 DEFINITIONS

No deliverables listed for this Article.

EXHIBIT A, ATTACHMENT I – 2.0 ACRONYMS

No deliverables listed for this Article.

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

See specific contract Sections below for details.

EXHIBIT A, ATTACHMENT III – 1.1 PLAN ORGANIZATION AND ADMINISTRATION

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

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

EXHIBIT A, ATTACHMENT III – 1.2 FINANCIAL INFORMATION

Identifier	Operational Readiness Requirement
R.0012	Submit most recent audited annual financial reports.
R.0013	Submit quarterly Financial Statements with the most recent quarter prior to execution of the Contract.
R.0014	Submit the Knox-Keene license exhibits reflecting projected financial viability as specified in Exhibit A, Attachment III, Section 1.2 (*Financial Information*) and 28 CCR section 1300.76.
R.0015	Submit Knox-Keene license Exhibit HH-6 as specified in Exhibit A, Attachment III, Section 1.2 (*Financial Information*) and 28 CCR section 1300.51(d)(HH).
R.0016	1) Describe any risk sharing or Incentive Arrangements. 2) Explain any intent to enter into a stop loss option with DHCS. 3) Describe any reinsurance and risk-sharing arrangements with any Subcontractors and Downstream Subcontractors shown in this Contract. 4) Submit copies of all policies and agreements. 5) Comply with assumption of financial risk and reinsurance requirements pursuant to 22 CCR sections 53863 and 53868. Comply with directed payments requirements pursuant to 42 Code of Federal Regulations (CFR) section 438.6.
R.0017	Fiscal Arrangements: Submit the Knox-Keene license exhibits as described in Exhibit A, Attachment III, Section 1.2 (*Financial Information*) and in 28 CCR section 1300.51.
R.0018	Describe systems for ensuring that Subcontractors, Downstream Subcontractors, and Network Providers who are providing services to Medi-Cal Members, have the administrative and financial capacity to meet its contractual obligations and requirements, as described in Exhibit A, Attachment III, Section 1.2 (*Financial Information*) and in 22 CCR section 53250 and 28 CCR section 1300.70.
R.0019	Submit financial policies that relate to Contractor's systems for budgeting and operations forecasting. The policies should include comparison of actual operations to budgeted operations, timelines used in the budgetary process, number of years prospective forecasting is performed, and variance analysis and follow-up procedures.

Identifier	Operational Readiness Requirement
R.0020	Describe process to ensure timely filing of required financial reports as described in Exhibit A, Attachment III, Section 1.2 (*Financial Information*). Contractor must also describe how it will comply with the Administrative Cost requirements referenced in 22 CCR section 53864(b).
R.0021	Provide letters of financial support, credit, bond, or loan guarantee or other financial guarantees, if any, in at least the same amount that the obligations to Members will be performed.

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

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

EXHIBIT A, ATTACHMENT III – 2.1 MANAGEMENT INFORMATION SYSTEM

Identifier	Operational Readiness Requirement
R.0026	Submit a completed MCO Baseline Assessment Form.
R.0027	If procuring a new Management and Information System (MIS) or modifying a current system, Contractor must provide a detailed implementation plan that includes the following: 1) Outline of the tasks required; 2) The major milestones; and 3) The responsible party for all related tasks. In addition, the implementation plan must also include: 1) A full description of the acquisition of software and hardware, including the schedule for implementation; 2) Full documentation of support for software and hardware by the manufacturer or other contracted party; 3) System test flows through a documented process that has specific control points where evaluation data can be utilized to correct any deviations from expected results; and 4) Documentation of system changes related to Exhibit G, (*Business Associate Addendum*) requirements.

Identifier	Operational Readiness Requirement
R.0028	Submit a detailed description, including a diagram and/or flow chart, of how Contractor will monitor the flow of Encounter Data, Network Provider Data, Program Data, Template Data, and all other data required by this Contract from origination at the Provider level to Contractor, through submission to DHCS as well as how Contractor will transmit information regarding general and specific data quality issues identified by DHCS from origination to Providers for correction.
R.0029	Submit Encounter Data, Provider data, Program Data, and Template Data test files as required by DHCS, produced using real or proxy data processed by a new or modified MIS to DHCS. Production data submissions from a new or modified MIS may not take place until this test has been successfully reviewed and approved by DHCS.
R.0030	Submit policies and procedures for the submission of complete, accurate, reasonable and timely Encounter Data, Provider data, Program Data, Template Data, and all other data required by this Contract, including how Contractor will correct data quality issues identified by DHCS.
R.0032	Submit the data security, backup, or other data disaster processes used in the event of a MIS failure.
R.0033	Submit a detailed description, including details regarding interoperability, of the proposed and/or existing MIS as it relates to each of the subsystems described in Exhibit A, Attachment III, Section 2.1 (*Management Information System*).
R.0246	Submit policies and procedures to demonstrate how Contractor will conduct routine testing and monitoring, and update their systems as appropriate to ensure the Application Programming Interfaces (APIs) are functioning properly and complying with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirements.

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

Identifier	Operational Readiness Requirement
R.0035	Submit a flow chart and/or organization chart identifying all components of the Quality Improvement and Health Equity Transformation Program (QIHETP) including who is involved and responsible for each activity.
R.0036	Submit a flow chart and/or organization chart identifying all components of the QIHETP including who is involved and responsible for each activity, for each Fully Delegated Subcontractor, and each health plan downstream Subcontractor.
R.0037	Submit policies that specify the responsibility of the Governing Board in the QIHETP.

Identifier	Operational Readiness Requirement
R.0038	Submit policies for the Quality Improvement and Health Equity Committee (QIHEC) including membership, activities, roles and responsibilities and reporting relationships to other committees within the organization.
R.0039	Submit policies for each Fully Delegated Subcontractor's and health plan Downstream Subcontractor's QIHEC including membership, activities, roles and responsibilities, and reporting relationships to other committees within the organization.
R.0040	Submit procedures outlining how Providers, health plan Subcontractors, and health plan Downstream Subcontractors will participate in the QIHETP and Population Needs Assessment (PNA) and how the findings from both will be shared with Providers, health plan Subcontractors and health plan Downstream Subcontractors.
R.0041	Submit policies and procedures related to the oversight of Subcontractors and Downstream Subcontractors for any delegated QIHETP activities, including a complete list of all Subcontractors, Downstream Subcontractors, and their delegated QIHETP activities.
R.0042	Submit policies and procedures that describe how Contractor will develop and submit an annual QIHETP Plan that provides a comprehensive assessment of all Quality Improvement (QI) and Health Equity activities undertaken, including an evaluation of the effectiveness of QI and Health Equity interventions, and an assessment of all Subcontractors' performance for any delegated QI and/or Health Equity activities.
R.0043	Submit policies and procedures to address how Contractor will meet each of the following requirements: 1) Quality and Health Equity Performance Measure annual reporting requirements; 2) Meet or exceed DHCS established Quality and Health Equity Performance measure benchmarks; 3) Ensure all Fully Delegated Subcontractors meet or exceed DHCS established Quality and Health Equity Performance measure benchmarks; 4) Performance Improvement Projects; 5) Consumer Satisfaction Survey; 6) Network Adequacy Validation; 7) Encounter Data Validation; 8) Focused Studies; and 9) Technical Assistance Recommendations.
R.0044	Submit policies and procedures for reporting any disease or condition to public health authorities.
R.0045	Submit policies and procedures for Credentialing and recredentialing that ensure all Network Providers who deliver Covered Services to Members are qualified in accordance with applicable standards and are licensed, certified, or registered, as appropriate.

Identifier	Operational Readiness Requirement
R.0046	No later than January 1, 2024, submit either (A) or (B and C): A. Evidence of National Committee for Quality Assurance (NCQA) Health Plan Accreditation. B. Timeline that demonstrates the NCQA Health Plan Accreditation process will be started no later than January 1, 2024, and full NCQA Health Plan Accreditation will be received no later than January 1, 2026. C. Evidence of interim NCQA Health Plan Accreditation approval within five Working Days of receipt.
R.0047	No later than January 1, 2024, submit either (A) or (B): A. Evidence of NCQA Health Equity Accreditation. B. Timeline that demonstrates the NCQA Health Equity Accreditation process will be started no later than January 1, 2024, and completed no later than January 1, 2026.
R.0048	Submit policies and procedures for identifying, evaluating, and reducing Health Disparities.
R.0049	Submit policies and procedures that describe how Contractor ensures the adoption, dissemination and monitoring of the use of clinical practice guidelines.
R.0050	Submit policies and procedures that describe the integration of Utilization Management into the QIHETP.
R.0051	Submit policies and procedures that describe how Contractor will detect both over- and under-utilization of services, including outpatient Prescription Drugs.
R.0052	Submit policies and procedures that describe how Contractor will ensure the provision of all screening, preventive and Medically Necessary diagnostic and treatment services provided for Members less than 21 years of age, and how Contractor will identify and address underutilization of preventive services for such Members.
R.0053	Submit policies and procedures that describe how Contractor will promote Early and Periodic Screening, Diagnostic and Treatment (EPSDT) and preventive services to Members less than 21 years of age, as well as outreach to Members less than 21 years of age overdue for such services.
R.0055	Submit a description of a comprehensive wellness program for Members less than 21 years of age.
R.0056	Submit policies and procedures that describe how Contractor will maintain and continually monitor, evaluate, and improve Cultural and Linguistic (C&L) services that support the delivery of Covered Services to Members less than 21 years of age.
R.0057	Submit policies and procedures that describe how Contractor will develop and maintain a school-linked statewide Network of School Site Behavioral Health counselors.

Identifier	Operational Readiness Requirement
R.0058	Submit policies and procedures that describe how Contractor will inform its Network Providers about the Vaccines for Children (VFC) program and how they will promote and support Enrollment of appropriate Providers in VFC.
R.0059	Submit policies and procedures that describe Contractor's Member and family engagement strategy and how Members and/or parents and caregivers are engaged in the development of QI and Health Equity activities and interventions.
R.0060	Submit policies and procedures that describe how Contractor will engage with local entities when developing interventions and strategies to address deficiencies in performance measures related to Members less than 21 years of age.
R.0061	Submit policies and procedures that describe how Contractor will ensure the provision of all Medically Necessary mental health and Substance Use Disorder (SUD) services to Members less than 21 years of age.

EXHIBIT A, ATTACHMENT III – 2.3 UTILIZATION MANAGEMENT PROGRAM

Identifier	Operational Readiness Requirement
R.0062	Submit written description of Utilization Management (UM) program that describes appropriate processes to be used to review, approve, modify, deny, and delay the provision of medical, mental health, and SUD services to demonstrate compliance with mental health parity.
R.0063	Submit written description of procedures for reviews and annual updates of UM program.
R.0064	Submit written description of Grievances and Appeals procedures for Providers and Members that will be published on Contractor's website.
R.0065	Submit policies and procedures for Standing Referrals.
R.0066	Submit policies and procedures on Standing Referrals when a Member condition requires a specialized medical care over a prolonged period of time.
R.0067	Submit policies and procedures for Prior Authorization, concurrent review, and Retrospective Review.
R.0068	Submit a list of services requiring Prior Authorization and the Utilization Review criteria.
R.0069	Submit policies and procedures for the Utilization Review Appeals process for Providers and Members.
R.0070	Submit policies and procedures that specify timeframes for medical authorization.
R.0072	Submit policies and procedures to detect both under- and over-utilization of health care services.

Identifier	Operational Readiness Requirement
R.0073	Submit policies and procedures showing how UM functions which may be delegated to a Subcontractor or Downstream Subcontractor will be regularly evaluated for compliance with Contract requirements and, that any issues identified through the UM program are appropriately resolved; and that UM activities are properly documented and reported.
R.0074	Submit policies and procedures to refer Members who are potentially eligible for Multipurpose Senior Service Program (MSSP) services to MSSP services Providers for authorization.

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

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

EXHIBIT A, ATTACHMENT III – 3.2 PROVIDER RELATIONS

Identifier	Operational Readiness Requirement
R.0077	Submit policies and procedures for the Provider Dispute Resolution Mechanism.
R.0078	Submit a written description of how Contractor will communicate the Provider Dispute Resolution Mechanism to Network Providers, out-of-Network Providers, Subcontractors, and Downstream Subcontractors.
R.0079	Submit protocols for payment and communication with out-of-Network Providers.

Identifier	Operational Readiness Requirement
R.0080	Submit policies and procedures for ensuring out-of-Network Providers receive Contractor's clinical protocols and evidence-based practice guidelines.
R.0081	Submit copy of Contractor's Provider manual.
R.0082	Submit a schedule of Network Provider training to be conducted during year one of operation. Include date, time and location, and complete curriculum.
R.0083	Submit policies and procedures for ensuring Network Providers receive training within the required timeframes, regarding clinical protocols, evidenced-based practice guidelines, and DHCS developed cultural awareness and sensitivity instruction for Senior and Person with Disability (SPD) Members.
R.0084	Submit protocols for communicating and interacting with emergency departments in and out of Contractor's Service Area.

EXHIBIT A, ATTACHMENT III – 3.3 PROVIDER COMPENSATION ARRANGEMENTS

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

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

EXHIBIT A, ATTACHMENT III – 4.1 MARKETING

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

EXHIBIT A, ATTACHMENT III – 4.2 ENROLLMENTS AND DISENROLLMENTS

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

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

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

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

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

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

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

EXHIBIT A, ATTACHMENT III – 4.4 ENHANCED CARE MANAGEMENT

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

EXHIBIT A, ATTACHMENT III – 4.5 COMMUNITY SUPPORTS

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

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

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

EXHIBIT A, ATTACHMENT III – 5.1 MEMBER SERVICES

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

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

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

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

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

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

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

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

EXHIBIT A, ATTACHMENT III – 5.3 SCOPE OF SERVICES

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

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

EXHIBIT A, ATTACHMENT III – 5.4 COMMUNITY BASED ADULT SERVICES

Identifier	Operational Readiness Requirement
R.0215	Submit policies and procedures for referring a Member to a Community Based Adult Services (CBAS) Provider.
R.0216	Submit policies and procedures on arranging for the provision of CBAS unbundled services.
R.0217	Submit all policies and procedures required by the California Advancing and Innovating Medi-Cal (CalAIM) Terms and Conditions, Section V.A.23.
R.0218	Submit policies and procedures for the initial assessment and reassessment of Members for eligibility to receive CBAS, including circumstances where Contractor may forgo a face-to-face review if eligibility has already been determined through another process.
R.0219	Submit policies and procedures for an expedited assessment process.
R.0220	Submit final draft of the written notice to be sent to Members after a CBAS assessment determination that results in a change to the Member's CBAS benefit.
R.0253	Submit all policies and procedures on providing CBAS Emergency Remote Services (ERS).

Identifier	Operational Readiness Requirement
R.0254	Submit policies and procedures for community participation for Members receiving CBAS.
R.0255	Submit policies and procedures for notifying DHCS of payments made to a CBAS Provider involved in a credible allegation of Fraud.

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

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

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

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

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Identifier	Operational Readiness Requirement
R.0225	Submit executed MOUs, or documentation substantiating Contractor's efforts to negotiate MOUs to coordinate programs and services for Members with LGAs, third-party entities, and county programs in Contractor's Service Area, even if Contractor is coordinating care and not financially responsible, to ensure Care Coordination, data sharing, and non-duplicative services for Members, including at a minimum: ~~1) LEAs for IEPs or IFSPs;~~ ~~2) California Department of Corrections and Rehabilitation, County Jails, and youth correctional facilities, as applicable~~ ~~3)~~**1)** Third-party entities in each county within Contractor's Service Area, at a minimum~~:~~**,** ~~a) HCBS program agencies;~~ ~~b) Continuums of Care;~~ ~~c)~~ First 5 ~~c~~**C**ounty ~~c~~**C**ommissions~~;~~**.**
R.0226	Submit policies and procedures for exchanging Member Information with MHPs and DMC-ODS or county Drug Medi-Cal Programs in compliance with State and federal privacy laws and regulations.
R.0227	Submit policies and procedures for maintaining collaboration among the parties to the MOU and monitoring and assessing the effectiveness of MOUs. Policies and procedures should include the requirement to review its MOUs annually for any needed modifications or renewal of responsibilities and obligations.
R.0228	Submit executed MOUs, or documentation substantiating Contractor's efforts to negotiate MOUs to coordinate programs and services for Members with LGAs in each county within Contractor's Service Area to assist with coordinating, at a minimum, Targeted Case Management (TCM).
R.0256	**Submit executed MOUs, or documentation substantiating Contractor's efforts to negotiate MOUs to coordinate programs and services for Members with LGAs, third-party entities, and county programs in Contractor's Service Area, even if Contractor is coordinating care and not financially responsible, to ensure Care Coordination, data sharing, and non-duplicative services for Members, including at a minimum:** **1) LEAs for IEPs or IFSPs;** **2) California Department of Corrections and Rehabilitation, County Jails, and Youth Correctional Facilities, as applicable.**

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EXHIBIT A, ATTACHMENT III – 6.0 EMERGENCY PREPAREDNESS AND RESPONSE

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

Identifier	Operational Readiness Requirement
R.0239	**Submit Emergency Preparedness and Response Plan.**
R.0229	**Submit Risk Assessment and Emergency Plan.**
R.0230	**Submit Policies and Procedures to support execution of emergency plan and risks identified.**
R.0231	**Submit Communication Plan to Providers/facilities/contracted entities.**
R.0232	**Submit training and testing program for emergency preparedness.**

EXHIBIT B, BUDGET DETAIL AND PAYMENT PROVISIONS

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

EXHIBIT C, GENERAL TERMS AND CONDITIONS

No deliverables listed for this Exhibit.

EXHIBIT D(f), SPECIAL TERMS AND CONDITIONS

No deliverables listed for this Exhibit.

EXHIBIT E, PROGRAM TERMS AND CONDITIONS

Identifier	Operational Readiness Requirement
R.0234	Submit policies and procedures explaining Contractor's data certification reporting method. Policies and procedures must include a template certification statement.
R.0235	Submit policies and procedures for the treatment of recoveries, including retention policies, process, timeframes, and documentation for reporting, for all recovery of overpayments.
R.0236	Submit policies and procedures for how Contractor will comply with Cost Avoidance and Post-Payment Recovery for Members with Other Healthcare Coverage (OHC).
R.0237	Submit policies and procedures for how Contractor will comply with Third-Party Tort and Worker's Compensation Liability.

Identifier	Operational Readiness Requirement
R.0238	Submit policies and procedures for how Contractor will comply with an investigation or a prosecution conducted by the Division of Medi-Cal Fraud and Elder Abuse (DMFEA) and/or the United States Department of Justice (US DOJ), including communicating requirements with Subcontractors and Downstream Subcontractors.

EXHIBIT F, CONTRACTOR'S RELEASE

No deliverables listed for this Exhibit.

EXHIBIT G, BUSINESS ASSOCIATE ADDENDUM

No deliverables listed for this Exhibit.

EXHIBIT H, CONFLICT OF INTEREST AVOIDANCE REQUIREMENTS

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

EXHIBIT I, CONTRACTOR'S PARENT GUARANTY REQUIREMENTS

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

EXHIBIT J, DELEGATION REPORTING AND COMPLIANCE PLAN

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

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

No deliverables listed for this Exhibit.

EXHIBIT L, REQUIREMENTS SPECIFIC TO CONTRACTOR

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

Exhibit A, ATTACHMENT III

1.0 Organization

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

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

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

1.1 Plan Organization and Administration

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

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Exhibit A, ATTACHMENT III

1.1 Plan Organization and Administration

1.1.1 Legal Capacity

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

1.1.2 Key Personnel Disclosure Form

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

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

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

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

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

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1.1.3 Conflict of Interest – Current and Former State Employees

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

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

1.1.4 Contract Performance

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

A. Contractor has an accountable Governing Board;

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

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

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

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

1.1.5 Medical Decisions

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

1.1.6 Medical Director

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

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

1) Rendered by qualified medical personnel; and

2) Not influenced by fiscal or administrative management considerations.

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

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

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

E. Resolving Grievances related to Quality of Care;

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

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

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

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

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

1.1.7 Chief Health Equity Officer

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

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

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

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

1) Marketing strategy;

2) Medical and other health services policies;

3) Member and provider outreach;

4) Community Advisory Committee;

5) Quality Improvement activities, including delivery system reforms;

6) Grievance and Appeals; and

7) Utilization Management.

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

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

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

F. Develop targeted interventions designed to eliminate Health Inequities;

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

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

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

2) Maintaining records of training completion.

1.1.8 Key Personnel Changes

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

1.1.9 Administrative Duties/Responsibilities

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

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

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

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

Section 4.6 (*Member Grievance and Appeal System*), and Section 5.1 (*Member Services*);

D. Maintain data reporting capabilities sufficient to provide necessary and timely reports to DHCS, as required by Exhibit A, Attachment III, Section 2.1 (*Management Information System*);

E. Maintain data and information exchange capabilities as needed to meet Contractor's obligation under the Contract and to support DHCS administration of the Medi-Cal program through data sharing with other trading partners. This includes, but is not limited to, Encounter Data, Medical Record information, Network Provider and Provider information, Member demographics, and case notes;

F. Maintain Quality Improvement activities and Population Health Management activities. Comply with all National Committee for Quality Assurance (NCQA) and accreditation requirements by calendar year 2026 as described in Exhibit A, Attachment III, Section 2.2 (*Quality Improvement and Health Equity Transformation Program (QIHETP)*);

G. Maintain a Utilization Management (UM) program, as described in Exhibit A, Attachment III, Section 2.3 (*Utilization Management Program*);

H. Maintain Network adequacy as described in Exhibit A, Attachment III, Section 5.2 (*Network and Access to Care*);

I. Comply with requirements, as described in Exhibit A, Attachment III, Section 3.2 (*Provider Relations*);

J. Maintain claims processing capabilities as described in Exhibit A, Attachment III, Section 3.3 (*Provider Compensation Arrangements*);

K. Maintain adequate access and availability of Primary Care Providers (PCP) and Specialists for all Medically Necessary Covered Services for Members, as described in Exhibit A, Attachment III, Section 5.2 (*Network and Access to Care*);

L. Form a Community Advisory Committee (CAC) and meet expectations, as described in Exhibit A, Attachment III, Section 5.2 (*Network and Access to Care*), including CAC's active participation in addressing Quality of Care, Health Equity, Health Disparities, Population Health Management, Children services, and other ongoing Contractor functions;

M. Provide or arrange for all Medically Necessary Covered Services for Members, as described in Exhibit A, Attachment III, Section 5.3 (*Scope of Services*), Exhibit A, Attachment III, Section 5.4 (*Community Based Adult Services*), and Exhibit A, Attachment III, Section 5.5 (*Mental Health and Substance Use Disorder Benefits*);

N. Provide Care Coordination, including but not limited to all Medically Necessary services delivered both within and outside Contractor's Network, as described in Exhibit A, Attachment III, Section 4.3 (*Population Health Management and Coordination of Care*);

O. Negotiate in good faith and execute Network Provider Agreements, Subcontractor Agreements, or Memorandums of Understanding (MOUs), as appropriate, with third party entities, including county programs, and local health jurisdictions covered by this Contract, as described in Exhibit A, Attachment III, Section 5.6 (*MOUs with Local Government Agencies, County Programs, and Third Parties*) and Exhibit A, Attachment III, Subsection 3.1.9 *(Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements with Local Health Departments)*;

P. Comply with the requirements described in Exhibit A, Attachment III, Section 5.1 (*Member Services*);

Q. Maintain Member Grievance procedures, as specified in Exhibit A, Attachment III, Section 4.6 (*Member Grievance and Appeal System*);

R. Develop training and certification for Marketing activity, if Contractor conducts Marketing, as described in Exhibit A, Attachment III, Section 4.1 (*Marketing*);

S. Cooperate with the DHCS Enrollment program, as described in Exhibit A, Attachment III, Section 4.2 (*Enrollments and Disenrollments*); and

T. Comply with all requirements and deliverables, as described in Exhibit A, Attachment III, Article 7.0 (*Operations Deliverables and Requirements*).

1.1.10 Member Representation

Contractor must ensure that Medi-Cal Members, including Seniors and Persons with Disabilities (SPD), persons with chronic conditions (such as asthma, diabetes, congestive heart failure), Limited English Proficient (LEP) Members, and Members from diverse cultural and ethnic backgrounds or their representatives are included and invited to participate in establishing public

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policy within Contractor's advisory committee and CAC, as specified in Exhibit A, Attachment III, Subsection 5.2.11.E. (*Cultural and Linguistic Programs and Committees*), or other similar committees or groups.

1.1.11 Diversity, Equity, and Inclusion Training

Contractor must ensure that all staff who interact with, or may potentially interact with, Members and any other staff deemed appropriate by Contractor or DHCS, receive annual sensitivity, diversity, communication skills, and cultural competency/humility training as specified in Exhibit A, Attachment III, Subsection 5.2.11.C. (*Cultural and Linguistic Programs and Committees*).

Exhibit A, ATTACHMENT III

1.2 Financial Information

1.2.1 Financial Viability and Standards Compliance
1.2.2 Contractor's Financial Reporting Obligations
1.2.3 Independent Financial Audit Reports
1.2.4 Cooperation with DHCS' Financial Audits
1.2.5 Medical Loss Ratio
1.2.6 Contractor's Obligations
1.2.7 Community Reinvestment Plan and Report

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1.2 Financial Information

1.2.1 Financial Viability and Standards Compliance

Contractor must meet and maintain financial viability and standards compliance to DHCS' satisfaction for each of the following elements:

A. Tangible Net Equity (TNE).

Contractor at all times must be in compliance with the TNE requirements set forth in 28 California Code of Regulations (CCR) section 1300.76, even in circumstances where Contractor is not otherwise legally required to comply with this provision.

B. Administrative Costs.

Contractor's Administrative Costs must comply with the standards set forth in 22 CCR section 53864(b) and 28 CCR section 1300.78.

C. Standards of organization and financial soundness.

Contractor must maintain an organizational structure sufficient to conduct the operations required by this Contract and ensure that its financial resources are sufficient for sound business operations in accordance with 28 CCR sections 1300.67, 1300.67.3, 1300.75.1, 1300.75.4.1, 1300.76.3, 1300.77.1, 1300.77.2, 1300.77.3, and 1300.77.4.

D. Working Capital Ratio of one of the following:

1) Contractor must maintain a Working Capital Ratio of current assets to current liabilities of at least 1:1 in accordance with Health & Safety Code (H&S) section 1375.4(b)(1)(A)(iv); or

2) Contractor must demonstrate to DHCS that Contractor is meeting financial obligations on a timely basis and has been doing so for at least the preceding two years; or

3) Contractor must provide evidence that sufficient noncurrent assets, which are readily convertible to cash, are available to achieve an equivalent Working Capital Ratio of 1:1, if the noncurrent assets are considered current.

E. In the event DHCS finds Contractor non-compliant with any of the elements or obligations set forth in this provision, DHCS may impose a

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Corrective Action plan or sanctions in accordance with Exhibit E (*Program Terms and Conditions*) and Welfare and Institutions Code (W&I) section 14197.7, as set forth in in All Plan Letter (APL) 23-012. See Exhibit E, Section 1.19 (*Sanctions*).

1.2.2 Contractor's Financial Reporting Obligations

A. Form and Standards for Financial Reporting

Contractor must provide financial information and reports, including but not limited to Financial Statements, to DHCS in the form and manner specified by DHCS. Unless otherwise specified by DHCS, Contractor must prepare all financial information requested by DHCS in accordance with Generally Accepted Accounting Principles (GAAP) and the 1989 Health Maintenance Organization (HMO) Financial Report of Affairs and Conditions format. Any Department of Managed Health Care (DMHC) required reports must be prepared in DMHC-required financial reporting format, and in accordance with 28 CCR section 1300.84. Information submitted by Contractor must be based on current operations. Where appropriate, reference has been made to the Knox-Keene Health Care Service Plan Act of 1975 (KKA) rules found under 28 CCR sections 1300.51 *et seq*.

Unless otherwise specified by DHCS, all Financial Statements must include, at a minimum, the following reports/schedules unless explicitly excluded in this Attachment:

1) Jurat;

2) Report 1A and 1B: Balance Sheet;

3) Report 2: Statement of Contract Revenue, Expenses, and Net Worth;

4) Statement of Cash Flow, prepared in accordance with Financial Accounting Standards Board Statement Number 95 in lieu of Report 3: Statement of Changes in Financial Position for GAAP compliance;

5) Report 4: Enrollment and Utilization Table;

6) Schedule G: Unpaid Claims Analysis;

7) Appropriate footnote disclosures in accordance with GAAP; and

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8) Schedule H: Aging of All Claims.

In addition, Contractor must prepare and submit a stand-alone Medi-Cal line of business income statement and Enrollment table on each financial reporting period required. Contractor must prepare this income statement and Enrollment table in the DMHC required financial reporting format for each specific county or rating region of operation, as specified by DHCS and must include, at a minimum, the following reports/schedules:

1) Report 2: Statement of Contract Revenue and Expenses; and

2) Report 4: Enrollment and Utilization Table by County/Rating Region.

Medi-Cal line of business Financial Statements are to include expenses, Contract Revenues, and Enrollment only for Medi-Cal Members enrolled through direct contract with DHCS.

Contactor must submit the Medi-Cal line of business Financial Statements within the same timeframe as indicated for each required Financial Statement.

B. Monthly Reporting Obligations

Contractor must submit to DHCS, no later than 30 calendar days after the close of Contractor's fiscal month, an exact copy of any reports required be filed in accordance with 28 CCR section 1300.84.3.

C. Quarterly Reporting Obligations

Contractor must submit to DHCS, no later than 45 calendar days after the close of Contractor's fiscal quarter, an exact copy of any reports required to be filed in accordance with 28 CCR section 1300.84.2.

D. Annual Reporting Obligations

Contractor must prepare and submit to DHCS, no later than 120 calendar days after the close of Contractor's Fiscal Year, an exact copy of any reports required to be filed in accordance with 28 CCR section 1300.84.06. Contractor must also submit Medi-Cal line of business Financial Statements no later than 120 calendar days of after the close of the applicable Rating Period.

E. Annual Forecasts

Contractor must submit to DHCS annual forecasts of Contractor's next Fiscal Year no later than 60 calendar days prior to the beginning each Fiscal Year. Contractor's annual forecast must be prepared using DMHC required financial reporting forms and must include, at a minimum, the following reports/schedules:

1) Report 2: Statement of Contract Revenue and Expenses (Medi-Cal line-of-business);

2) Report 4: Enrollment and Utilization Table by County/Rating Region (Medi-Cal line-of-business);

3) TNE (All lines of business); and

4) A detailed explanation of all underlying assumptions used to develop the forecast.

F. Publication of Financial Reports

Financial Reports submitted in accordance with this Section 1.2 are public records and may be made public by DHCS.

1.2.3 Independent Financial Audit Reports

Contractor must ensure that an annual audit is performed by an independent Certified Public Accountant in accordance with 42 Code of Federal Regulations (CFR) section 438.3(m) and W&I section 14459. Except as indicated in Paragraph B of this provision, a copy of the resulting independent financial audit report must be submitted to DHCS no later than 120 calendar days after the close of Contractor's Fiscal Year.

When the delivery of care or other services is dependent upon Affiliates of Contractor, Contractor must submit combined, annual Financial Statements that reflect the financial position of Contractor's overall health care delivery system in accordance with 28 CCR section 1300.84(c). Such combined, annual Financial Statements must be presented in a form that clearly shows the financial position of Contractor separately from the combined totals set forth in the combined Financial Statements. Intra-entity or related party transactions and profits must be eliminated if consolidated Financial Statements are prepared and submitted by Contractor. Contractor also must submit to DHCS any financial audit conducted by DMHC pursuant to H&S section 1382 within 30 calendar days of Contractor's receipt thereof.

In the event that Contractor's retained independent Certified Public Accountant determines that preparation of combined, annual Financial Statements is inappropriate or impracticable under the circumstances, separate certified Financial Statements must be prepared for each entity involved in the delivery of health care services by Contractor, and such separate, annual Financial Statements must be submitted to DHCS, along with the following:

A. Contractor must provide the independent Certified Public Accountant's written statement of the reasons for not preparing combined Financial Statements;

B. Contractor must provide supplemental schedules that clearly reflect all intra-entity or related party transactions and eliminations necessary to enable DHCS to analyze the overall financial position of Contractor's entire health care delivery system. If Contractor is a public entity or a political subdivision of the State and a county grand jury conducts Contractor's financial audits, Contractor must submit its Financial Statements within 180 calendar days after the close of Contractor's Fiscal Year in accordance with H&S section 1384;

C. Contractor must authorize its independent Certified Public Accountant to allow DHCS' designated representatives or agents, upon written request, to inspect any and all working papers related to the preparation of the audit report;

D. Contractor must submit to DHCS all financial reports relevant to Affiliates as specified in 28 CCR section 1300.84(c); and

E. Contractor must submit to DHCS copies of any financial reports submitted to any other public or private organization within ten calendar days of submission to such other public or private organization.

1.2.4 Cooperation with DHCS' Financial Audits

DHCS must conduct, or contract for the conduct of, periodic audits of the accuracy, truthfulness, and completeness of the financial data submitted by, or on behalf of, Contractor in accordance with 42 CFR section 438.602(e). Contractor must cooperate with these audits and provide all information and materials requested by DHCS, or its contracted auditor, for this purpose. Please see Exhibit A, Attachment III, Section 2.1 (*Management Information System*) for related requirements.

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1.2.5 Medical Loss Ratio

Contractor must annually report a Medical Loss Ratio (MLR) as described in this provision and in accordance with 42 CFR section 438.8. Contractor must impose equivalent MLR reporting requirements on Fully Delegated Subcontractors, Partially Delegated Subcontractors, Downstream Fully Delegated Subcontractors, and Downstream Partially Delegated Subcontractors.

A. Contractor must calculate and report a MLR as stated in 42 CFR sections 438.8 and 438.604(a)(3) in a form and manner specified by DHCS.

1) Contractor must ensure that revenues, expenditures, and other amounts are appropriately identified and classified including by distinguishing which amounts were actually paid for benefits or activities that improve health care quality, and which amounts were actually paid for administrative services, taxes, or other activities in accordance with the Centers for Medicare & Medicaid Services (CMS) Informational Bulletin published May 15, 2019, with the subject “Medical Loss Ratio Requirements Related to Third-Party Vendors.”

2) Contractor must, in compliance with 42 CFR section 438.230(c)(1) and California Advancing and Innovating Medi-Cal (CalAIM) Terms and Conditions, in particular Paragraph 11 of the 1915(b) Waiver STCs, require all applicable Subcontractors and Downstream Subcontractors to comply with the MLR reporting responsibilities in this Section, including the requirement to distinguish which amounts are actually paid for benefits or activities that improve health care quality, and which amounts were actually paid for administrative services, taxes, or other activities in accordance with the CMS Informational Bulletin published May 15, 2019 with the subject “Medical Loss Ratio Requirements Related to Third-Party Vendors.” Payments to a Subcontractor or Downstream Subcontractor that are not the amount actually paid to a Provider or supplier for furnishing Covered Services must not be included in incurred claims.

B. The MLR experienced by Contractor in a MLR reporting year is the ratio of the numerator, as stated in Paragraph E of this Section, to the denominator, as stated in Paragraph F of this Section. A MLR may be increased by a credibility adjustment in accordance with Paragraph HH of this provision.

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

1) Annual Medi-Cal revenue;

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

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

4) Other factors.

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

E. The numerator of Contractor's, Subcontractors', and Downstream Subcontractors' MLR for a MLR reporting year is the sum of Contractor's, Subcontractors', and Downstream Subcontractors' incurred claims, expenditures for activities that improve health care quality, and Fraud prevention activities.

1) Contractor's, Subcontractors', and Downstream Subcontractors' Incurred Claims

a) Incurred claims must include the following:

i. Direct claims that Contractor, Subcontractors, and Downstream Subcontractors, as applicable, paid to Providers, including under capitated contracts with Network Providers, for Covered Services or supplies under this Contract, a Subcontractor Agreement, or a Downstream Subcontractor Agreement, as applicable, and meeting the requirements of 42 CFR section 438.3(e);

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ii. Unpaid claims liabilities for the MLR reporting year, including claims reported that are in the process of being adjusted or claims Incurred but Not Reported;

iii. Withholds from payments made to Network Providers;

iv. Claims that are recoverable for anticipated coordination of benefits;

v. Claims payments recoveries received due to subrogation;

vi. Incurred but Not Reported claims based on past experience, and modified to reflect current conditions, such as changes in exposure or claim frequency or severity;

vii. Changes in other claims-related reserves; and

viii. Reserves for contingent benefits and the medical claim portion of lawsuits.

b) Amounts that must be deducted from incurred claims include the following:

i. Identified unrecovered Overpayments and Overpayment recoveries received from Network Providers;

ii. Prescription Drug rebates received and accrued; and

iii. Amounts received as remittances from Subcontractors and Downstream Subcontractors, as applicable, in accordance with Paragraph P of this provision and Exhibit B of this Contract. Subcontractors and Downstream Subcontractors must deduct amounts received as remittances from their downstream entities. The contracts between all downstream entities in Contractor's delegation arrangement must include this reference.

c) Expenditures that must be included in incurred claims include the following:

i. The amount of incentive and bonus payments made, or expected to be made, to Network Providers that are tied to clearly-defined, objectively measurable, and well-documented clinical or quality improvement standards that apply to Providers; and

ii. The amount of claims payments recovered through Fraud reduction efforts, not to exceed the amount of Fraud reduction expenses. The amount of Fraud reduction expenses must not include activities specified in E.2.c of this provision.

iii. The amount of payments made to providers under Directed Payment Initiatives.

d) Amounts that must either be included in or deducted from incurred claims include, respectively, net payments or receipts related to solvency funds mandated by DHCS.

e) The following amounts must be excluded from incurred claims.

i. Non-claims costs, which include:

(1) the amounts paid to third-party vendors for secondary network savings;

(2) amounts paid to third-party vendors for network development, administrative fees, claims processing, and Utilization Management (UM);

(3) amounts paid for professional or administrative services, including amounts paid to a Provider, that do not represent compensation or reimbursement for California Medicaid State Plan services or services defined in 42 CFR section 438.3(e) and provided to Members; and

(4) amounts paid for fines and penalties assessed by regulatory authorities; and

ii. Amounts paid to DHCS as remittances in accordance with Paragraph P of this provision and Exhibit B of this Contract; and

iii. Amounts paid to upstream entities as remittance in accordance with Paragraph P of this Subsection. The contracts between all downstream entities in Contractor's delegation arrangement must include this reference; and

iv. Amounts paid to Network Providers under 42 CFR section 438.6(d).

f) Incurred claims paid by an entity that is later assumed by another entity must be reported by the assuming entity for the entire MLR reporting year and no incurred claims for that MLR reporting year may be reported by the ceding entity.

2) Activities that improve health care quality must be in one of the following categories:

a) Contractor's, Subcontractors', and Downstream Subcontractors', as applicable, activity that meets the requirements of 45 CFR section 158.150 (a) and (b) and is not excluded under 45 CFR section 158.150(c);

b) Contractor's, Subcontractors', and Downstream Subcontractors', as applicable, activity related to any External Quality Review-related activity as described in 42 CFR sections 438.358(b) and (c); or

c) Contractor's, Subcontractors', and Downstream Subcontractors', as applicable, expenditure that is related to Health Information Technology (HIT) and meaningful use, meets the requirements placed on issuers set forth in 45 CFR section 158.151, and is not considered incurred claims, as defined in this Subsection.

3) Contractor's, Subcontractors', and Downstream Subcontractors', as applicable, expenditures on activities related to Fraud prevention as described in 45 CFR part 158, and not including expenses for Fraud reduction efforts as stated in Paragraph E.1.c.ii of this Subsection.

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F. The denominator of Contractor's, Subcontractors', and Downstream Subcontractors' MLR for a MLR reporting year must equal the adjusted premium revenue for Contractor's, Subcontractors', and Downstream Subcontractors' Medi-Cal line of business. The adjusted premium revenue is Contractor's, Subcontractors', and Downstream Subcontractors' premium revenue minus Contractor's, Subcontractors', and Downstream Subcontractors' federal, State, and local taxes and licensing and regulatory fees, and is aggregated in accordance with this Subsection.

1) Premium revenue includes the following for the MLR reporting year:

a) Capitation Payments, developed in accordance with 42 CFR section 438.4, and excluding payments made per 42 CFR section 438.6(d);

b) One-time payments for Member life events as specified in this Contract, including, but not limited to, Supplemental Payments and Additional Payments as set forth in provisions 1.7 and 1.8 of Exhibit B, respectively;

c) Other payments to Contractor approved under 42 CFR section 438.6(b)(3);

d) All changes to unearned premium reserves; and

e) Net payments or receipts related to Risk Sharing Mechanisms developed in accordance with 42 CFR sections 438.5 or 438.6.

f) Payments to Contractor for expenditures under Directed Payment Initiatives.

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

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

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

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

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

d) State and local taxes and assessments including:

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

ii. Guaranty fund assessments.

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

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

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

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

i. 3 percent of earned premium; or

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

3) If Contractor, or any Subcontractor or Downstream Subcontractor, is later assumed by another entity that becomes the new Contractor, Subcontractor, or Downstream Subcontractor under this

Contract, a Subcontractor Agreement, or a Downstream Subcontractor Agreement, the new Contractor, Subcontractor, or Downstream Subcontractors must report the total amount of the denominator for the entire MLR reporting year, and no amount under this Paragraph for that year may be reported by the ceding Contractor, Subcontractor, or Downstream Subcontractor.

G. In the allocation of expense, Contractor, Subcontractors, and Downstream Subcontractors must include each expense under only one type of expense, unless a portion of the expense fits under the definition of, or criteria for, one type of expense and the remainder fits into a different type of expense, in which case the expense must be pro-rated between types of expenses. Expenditures that benefit multiple contracts or populations, or contracts other than those being reported, must be reported on a pro rata basis. Contractor, Subcontractors, and Downstream Subcontractors must use the following methods to allocate expenses:

1) Allocation to each category must be based on a Generally Accepted Accounting Principles (GAAP) method that is expected to yield the most accurate results;

2) Shared expenses, including expenses under the terms of a management contract, must be apportioned pro rata to the contract incurring the expense; and

3) Expenses that relate solely to the operation of a reporting entity, such as staff costs associated with the adjusting and paying of claims, must be borne solely by the reporting entity and are not to be apportioned to the other entities.

H. Contractor, Subcontractors, and Downstream Subcontractors may add a credibility adjustment to a calculated MLR if the MLR reporting year experience is partially credible to account for a difference between the actual and target MLRs that may be due to random statistical variation. The credibility adjustment is added to the reported MLR calculation before calculating any remittance.

1) Contractor, Subcontractors, and Downstream Subcontractors may not add a credibility adjustment to a calculated MLR if the MLR reporting year experience is fully credible.

2) If Contractor’s, Subcontractors, or Downstream Subcontractor’s experience is Non-Credible, it is presumed to meet or exceed the MLR calculation standards in this Subsection.

3) Non-credible and partially-credible Contractors, Subcontractors, and Downstream Subcontractors that meet the materiality threshold must submit an MLR report regardless of credibility.

4) Contractor, Subcontractors, and Downstream Subcontractors must fulfill these requirements by using the base credibility factors that CMS publishes in accordance with 42 CFR section 438.8(h)(4).

5) Contractor must submit a MLR report regardless of credibility. DHCS may require MLR reporting by certain Subcontractors or Downstream Subcontractors regardless of credibility.

I. Contractor, Subcontractors, and Downstream Subcontractors must aggregate data by Member groups as defined in this Contract, or as otherwise directed by DHCS. This may require separate reporting and MLR calculations for specific populations.

J. Contractor must report its MLR to DHCS by county or rating region. Subcontractors and Downstream Subcontractors must report their MLR at the Subcontractor or Downstream Subcontractor arrangement level, by county or rating region, to their upstream entity.

K. MLR Reporting requirements.

1) Contractor, Subcontractors, and Downstream Subcontractors must submit a report to DHCS that includes at least the following information for each MLR reporting year:

a) Total incurred claims;

b) Expenditures on Quality Improvement activities;

c) Expenditures related to activities compliant with 42 CFR sections 438.608(a) – (5), (7), (8), and (b);

d) Non-claims costs;

e) Premium revenue;

f) Taxes, licensing, and regulatory fees;

g) Methodology(ies) for allocation of expenditures, which must include a detailed description of the methods used to allocate expenses, including incurred claims, quality

improvement expenses, federal and State taxes and licensing or regulatory fees, and other non-claims costs, as described in 45 CFR section 158.170(b);

h) Any credibility adjustment applied;

i) The calculated MLR;

j) Any remittance owed to DHCS, if applicable;

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

l) A description of the method used to aggregate data; and

m) The number of Member months.

2) Contractor must submit this report in a timeframe and manner determined by DHCS, but no longer than 12 months after the end of the MLR reporting year.

3) Contractor must require any Subcontractor or other third-party vendor providing claims adjudication activities to provide all underlying data associated with MLR reporting to Contractor within 180 calendar days from the end of the MLR reporting year, or within 30 calendar days of being requested by Contractor, whichever is sooner, regardless of current contracting limitations, to calculate and validate the accuracy of MLR reporting.

4) Contractor must require Subcontractors impose reporting requirements equivalent to the information required in 42 CFR section 438.8(k) on Downstream Subcontractors who accept financial risk to perform delegated activities and reporting responsibilities specific for those services they do not directly provide to Members, in accordance with 42 CFR section 438.230(c)(1). Subcontractors must comply with all applicable Medi-Cal laws and regulations, including applicable sub-regulatory guidance and provisions of this Contract, in accordance with 42 CFR section 438.230(c)(2).

5) Contractor, Subcontractors, and Downstream Subcontractors must attest to the accuracy of the MLR calculation in accordance with requirements of this provision when submitting the MLR report.

6) Contractor must ensure Subcontractor submissions are in accordance with the information required in 42 CFR section 438.8(k). Contractor is expected to review and provide oversight of Subcontractor MLR submissions. Specific expectations include, but are not to be limited to:

   a) Review of each applicable Subcontractor's MLR and reported medical cost per Member per month to identify and investigate outliers;

   b) Review of reported expenses to ensure medical and non-medical expenses are appropriately accounted for in the MLR calculation;

   c) Verification that reported expenses align with service volume reported in encounters;

   d) Verification that reported revenues align with the upstream entities' reported payments;

   e) Review of the reasonableness of methodologies for allocation of expenditures across multiple lines of business;

   f) Review of the reasonableness of IBNR estimates.

Contractor will impose the aforementioned review and oversight expectations on Subcontractors and Downstream Subcontractors, as applicable, for their downstream entities. The contracts between all downstream entities in Contractor's delegation arrangement must include a reference to Exhibit A, Attachment III, Subsection 1.2.5.K.4 and 6 (*Medical Loss Ratio*).

L. Contractor may be excluded from the reporting requirements in this provision in the first MLR reporting year of its operation. Contractor then must comply with these requirements beginning with the next MLR reporting year in which it contracts with DHCS, even if the first MLR reporting year was not a full 12 months.

M. Consistent with 42 CFR section 438.8(l), Contractor may exempt newly contracted Subcontractors and Downstream Subcontractors from the MLR reporting requirements in the Subcontractor's or Downstream Subcontractor's first MLR reporting year of its operation. Contractor then must require Subcontractors and Downstream Subcontractors to comply

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with the MLR reporting year requirements in the next reporting year even if the first MLR reporting year did not cover a full 12 months of operation.

1) Contractors must report any excluded Subcontractors and Downstream Subcontractors to DHCS by the end of the third quarter of that MLR reporting year utilizing DHCS' reporting form.

2) DHCS retains the discretion to reverse any exemption based on information obtained during the initial review of MLR reporting and/or subsequent State or federal reviews or audits. Contractor must comply, and must require their Subcontractors and Downstream Subcontractors to comply, with any such reversal and submit or amend MLR reporting as needed.

N. In any instance where DHCS makes a retroactive change to the Capitation Payments for a MLR reporting year and the MLR report has already been submitted to DHCS, Contractor must re-calculate the MLR for all MLR reporting years affected by the change and submit a new report meeting the reporting requirements in this Subsection.

O. Contractor must impose the above retroactive reporting requirements on its Subcontractors and Downstream Subcontractors where DHCS makes a retroactive change to the Capitation Payments for a MLR reporting year and the MLR report has already been submitted to Contractor or upstream Subcontractor. In its sole discretion, DHCS reserves the right to limit MLR re-reporting for Subcontractors and Downstream Subcontractors to no more than one instance and may require re-reporting on an ad hoc basis. Subcontractors and Downstream Subcontractors must not re-report a MLR more than once for any MLR reporting year absent DHCS' review and express permission for any such MLR re-reporting. DHCS has the sole authority and discretion to grant or deny permission to any request for a Subcontractor or Downstream Subcontractor to re-report more than once for any MLR reporting year. The contracts between all downstream entities in Contractor's delegation arrangement must include this reference.

P. Contractor must, if applicable, provide a remittance for a MLR reporting year in accordance with W&I section 14197.2(c)(1) and Exhibit B of this Contract. Starting January 1, 2025, Contractor must impose equivalent remittance requirements on Subcontractors and Downstream Subcontractors.

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Q. In accordance with the CalAIM 1915(b) Waiver STCs, DHCS will work with CMS to effectuate an audit of MLR reports no sooner than the 2028 calendar year. The MLR audit will include the time period covered by the CalAIM 1915(b) Waiver (January 1, 2022 through December 31, 2026).

1) To allow DHCS and CMS to complete an accurate audit of the MLR reports, Contractors, Subcontractors, and Downstream Subcontractors must maintain all records and documents relating to MLR reports for a minimum of 10 years as described in 42 CFR section 438.3(u).

2) Pursuant to 42 CFR section 438.3(h), DHCS and its contractor(s) may, at any time, request, inspect, and audit any of Contractor's, Subcontractors', and Downstream Subcontractors' records or documents. Record retention requirements are also referenced in Exhibit E of this Contract.

1.2.6 Contractor's Obligations

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

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

1.2.7 Community Reinvestment Plan and Report

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

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B. If Contractor has a ~~Fully Delegated Subcontractor or Downstream Fully Delegated~~ Subcontractor **subject to community reinvestment requirements pursuant to Exhibit B, Subsection 1.1.17 (*Community Reinvestment*) based on criteria established by DHCS through APLs or similar guidance**, ~~Contractor must require the Fully Delegated Subcontractor and Downstream Fully Delegated Subcontractor to annually submit a Community Reinvestment Plan for approval that details its anticipated community reinvestment activities, pursuant to Exhibit B, Section, 1.17 (*Community Reinvestment*), in a form and manner specified by DHCS through APLs or similar guidance.~~ Contractor must **annually request from Subcontractor and incorporate** ~~submit~~ the ~~Fully Delegated Subcontractor's and Downstream Fully Delegated Subcontractor's~~ **applicable** Community Reinvestment Plan **in the submission** to DHCS **pursuant to Exhibit A, Attachment III, Subsection 1.2.7(A)**.

C. Contractor must ~~annually~~ submit a Community Reinvestment Report, including information related to any ~~Fully Delegated Subcontractor's or Downstream Fully Delegated~~ Subcontractor~~'s Community Reinvestment Plan, to DHCS~~ **subject to community reinvestment requirements pursuant to Exhibit B, Subsection 1.1.17 (Community Reinvestment) based on criteria and timelines established by DHCS through APLs or similar guidance,** in a form and manner specified by DHCS through APLs or similar guidance. The Community Reinvestment Report must detail Contractor's community reinvestment activities in accordance with the Community Reinvestment Plan, and the outcomes thereof. DHCS will make available the minimum information requirements for the report through APLs or similar guidance.

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Exhibit A, ATTACHMENT III

1.3 Program Integrity and Compliance Program

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

1.3 Program Integrity and Compliance Program

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

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

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

1.3.1 Compliance Program

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

A. A compliance plan which:

1) Outlines the key elements of the compliance program;

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

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

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

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

6) References the delegation reporting and compliance plan

7) References policies and procedures operationalizing the compliance program;

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

9) Is publicly posted on Contractor's website.

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

C. Written policies and procedures which address the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1.3.2 Fraud Prevention Program

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

A. Fraud Prevention Officer

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

B. Notification of Changes in Member's Circumstances

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

C. Method to Verify Services Received

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

D. Contractor's Reporting Obligations

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In accordance with 42 CFR section 438.608(a)(7), Contractor must refer, investigate, and report all Fraud, Waste, and Abuse activities that Contractor identifies to DHCS' Program Integrity Unit (PIU), in a manner prescribed by PIU, as follows:

1) Preliminary Fraud, Waste, and Abuse Reports

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

2) Completed Investigation Report

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

3) Quarterly Fraud, Waste, Abuse Status Report

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

4) Manner of Report Submission

Contractor must electronically submit each Fraud, Waste, and Abuse report required under the Contract in a manner prescribed by DHCS' PIU. The required reports must include but not be limited

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to the preliminary Fraud report, the completed investigation report, and the quarterly status report, including all supporting documents, and any additional documents requested by DHCS, in a form and manner specified by DHCS through APLs, or other similar instructions.

5) Contractor's Obligation to Investigate State, federal, and other Medi-Cal managed care plans' Referrals of Fraud, Waste, and Abuse.

DHCS may, from time to time, share with Contractor relevant Fraud, Waste, and Abuse referrals received from State and federal agencies and other Medi-Cal managed care plans. Contractor may also receive Fraud, Waste, and Abuse referrals directly from other federal agencies, State agencies (other than DHCS), and Medi-Cal managed care plans.

Contractor must conduct a complete investigation of all Fraud, Waste, and Abuse referrals received from DHCS, other State and federal agencies, and other Medi-Cal managed care plans, relating to Contractor's Subcontractors, Downstream Subcontractors, and Network Providers. Contractor must submit a completed investigation report and a quarterly status report, as set forth above in this Exhibit A, Attachment III, Subsection 1.3.2.D (*Contractor's Reporting Obligations*), in connection with all DHCS, State and federal agency, and Medi-Cal managed care plan referrals of Fraud, Waste, and Abuse.

6) Confidentiality

Contractor acknowledges that information shared by DHCS, other State and federal agencies, and other Medi-Cal managed care plans in connection with any Fraud, Waste, or Abuse referral must be considered confidential, until formal criminal proceedings are made public. Contractor further acknowledges that it is receiving this Confidential Information as a DHCS business associate in order to facilitate Contractor's contractual obligations to maintain a Fraud, Waste, and Abuse prevention program. Contractor must receive and maintain this Confidential Information in its capacity as a Medi-Cal managed care plan and will use the Confidential Information only for conducting an investigation into any potential Fraud, Waste, or Abuse activities and in furtherance of any other program integrity activities.

In the event Contractor is required to share this Confidential Information with a Subcontractor, Downstream Subcontractor, or Network Provider, Contractor must ensure that Subcontractor, Downstream Subcontractor and Network Provider acknowledge that such information must be kept confidential by Subcontractor, Downstream Subcontractor, and Network Provider, and a similar provision of confidentiality must be included in all Subcontractor Agreements, Downstream Subcontractor Agreements, and Network Provider Agreements.

1.3.3 Provider Screening, Enrolling, and Credentialing/Recredentialing

A. Screening and Enrolling

All Network Providers must be screened and enrolled in accordance with this Contract, applicable State and federal law, including 42 CFR section 438.602(b), and APL 22-013.

1) If Contractor chooses not to utilize the State level Enrollment pathway, Contractor must notify DHCS and send to DHCS its policies and procedures for review and approval before conducting its own Enrollment process.

2) Contractor may allow Network Providers to participate in their Network for up to 120 calendar days if the Network Provider has a pending Enrollment application in review with DHCS or with Contractor in accordance with 42 CFR section 438.602(b)(2).

3) Contractor must terminate its contract with the provider no later than 15 calendar days of the provider receiving notification from DHCS that the provider has been denied Enrollment in the Medi-Cal program, or upon the expiration of the first 120-day period. Contractor cannot continue to contract with providers during the period in which the provider resubmits its Enrollment application to DHCS or Contractor and can only re-initiate a contract upon the provider's successful enrollment.

B. Credentialing/Recredentialing

Contractor has an on-going obligation to credential and recredential Providers and Network Providers in accordance with this Contract (Exhibit A, Attachment III, Subsection 2.2.13 (*Credentialing and Recredentialing*)), applicable State and federal law, including 42 CFR section 438.602(b), and APL 22-013.

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1.3.4 Contractor's Obligations Regarding Suspended, Excluded, and Ineligible Providers

Contractor has a continuing obligation to verify that Contractor's Network Providers are enrolled and remain enrolled in the Medi-Cal program. Contractor is responsible for knowledge of all ineligible Providers and individuals on these lists.

A. Tracking Suspended, Excluded, and Ineligible Providers

Contractor must review the following exclusionary databases and lists no less frequently than monthly and take appropriate action in accordance with APL 15-026 and APL 21-003.

1) List of Suspended and Ineligible Providers located at https://www.medi-cal.ca.gov;

2) List of excluded individuals and entities maintained by the U.S. Department of Health and Human Services (U.S. DHHS), Office of Inspector General located at https://oig.hhs.gov;

3) The System of Award Management (SAM);

4) The Social Security Administration Death Master File (SSADMF);

5) To the extent applicable, National Plan and Provider Enumeration System (NPPES); and

6) Restricted Provider Database

Contractor must notify DHCS' PIU within ten Working Days of removing a suspended, excluded, or ineligible Providers or individual from its Network and confirm that the ineligible Provider is no longer receiving payments, either directly or indirectly, in connection with the Medi-Cal program. A suspended, excluded, and ineligible Provider report must be sent to DHCS PIU in a manner prescribed by DHCS' PIU.

B. No Contracts with Excluded, Suspended, or Ineligible Providers

Contractor is prohibited from employing, paying, contracting, or maintaining a Medi-Cal contract with Providers that are excluded, suspended, or ineligible to participate, either directly or indirectly, in the

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

C. Notification and Termination of Contracts

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

D. Actions to be taken where Credible Allegation of Fraud

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

1.3.5 Disclosures

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

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

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

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

1.3.6 Treatment of Overpayment Recoveries

A. Retention, Reporting, and Payment of Recoveries

1) Contractor must comply with guidelines issued by DHCS pertaining to ~~retention policies for~~ the treatment of recoveries of all overpayments from Contractor to a Provider, including for the treatment of recoveries of overpayments due to Fraud, Waste, or Abuse. Contractor must also comply with the process, timeframes, and documentation required for reporting and paying to DHCS the recovery of overpayments **that Contractor identifies**, as set forth in APL 23-011. ~~APL 23-011 requires~~ Contractor ~~to~~ **must** notify DHCS of any identified or recovered overpayments to **Subcontractors, Downstream Subcontractors, Network Providers, and/or Providers of Medi-Cal services, medical supplies, or drugs**~~Provider,~~ due to potential ~~f~~**F**raud, ~~w~~**W**aste or ~~a~~**A**buse **in the manner set forth in APL 23-011 or any subsequent APL**. Contractor must notify its Managed Care Operations Division (MCOD) Contract Manager (CM) **and the DHCS Audits and Investigations Intake Unit** within 10 calendar days of the date that ~~the~~ **Contractor identifies such** overpayment **due to Fraud, Waste, or Abuse**, ~~and the DHCS Audits and Investigations Unit~~ regardless of the amount.

2) **Contractor may retain overpayment recoveries from Subcontractors, Downstream Subcontractors, Network Providers, and/or Providers of Medi-Cal services, medical supplies, or drugs associated with overpayments that Contractor identifies if the overpayment recovery is less than $25 million.**

3) Contractor must split ~~equally~~ **with DHCS** overpayment recoveries **from Subcontractors, Downstream Subcontractors, Network Providers, and/or Providers of Medi-Cal services, medical supplies, or drugs associated with overpayments that Contractor identifies** ~~of~~ **if the overpayment recovery is** $25 million or more**,** with ~~DHCS~~ **Contractor retaining all amounts up to $25 million and DHCS retaining all amounts over $25 million**.

4) **DHCS may retain all overpayment recoveries associated with overpayments to Subcontractors, Downstream Subcontractors, Network Providers, and/or Providers of Medi-**

Cal services, medical supplies, or drugs identified by DHCS, CMS, DMFEA, state or federal departments of justice, state or federal Inspectors General, or the agent or designee of DHCS, CMS, DMFEA, state or federal departments of justice, state or federal Inspectors General, whether through audit, investigation, or otherwise, regardless of amount, and may recover such as set forth in Exhibit B, Subsection 1.1.9 (*Recovery of Amounts Paid to Contractor*).

5) **In addition to Contractor's obligation to report any identified or recovered overpayments to Subcontractors, Downstream Subcontractors, Network Providers, and/or Providers of Medi-Cal services, medical supplies, or drugs due to potential Fraud, Waste or Abuse,** Contractor must report an overpayment of $25 million or more**, regardless of cause,** to DHCS through their assigned **Managed Care Operations Division (**MCOD**) Contract Manager (**CM**)** within 60 calendar days of the date that the overpayment **of $25 million or more was identified**. In addition, Contractor must comply with this Contract, and all applicable State and federal law regarding overpayment recoveries, including 42 CFR sections 438.608(a)(2) and (d).

6) ~~A Contractor can retain each overpayment recovery that is less than $25 million.~~ Contractor is required to report all overpayments in their annual report to DHCS, using the rate development template, including recoveries that are less than $25 million. Contractor does not need to report overpayments that are less than $25 million **and not due to Fraud, Waste, or Abuse** within 60 calendar days of when the overpayment was identified.

B. Annual Report

Contractor must annually report to DHCS its recoveries of overpayments using the rate development **template** (42 CFR section 438.608(d)(3)).

1.3.7 Federal False Claims Act Compliance and Support

A. Employee Education about False Claims Recovery

Contractor must provide to all its employees, Subcontractors, Downstream Subcontractors, and Network Providers written policies containing detailed information about the False Claims Act and other federal and State laws

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described in 42 United States Code (USC) section 1396a(a)(68), including information about rights of employees to be protected as whistleblowers (See also 42 CFR section 438.608(a)(6)).

Upon request by DHCS, Contractor must demonstrate compliance with this Exhibit A, Attachment III, Subsection 1.3.7.A (*Employee Education about False Claims Recovery*), which may include providing DHCS with copies of Contractor's applicable written policies and procedures and any relevant employee handbook excerpts.

B. Cooperation with the Office of the Attorney General, DMFEA, or the US DOJ Investigations and Prosecutions.

Contractor must fully cooperate in any investigation or prosecution conducted by the Office of the Attorney General, DMFEA or the US DOJ. Contractor's cooperation must include, but is not limited to, providing upon request, information, and access to records. Contractor is also responsible for making their staff available for in-person interviews, consultation, grand jury proceedings, pre-trial conference, depositions, and hearings at DHCS headquarters in Sacramento.

C. Money Recovered from State Action Belongs to the State

In the event that DHCS receives a monetary recovery from the Office of the Attorney General, DMFEA, or the US DOJ, as a result of DMFEA's or US DOJ's prosecution of a Subcontractor, Downstream Subcontractor, or Network Provider under the California False Claims Act (Government Code (GC) § 12650 *et seq.*), the Federal False Claims Act (31 USC section 3729 *et seq.*), or any other applicable laws, the entirety of such monetary recovery belongs exclusively to DHCS, and Contractor waives any claim to any portion of the recovery, except as determined by DHCS in its sole discretion.

D. Payment to Contractor is from Government Funds

Medi-Cal payments to Contractor, Subcontractors, Downstream Subcontractors, Network Providers, and Providers are made from federal and State government funds. DHCS retains the right to recover overpayments made to Contractor, Subcontractors, Downstream Subcontractors, Network Providers, and/or Providers of Medi-Cal services, medical supplies, or drugs, **including such overpayments made by Contractor to Subcontractors, Downstream Subcontractors, Network Providers, and/or Providers of Medi-Cal services, medical supplies, or drugs,** as set forth in part in **Exhibit A, Subsection 1.3.6 (*Treatment***

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***of Overpayment Recoveries*) and** Exhibit B, Section 1.9 (*Recovery of Amounts Paid to Contractor*). In addition to DHCS' recovery rights, DMFEA and US DOJ may prosecute any act of health care Fraud involving such government funds under the California False Claims Act (GC § 12650 *et seq.*), the Federal False Claims Act (31 USC section 3729 *et seq.*), or any other applicable laws.

E. Contractor's Settlements with Subcontractors, Downstream Subcontractors, and Network Providers do not bind DHCS, DMFEA, or the US DOJ.

Any settlement or resolution of a disputed matter involving Fraud, Waste, or Abuse between Contractor and its Subcontractor, Downstream Subcontractor, or Network Provider must include a written provision that provides notice to the Subcontractor, Downstream Subcontractor, or Network Provider that the settlement and/or resolution is not binding on DHCS, DMFEA, or the US DOJ and does not preclude DHCS, DMFEA, or the US DOJ from taking further action against Contractor or its Subcontractor, Downstream Subcontractor, or Network Provider.

Exhibit A, ATTACHMENT III

2.0 Systems and Processes

DHCS is committed to ensuring Contractors have the capabilities, systems and processes that enable delivery of high-quality health care. The provisions in this Article lay out DHCS' expectations of Contractors to have Management Information Systems (MIS) to collect, report, and analyze data to identify Members' needs and support Population Health Management. Contractors must be able to not only submit Encounter Data, but have systems to ensure the data are complete, accurate, reasonable, and timely, including for Subcontractors, Downstream Subcontractors, and Network Providers.

The provisions of this Article are also intended to ensure that Medi-Cal systems and processes are innovative and adapting to the way in which Members seek and access care. DHCS expects Contractors to build upon their MIS capabilities to enable interoperability for data exchange with Health Information Technology (HIT) systems and Health Information Exchange (HIE) Networks. Further, Contractors must comply with the Centers for Medicare & Medicaid Services (CMS) Interoperability and Patient Access Final Rule set forth at CMS-9115-F and ensure that they and their Subcontractors, Downstream Subcontractors, and Network Providers have the system capabilities to comply with the California Health and Human Services Data Exchange Framework set forth in H&S section 130290. These requirements will enable the delivery system to have information for Members where and when they need care.

To further drive standards of high quality care and Health Equity, this Article includes provisions requiring Contractors to have both National Committee for Quality Assurance (NCQA) Health Plan Accreditation and Health Equity Accreditation by January 1, 2026. Further, DHCS specifies alignment of Quality Improvement and Health Equity activities that align in principle with the DHCS Comprehensive Quality Strategy and imposes requirements for Contractors to meet or exceed minimum performance standards.

DHCS is committed to transparency to demonstrate accountability to the public and community it serves. Consequently, DHCS requires public reporting of information related to access, quality, delegation, quality improvement, and Health Equity activities. Specific to public posting, this Article includes provisions requiring Contractors to make available on their websites their annual Quality Improvement and Health Equity Transformation Plan, meeting minutes from their Quality Improvement and Health Equity Committee (QIHEC), and Utilization Management policies and procedures.

2.1 Management Information System

2.1.1 Management Information System Capability
2.1.2 Encounter Data Reporting
2.1.3 Participation in the State Drug Rebate Program
2.1.4 Network Provider Data Reporting
2.1.5 Program Data Reporting
2.1.6 Template Data Reporting
2.1.7 Management Information System/Data Audits
2.1.8 Management Information System/Data Correspondence
2.1.9 Tracking and Submitting Alternative Format Selections
2.1.10 Interoperability Application Programming Interface System Requirements

2.1 Management Information System

2.1.1 Management Information System Capability

Contractor's Management and Information System (MIS) must be fully compliant with 42 Code of Federal Regulations (CFR) section 438.242 requirements and must have the capability to capture, edit, and utilize various data elements for both internal management use as well as to meet the data quality and timeliness requirements of DHCS's Encounter Data submission. Contractor must make available to DHCS and to the Centers for Medicare & Medicaid Services (CMS) upon request all data related to this Contract.

A. Contractor must have and maintain a MIS that supports, at a minimum:

1) All Medi-Cal eligibility data;

2) Information on Members enrolled with Contractor,

3) Provider claims status and payment data;

4) Health care services delivery Encounter Data;

5) Network Provider Data;

6) Program Data;

7) Template Data;

8) Screening and assessment data;

9) Referrals including tracking of referred services to follow up with Members to ensure that services were rendered;

10) Electronic health records;

11) Prior Authorization requests and a specialty referral system as specified in Exhibit A, Attachment III, Section 2.3 (*Utilization Management Program*);

12) Complex Care Management (CCM) Care Manager assignment as specified in Exhibit A, Attachment III, Subsection 4.3.7 *(Care Management Programs*);

13) Financial information as specified in Exhibit A, Attachment III, Subsection 1.2.2 (*Contractor's Financial Reporting Obligations*);

14) Social Drivers of Health (SDOH) data per All Plan Letter (APL) 21-009;

15) Member and Member's Authorized Representative (AR) Alternative Format Selection(s) (AFS); and

16) Data sources specified in DHCS policies and guidance, including APLs, the Enhanced Care Management (ECM) Policy Guide, Community Supports Policy Guide, the Population Health Management (PHM) Policy Guide, and the Policy and Operational Guide for Planning and Implementing CalAIM Justice-Involved Re-entry Initiative.

B. Contractor's MIS must have processes that support the interactions between financial data, Member/eligibility data, Network Provider Data, Encounter Data, claims data, Program Data, Template Data, quality management/quality improvement/Utilization Management data, and report generation subsystems. The interactions of Contractor's MIS subsystems must be interoperable, efficient, and successful with Contractor's other MIS subsystems and DHCS' systems and processes.

C. Contractor's MIS must have the capability to transmit and consume data files with and from DHCS, Subcontractors, Downstream Subcontractors, Network Providers, other State and federal and local governmental agencies, and other sources as needed to support Care Coordination and overall administration of the Medi-Cal program. Data that must be able to be transmitted and consumed include, but are not limited to:

1) Encounter Data;

2) Fee-For-Service (FFS) claims data; including carved-out claims data, such as Medically Necessary services carved out of this Contract and data available from partner organizations, including but not limited to the Local Education Agency Medi-Cal Billing Option Program (LEA BOP) and incarceration in-reach services;

3) Dental claims data;

4) Specialty mental health data;

5) Substance Use Disorder (SUD) data;

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6) Medi-Cal FFS Treatment Authorization Request data;

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

8) Targeted Case Management (TCM) data;

9) Pharmacy claims data;

10) Risk Tier assignment data;

11) Authorization and referral data; and

12) Medical record information including case notes.

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

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

2.1.2 Encounter Data Reporting

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

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

C. Contractor must require all Network Providers, Subcontractors, Downstream Subcontractors, and out-of-Network Providers to submit claims and Encounter Data to Contractor to ensure compliance with this

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

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

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

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

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

2.1.3 Participation in the State Drug Rebate Program

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

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

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

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

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

2.1.4 Network Provider Data Reporting

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

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

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

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

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

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

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

2.1.5 Program Data Reporting

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

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

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

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

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

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

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

2.1.6 Template Data Reporting

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

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

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

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

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

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

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

2.1.7 Management Information System/Data Audits

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

2.1.8 Management Information System/Data Correspondence

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

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

2.1.9. Tracking and Submitting Alternative Format Selections

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

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

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

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

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

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

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

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

2.1.10 Interoperability Application Programming Interface System Requirements

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

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

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

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

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Exhibit A, ATTACHMENT III

2.2 Quality Improvement and Health Equity Transformation Program

2.2.1 Quality Improvement and Health Equity Transformation Program Overview
2.2.2 Governing Board
2.2.3 Quality Improvement and Health Equity Committee
2.2.4 Provider Participation
2.2.5 Subcontractor and Downstream Subcontractor Quality Improvement Activities
2.2.6 Quality Improvement and Health Equity Transformation Program Policies and Procedures
2.2.7 Quality Improvement and Health Equity Annual Plan
2.2.8 National Committee for Quality Assurance Accreditation
2.2.9 External Quality Review Requirements
2.2.10 Quality Care for Children
2.2.11 Skilled Nursing Facilities—Long-Term Care
2.2.12 Disease Surveillance
2.2.13 Credentialing and Recredentialing

2.2 Quality Improvement and Health Equity Transformation Program

Contractor must implement a Quality Improvement and Health Equity Transformation Program (QIHETP) that includes, at a minimum, the standards set forth in 42 Code of Federal Regulations (CFR) sections 438.330 and 438.340, and 28 California Code of Regulations (CCR) section 1300.70, and be consistent with the principles outlined in the DHCS Comprehensive Quality Strategy and ~~and~~ a forthcoming All Plan Letter (APL). Contractor must monitor, evaluate, and take timely action to address necessary improvements in the Quality of Care delivered by all its Providers in any setting, and take appropriate action to improve upon Health Equity. Contractor is responsible for the quality and Health Equity of all Covered Services regardless of whether or not those services have been delegated to a Subcontractor, Downstream Subcontractor, or Network Provider.

A. Contractor must deliver quality care that enables all its Members to maintain health and improve or manage a chronic illness or disability. Contractor must ensure quality care in each of the following areas:

   1) Clinical quality of physical health care;

   2) Clinical quality of Behavioral Health care focusing on prevention, recovery, resiliency, and rehabilitation;

   3) Access to primary and specialty health care Providers and services;

   4) Availability and regular engagement with Primary Care Providers (PCP);

   5) Continuity of care and Care Coordination across settings and at all levels of care, including transitions in care, with the goal of establishing consistent Provider-patient relationships; and

   6) Member experience with respect to clinical quality, access and availability, culturally and linguistically competent health care and services, continuity of care, and Care Coordination.

B. Contractor must apply the principles of continuous quality improvement (CQI) to all aspects of Contractor's service delivery system through analysis, evaluation, and systematic enhancements of the following:

   1) Quantitative and qualitative data collection and data-driven decision-making;

2) Up-to-date evidence-based practice guidelines and explicit criteria developed by recognized sources or appropriately certified professionals or, where evidence-based practice guidelines do not exist, consensus of professionals in the field;

3) Feedback provided by Members, community partners, and Network Providers in the design, planning, and implementation of its CQI activities; and

4) Other issues identified by Contractor or DHCS.

C. Contractor must develop Population Health Management interventions designed to address Social Drivers of Health (SDOH), reduce disparities in health outcomes experienced by different subpopulations of Members, and work towards achieving Health Equity by:

1) Developing equity-focused interventions intended to address disparities in the utilization and outcomes of physical and Behavioral Health care services; and

2) Engaging in a Member and family-centric approach in the development of interventions and strategies, and in the delivery of all health care services.

D. Contractor must ensure that the QIHETP requirements of this Contract are applied to the delivery of both physical and Behavioral Health Services.

2.2.1 Quality Improvement and Health Equity Transformation Program Overview

Contractor must maintain a QIHETP which includes the following, at a minimum:

A. Oversight and participation of Contractor's Governing Board;

B. Creation and designation of a Quality Improvement and Health Equity Committee (QIHEC) whose activities are supervised by Contractor's medical director or the medical director's designee, in collaboration with Contractor's Chief Health Equity Officer;

C. Supervision of QIHETP activities by Contractor's medical director and the Chief Health Equity Officer; and

D. The participation of a broad range of Network Providers, including but not limited to hospitals, clinics, county partners, physicians, Community Health

Workers (CHWs), and other non-clinical Providers in the process of QIHETP development and performance review.

2.2.2 Governing Board

Contractor must implement and maintain written policies and procedures that specify the responsibilities of its Governing Board, which include the following, at a minimum:

A. Approving the overall QIHETP and the annual plan of the QIHETP;

B. Appointing an accountable entity or entities within Contractor's organization responsible for the oversight of the QIHETP;

C. Receiving written QIHEC progress reports that describe actions taken, progress in meeting QIHETP objectives, and improvements made; and

D. Directing necessary modifications to QIHETP policies and procedures to ensure compliance with the Quality Improvement (QI) and Health Equity standards in this Contract and the DHCS Comprehensive Quality Strategy.

2.2.3 Quality Improvement and Health Equity Committee

A. Contractor must implement and maintain a Quality Improvement and Health Equity Committee (QIHEC) designated and overseen by its Governing Board. Contractor's medical director or the medical director's designee must head QIHEC in collaboration with Contractor's Chief Health Equity Officer. Contractor must ensure that a broad range of Network Providers, including but not limited to hospitals, clinics, county partners, physicians, Subcontractors, Downstream Subcontractors, Network Providers, and Members, actively participate in the QIHEC or in any sub-committee that reports to the QIHEC. The Subcontractors, Downstream Subcontractors, and Network Providers that are part of QIHEC must be representative of the composition of Contractor's Network and include, at a minimum, Network Providers who provide health care services to Members affected by Health Disparities, Limited English Proficiency (LEP) Members, Children and Youth with Special Health Care Needs (CYSHCN), Seniors and Persons with Disabilities (SPDs), and persons with chronic conditions.

The QIHEC's responsibilities include the following:

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

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

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

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

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

D. Contractor must make the written summary of the QIHEC activities publicly available on Contractor's website at least on a quarterly basis.

E. Contractor must ensure that its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors maintain a QIHEC that meets the requirements set forth in this Section. Contractor must also ensure that they report to Contractor's QIHEC quarterly, at a minimum.

2.2.4 Provider Participation

Contractor must ensure that its Network Providers, Fully Delegated Subcontractors, and Downstream Fully Delegated Subcontractors participate in the QIHETP and Population Needs Assessment (PNA) as described in Exhibit A, Attachment III, Subsection 4.3.2 (*Population Needs Assessment*). Contractor must incorporate its Fully Delegated Subcontractor and Downstream Fully Delegated Subcontractor data and results into the development of its PNA, as described in Exhibit A, Attachment III, Subsection 4.3.2 (*Population Needs Assessment*). Contractor must regularly update its Network Providers, Fully Delegated Subcontractors, and Downstream Fully Delegated Subcontractors on activities, findings, and recommendations of the QIHEC's QIHETP and PNA results.

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2.2.5 Subcontractor and Downstream Subcontractor Quality Improvement Activities

A. Contractor is accountable for all QI and Health Equity functions and responsibilities that are delegated to Subcontractors and any Downstream Subcontractors, in accordance with Exhibit A, Attachment III, Subsection 3.1.1 (*Overview of Contractor's Duties and Obligations*). Contractor must, at a minimum, specify the following requirements in its Subcontractor Agreements and Downstream Subcontractor Agreements, as applicable:

1) QI or Health Equity responsibilities, and specific subcontracted functions and activities of Subcontractor and Downstream Subcontractor;

2) The schedule for Contractor's ongoing oversight, monitoring, and evaluation of Subcontractor and Downstream Subcontractor, including quarterly reporting and an annual review of Subcontractor's and Downstream Subcontractor's performance;

3) Subcontractor's and Downstream Subcontractor's reporting requirements and Contractor's approval procedure of Subcontractor's and Downstream Subcontractor's reports;

4) Subcontractor's and Downstream Subcontractor's obligation to report findings and actions of QI or Health Equity activities at least quarterly to Contractor; and

5) Contractor's actions and remedies if Subcontractor's and Downstream Subcontractor's obligations are not satisfactorily performed.

B. Contractor must maintain an adequate oversight procedure to ensure Subcontractor's and Downstream Subcontractor's compliance with all QI or Health Equity delegated activities that, at a minimum:

1) Evaluates Subcontractor's and Downstream Subcontractor's ability to perform the delegated activities, including an initial determination that Subcontractor and Downstream Subcontractor have the administrative capacity, experience, and budgetary resources to fulfill their contractual obligations;

2) Ensures Subcontractor and Downstream Subcontractor meet QI and Health Equity standards set forth in this Contract; and

3) Includes Contractor's continuous monitoring, evaluation and approval of its delegated functions to Subcontractor and Downstream Subcontractor. Contractor must make the findings of its continuous monitoring and evaluation of the Subcontractor and Downstream Subcontractor available to DHCS at least annually, but more frequently when directed by DHCS.

2.2.6 Quality Improvement and Health Equity Transformation Program Policies and Procedures

Contractor must develop, implement, maintain, and periodically update its QIHETP policies and procedures that include, at a minimum, the following:

A. Contractor's commitment to the delivery of quality and equitable health care services;

B. Contractor's, Fully Delegated Subcontractor's, and Downstream Fully Delegated Subcontractor's organizational chart, listing the key staff and the committees responsible for QI and Health Equity activities, including reporting relationships of QIHEC to executive staff;

C. Qualification and identification of staff who are responsible for QI and Health Equity activities;

D. A process for sharing QIHETP findings with its Subcontractors, Downstream Subcontractors, and Network Providers;

E. The role, structure, and function of the QIHEC;

F. The policies and procedures to ensure that all Covered Services are available and accessible to all Members regardless of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, health status, genetic information, marital status, gender, gender identity, or sexual orientation, or identification with any other persons or groups defined in Penal Code section 422.56, and that all Covered Services are provided in a culturally and linguistically appropriate manner;

G. The policies and procedures designed to identify, evaluate, and reduce Health Disparities, by performing the following:

1) Analyzing data to identify differences in Quality of Care and utilization, as well as the underlying reasons for variations in the provision of care to its Members;

2) Developing equity-focused interventions to address the underlying factors of identified Health Disparities, including SDOH; and

3) Meeting disparity reduction targets for specific populations and/or measures as identified by DHCS and as directed under Exhibit A, Attachment III, Subsection 2.2.9.A (*Quality Performance Measures*).

H. Description of the integration of Utilization Management (UM) activities into the QIHETP as specified in Exhibit A, Attachment III, Section 2.3 (*Utilization Management Program*), including a process to integrate reports on the number and types of service requests, denials, deferrals, modifications, Appeals, and Grievances to the medical director or the medical director's designee;

I. Policies and procedures to adopt, disseminate, and monitor the use of clinical practice guidelines that:

1) Are based on valid and reliable clinical evidence or a consensus of health care professionals in the relevant field;

2) Consider the needs of Members;

3) Stem from recognized organizations that develop or promulgate evidence-based clinical practice guidelines, or are developed with involvement of board-certified Providers from appropriate specialties;

4) Have been reviewed by Contractor's medical director, as well as Subcontractors, Downstream Subcontractors, and Network Providers, as appropriate; and

5) Are reviewed and updated at least every two years;

J. The inclusion of Population Health Management (PHM) activities, including the findings of the annual PNA, as required in Exhibit A, Attachment III, Subsection 4.3.2 (*Population Needs Assessment*);

K. Policies and procedures that ensure the delivery of Medically Necessary **N**~~n~~on-**S**~~s~~specialty **Mental Health Services (NSMHS)** and Specialty Mental Health Services **(SMHS)** as outlined in Exhibit A, Attachment III, Section 5.5 (*Mental Health and Substance Use Disorder Benefits*);

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L. Policies and procedures that ensure that Contractor and its Subcontractors, Downstream Subcontractors, Network Providers, and other entities with which Contractor contracts for the delivery of health care services comply with all mental health parity requirements in 42 CFR section 438.900 *et seq*.;

M. Mechanisms to detect both over- and under-utilization of services including, but not limited to, outpatient Prescription Drugs;

N. Mechanisms to continuously monitor, review, evaluate, and improve access to and availability of all Covered Services. The mechanisms must include oversight processes that ensure Members are able to obtain Medically Necessary appointments within established standards for time or distance, timely access, and alternative access in accordance with APL 23-001, and Welfare and Institutions Code (W&I) sections 14197 and 14197.04;

O. Mechanisms to continuously monitor, review, evaluate, and improve quality and Health Equity of clinical care services provided, including, but not limited to, preventive services for Children and adults, perinatal care, Primary Care, specialty, emergency, inpatient, Behavioral Health and ancillary care services; and

P. Mechanisms to continuously monitor, review, evaluate, and improve coordination and continuity of care services to all Members, including SPDs, CYSHCNs, Members with chronic conditions, including Behavioral Health, Members experiencing homelessness, Members recently released from incarceration, Members who use Long-Term Services & Supports (LTSS), and Children receiving Child welfare services.

2.2.7 Quality Improvement and Health Equity Annual Plan

Through regional quality and health equity teams, Contractor must develop and submit an annual QI and Health Equity plan to DHCS, as directed below and in and a forthcoming APL.

A. Develop QI and Health Equity plan annually for submission to DHCS that includes the following, at a minimum:

1) A comprehensive assessment of the QI and Health Equity activities undertaken, including an evaluation of the effectiveness of QI interventions;

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2) A written analysis of required Quality Performance Measure results, and a plan of action to address performance deficiencies, including analyses of each Fully Delegated Subcontractor's and Downstream Fully Delegated Subcontractor's performance measure results and actions to address any deficiencies;

3) An analysis of actions taken to address any Contractor-specific recommendations in the annual External Quality Review (EQR) technical report and Contractor's specific evaluation reports;

4) An analysis of the delivery of services and Quality of Care of Contractor and its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors, based on data from multiple sources, including quality performance results, Encounter Data, Grievances and Appeals, Utilization Review and the results of consumer satisfaction surveys;

5) Planned equity-focused interventions to address identified patterns of over- or under-utilization of physical and Behavioral Health care services;

6) A description of Contractor's commitment to Member and/or family focused care through Member and community engagement such as review of CAC findings, Member listening sessions, focus groups or surveys, and collaboration with local community organizations; and how Contractor utilizes the information from this engagement to inform Contractor policies and decision-making;

7) PHM activities and findings as outlined in Exhibit A, Attachment III, Section 4.3 (*Population Health Management and Coordination of Care*); and

8) Outcomes/findings from Performance Improvement Projects (PIPs), consumer satisfaction surveys and collaborative initiatives.

To the extent that Contractor delegates its QI and Health Equity activities to its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors, Contractor's QI and Health Equity annual plan must include evaluation and findings specific to the Fully Delegated Subcontractor's and Downstream Fully Delegated Subcontractor's performance.

B. Provide annual copies of all final reports of independent private accrediting agencies (e.g. the National Committee for Quality Assurance

(NCQA)) relevant to Contractor's, Fully Delegated Subcontractor's, and Downstream Fully Delegated Subcontractor's Medi-Cal line of business, including:

1) Accreditation status, survey type, and level, as applicable;

2) Accreditation agency results, including recommended actions or improvements, Corrective Action plans, and summaries of findings; and

3) Expiration date of the accreditation.

In addition, pursuant to 42 CFR section 438.332, Contractor must authorize independent private accrediting agencies to provide DHCS a copy of Contractor's most recent accreditation review annually.

C. Provide an annual report to DHCS that includes an assessment of all Subcontractors' and Downstream Subcontractors' performance of its delegated QI or Health Equity activities.

D. Contractor must make the QI and Health Equity plan publicly available on its website on an annual basis.

E. Contractor must attend regional collaborative meetings which may include additional regional partners including but not limited to county Mental Health Plans (MHPs), Drug Medi-Cal (DMC), Drug Medi-Cal Organized Delivery System (DMC-ODS), Local Government Agencies, public hospitals, and community-based organizations (CBOs).

2.2.8 National Committee for Quality Assurance Accreditation

Contractor must have full NCQA Health Plan Accreditation (HPA) and NCQA Health Equity Accreditation by no later than January 1, 2026. Contractor must maintain full NCQA HPA and Health Equity Accreditation throughout the term of this Contract and submit every 3 years NCQA Health Plan Accreditation and Health Equity Accreditation results. Contractor must also complete additional NCQA accreditation programs as directed by DHCS.

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

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Contractor must ensure that its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors also complete additional NCQA accreditation programs as directed by DHCS.

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

A. Accreditation status;

B. Survey type;

C. Results of the review;

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

E. Recommended actions or improvements;

F. Corrective Action plans and summaries of findings; and

G. Expiration date of the accreditation.

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

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

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

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

2.2.9 External Quality Review Requirements

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

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

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

A. Quality Performance Measures

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

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

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

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its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors

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

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

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

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

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

In addition to sanctions and Corrective Actions, DHCS reserves the right, subject to actuarial judgment and generally accepted actuarial principles and practices, to consider Contractor's performance on specified quality and equity benchmarks, as determined by DHCS and communicated to Contractors in advance of each applicable Rating Period, within the determination of Capitation Payment rates for that Rating Period.

Contractor is responsible for ensuring that its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors also meet or exceed the DHCS-established MPL. If its Fully Delegated Subcontractor or Downstream Fully Delegated Subcontractor fails to meet or exceed the DHCS-established MPL, Contractor must have policies and procedures in place to subject its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors to appropriate enforcement actions, which may include, but are not limited to, financial sanctions, corrective action plans, and a requirement to change its executive personnel.

B. PIPs

1) Contractor must conduct or participate in PIPs, including any PIP required by CMS, in accordance with 42 CFR section 438.330. Contractor must conduct or participate in, at a minimum, two (2) PIPs per year, as directed by DHCS. At its sole discretion, DHCS may require Contractor to conduct or participate in additional PIPs, including statewide PIPs. DHCS may also require Contractor to participate in statewide collaborative PIP workgroups.

2) Contractor must have policies and procedures in place to ensure that its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors also conduct and participate in PIPs and any collaborative PIP workgroups as directed by CMS or DHCS.

3) Contractor must comply with the PIP requirements outlined in a forthcoming APL and must use the PIP reporting format as designated therein to request DHCS' approval of proposed PIPs.

4) Each PIP must include the following:

a) Measurement of performance using objective quality indicators;

b) Implementation of equity-focused interventions to achieve improvement in the access to and Quality of Care;

c) Evaluation of the effectiveness of the interventions based on the performance measures; and

d) Planning and initiation of activities for increasing or sustaining improvement.

5) Contractor must report the status of each PIP at least annually to DHCS.

C. Consumer Satisfaction Survey

1) On an annual basis until January 1, 2026, Contractor must timely provide all data requested by the EQRO in a format designated by the EQRO in conducting a consumer satisfaction survey.

2) Beginning January 1, 2026, concurrent with the requirement for HPA by the NCQA, Contractor must publicly post the annual results of its, and its Fully Delegated Subcontractor's and Downstream Fully Delegated Subcontractor's, CAHPS survey on Contractor's website, including results of any supplemental questions as directed by DHCS.

3) If Contractor has HPA prior to January 1, 2026 and reports its CAHPS data to the NCQA, Contractor must publicly post the annual results of its, and its Fully Delegated Subcontractor's and Downstream Fully Delegated Subcontractor's, CAHPS survey on Contractor's website, including results of any supplemental questions as directed by DHCS.

4) Contractor must incorporate results from the CAHPS survey in the design of QI and Health Equity activities.

D. Network Adequacy Validation

Contractor must participate in the EQRO's validation of Contractor's Network adequacy representations from the preceding 12 months to comply with requirements set forth in 42 CFR sections 438.14(b), 438.68, and 438.358.

E. Encounter Data Validation

As directed by DHCS, Contractor must participate in EQRO's validation of Encounter Data from the preceding 12 months to comply with requirements set forth in 42 CFR sections 438.242(d) and 438.818.

F. Focused Studies

As directed by DHCS, Contractor must participate in an external review of focused clinical and/or non-clinical topic(s) as part of DHCS' review of

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quality outcomes and timeliness of, and access to, services provided by Contractor.

G. Technical Assistance

In accordance with 42 CFR section 438.358(d) and at the direction of DHCS, Contractor must implement EQRO's technical guidance provided to Contractor in conducting mandatory and optional activities described in 42 CFR section 438.358 and this Contract.

2.2.10 Quality Care for Children

Contractor must maintain a robust program to ensure the provision of all physical, behavioral, and oral health services to Members less than 21 years of age. Contractor must also maintain mechanisms to identify and improve on gaps in the quality of and access to care in each of the following areas:

A. Scope of Services

1) Contractor must ensure the provision of all screening, preventive and Medically Necessary diagnostic and treatment services for Members less than 21 years of age in accordance with Exhibit A, Attachment III, Subsection 5.3.4 (*Services for Members Less Than 21 Years of Age*);

2) Contractor must actively promote Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screenings and American Academy of Pediatrics (AAP) Bright Futures preventive services to Members and their families. Per APL 23-005, on an annual basis by January 1 of each year, Contractor must mail or share electronically, DHCS Medi-Cal for Kids and Teens Materials for existing Members under the age of 21. For new Members, Contractor is required to mail or share electronically, DHCS Medi-Cal for Kids and Teens Materials within seven calendar days of the enrollment. Additionally, Contractor must ensure Network Providers receive standardized training on EPSDT utilizing the developed DHCS Medi-Cal for Kids and Teens Outreach and Education Toolkit;

3) Contractor must identify Members who have not utilized EPSDT screening services or AAP Bright Futures preventive services and ensure outreach to these Members in a culturally and linguistically appropriate manner;

4) Contractor must maintain Memorandums of Understanding (MOUs) with Local Health Departments (LHDs) and Local Government Agencies (LGAs), in Contractor's Service Area(s), including but not limited to California Children's Services (CCS), the Women, Infants and Children Supplemental Nutrition Program (WIC), maternal and Child health, social services, Regional Centers, and Child welfare departments, as outlined in Exhibit A, Attachment III, Subsection 5.6.1 (*MOU Purpose*) in order to facilitate the provision of EPSDT services to Members less than 21 years of age;

5) Contractor must comply with APL 23-005 requirements to include conducting ongoing training, at least once every two years, for Network Providers on required preventive healthcare services, including EPSDT services for Members less than 21 years of age as outlined in Exhibit A, Attachment III, Subsection 3.2.5.B (*Network Provider Training*), to ensure Providers are able to support Members and families in fully utilizing EPSDT services.

B. Utilization Management

Contractor must ensure that all requirements outlined in Exhibit A, Attachment III, Section 2.3 (*Utilization Management Program*) apply to the review and provision of Medically Necessary services for Members less than 21 years of age.

C. Population Health Management (PHM) and Coordination of Care

1) Contractor must ensure that all requirements outlined in Exhibit A, Attachment III, Section 4.3 (*Population Health Management and Coordination of Care*), including the development of the annual PNA, apply to Members less than 21 years of age;

2) Contractor and its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors must provide a comprehensive wellness and prevention program to all Members less than 21 years of age, which includes but is not limited to (see full requirements in Exhibit A, Attachment III, Subsection 4.3.8 (*Basic Population Health Management))* initiatives, programs, and evidence-based approaches to improving access to preventive health visits, developmental screenings, and services for Members less than 21 years of age, as described in Exhibit A, Attachment III, Subsection 5.3.4 (*Services for Members Less Than 21 Years of Age*).

D. Network and Access to Care

1) Contractor must ensure that each Member less than 21 years of age has an assigned PCP as well as access to Specialists for Covered Services and Medically Necessary services, in accordance with Exhibit A, Attachment III, Subsection 5.2.1 (*Access to Network Providers and Covered Services*);

2) Contractor must provide information to all Network Providers regarding the Vaccines for Children (VFC) Program and is expected to promote and support Enrollment of applicable Network Providers in the VFC program in order to improve access to immunizations; and

3) Contractor must maintain and continually monitor, improve, and evaluate cultural and linguistic services that support the delivery of Covered Services to Members less than 21 years of age, in accordance with Exhibit A, Attachment III, Subsection 5.2.11 (*Cultural and Linguistic Programs and Committees*).

E. Quality and Health Equity

1) Contractor must identify and address underutilization of Children's preventive services including but not limited to EPSDT services such as well Child visits, developmental screenings and immunizations;

2) Contractor must report on DHCS-identified Quality Performance Measures and Health Equity performance measures related to health care services for Members less than 21 years of age, and must exceed any DHCS-specified MPL, in accordance with Exhibit A, Attachment III, Subsection 2.2.9.A (*Quality Performance Measures*);

3) Contractor must engage with local entities when developing interventions and strategies to address deficiencies in performance measures related to health care services for Members less than 21 years of age;

4) Contractor must meet any Health Disparity reduction targets for specific populations and measures for Members less than 21 years of age, as identified by DHCS and in accordance with Exhibit A, Attachment III, Subsection 2.2.9.A.2 (*Quality Performance Measures*);

5) Contractor must participate in any value-based payment programs for services provided to Members less than 21 years of age, as directed by DHCS;

6) Contractor must engage in planned Health Equity-focused interventions to address identified gaps in the quality of and access to care for Members less than 21 years of age, including preventive and screening services; and

7) Contractor must engage in a Member and family-oriented engagement strategy to QI and Health Equity, including Children and caregiver representation on the Community Advisory Committee (CAC), and using CAC findings and recommendations, and the results of Member listening sessions, focus groups and surveys, to inform QI and Health Equity interventions, as outlined in Exhibit A, Attachment III, Subsection 5.2.11.D. (*Cultural and Linguistic Programs and Committees*).

F. Mental Health and Substance Use Disorder Services

Contractor must adhere to all requirements of Exhibit A, Attachment III, Section 5.5 (*Mental Health and Substance Use Disorder Benefits*) for the provision of mental health and Substance Use Disorder services to Members less than 21 years of age, as appropriate, including collaborating with county Behavioral Health plans and complying with APL 23-010 and all mental health parity requirements in 42 CFR section 438.900 *et seq*.

Contractor must collaborate with DHCS in its effort to implement the California Children and Youth Behavioral Health Initiative.

G. School-Based Services

By January 1, 2026, or a later date as determined by DHCS, ~~T~~**t**o facilitate the provision of Medically Necessary services to Children, Contractor must collaborate, **negotiate in good faith,** and~~, by January 1, 2025~~ execute~~, an~~ MOU**s** with Local Education Agencies (LEAs) **and/or County Offices of Education, as applicable, if agreed to by all stakeholders involved,** in each county within Contractor's Service Area for school-based services~~,~~**. School-based services** includ~~ing~~**e** but **are** not limited to EPSDT and Behavioral Health Services for Members less than 21 years of age. Contractor must also ensure that Members' PCP (PCP) cooperate and collaborate with LEAs in the development of Individualized Education Plans (IEPs) or Individualized Family Service Plans (IFSPs)

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and ultimately ensure that care is coordinated regardless of financial responsibility, as outlined in Exhibit A, Attachment III, Subsections 4.3.16 (*School-Based Services*) and 5.6.1 (*MOU Purpose*).

2.2.11 Skilled Nursing Facilities – Long-Term Care

Contractor must implement and maintain policies and procedures for providing applicable Long-Term Care (LTC) services for Members as detailed in Exhibit A Attachment III, Subsection 5.3.7.G *(Services for All Members).* Contractors must maintain a comprehensive Quality Assurance Performance Improvement (QAPI) program for LTC services provided. Contractors must have a system in place to collect quality assurance and improvement findings from CDPH to include, but not be limited to, survey deficiency results, site visit findings, and complaint findings. Contractor's comprehensive QAPI program must incorporate all requirements in APL 23-004.

2.2.12 Disease Surveillance

Contractor must implement and maintain procedures for reporting any serious diseases or conditions to both local and State public health authorities and to implement directives from the public health authorities as required by law, including but not limited to, 17 CCR section 2500 *et seq*.

2.2.13 Credentialing and Recredentialing

Contractor and its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors must implement and maintain written policies and procedures regarding the initial Credentialing, recredentialing, recertification, and reappointment of Network Providers in accordance with 42 CFR section 438.214 and APL 22-013. Contractor and its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors must ensure its policies and procedures are reviewed and approved by its Governing Board. Contractor must ensure that the responsibility for recommendations regarding Credentialing decisions rests with a Credentialing committee or other peer review body.

A. Standards

Contractor and its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors must ensure that all their Network Providers who deliver Covered Services and have executed Network Provider Agreements with Contractor are qualified in accordance with current applicable legal, professional, and technical standards, and are appropriately licensed, certified, or registered.

Contractor and its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors must ensure that all their Network Providers have good standing in the Medicare and Medicaid/Medi-Cal programs and have a valid National Provider Identifier (NPI) number. Contractor must ensure that Providers that have been terminated from either Medicare or Medicaid/Medi-Cal cannot participate in Contractor's Network.

Contractor and its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors must ensure that all contracted Laboratory Testing Sites have either a Clinical Laboratory Improvement Act (CLIA) certificate or waiver of a certificate of registration along with a CLIA identification number.

B. Subcontractor and Downstream Subcontractor Credentialing

Contractor may delegate Credentialing and recredentialing activities, but Contractor remains ultimately responsible for the completeness and accuracy of these activities, as outlined in Exhibit A, Attachment III, Subsection 3.1.1 (*Overview of Contractor's Duties and Obligations*).

C. Credentialing Provider Organization Certification
Contractor may obtain Credentialing provider organization certification (POC) from the NCQA. Contractor may accept evidence of NCQA POC certification in lieu of a monitoring visit at Network Provider's facilities.

D. Disciplinary Actions

Contractor must implement and maintain a system for the reporting of serious quality deficiencies that result in suspension or termination of a practitioner, including dentists, to the appropriate authorities. Contractor must implement and maintain policies and procedures for disciplinary actions including, reducing, suspending, or terminating the privileges of practitioners, including dentists. Contractor must implement and maintain a Provider appeal process.

E. Medi-Cal and Medicare Provider Status

Contractor must verify that its Subcontractors, Downstream Subcontractors, and Network Providers have not been terminated as Medi-Cal or Medicare Providers or have not been placed under a restriction (payment or temporary suspension) resulting in placement on the Suspended and Ineligible Provider List, List of Excluded Entities, or Restricted Provider Database. Contractor cannot maintain contracts with Network Providers, Subcontractors, or Downstream Subcontractors who

have been terminated by either Medicare or Medi-Cal or placed on the Suspended and Ineligible Provider List.

F. Contractor's NCQA Health Plan Accreditation

If Contractor has received an accredited status from NCQA, Contractor will be deemed to meet the DHCS requirements for Credentialing and may be exempt from the DHCS medical review audit for Credentialing.

G. Credentialing of Other Non-Physician Providers

Contractor and its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors must develop and maintain policies and procedures that ensure that the credentials of Nurse Practitioners, Certified Nurse Midwives (CNMs), clinical nurse Specialists, Physician Assistants, mental health Providers, and substance use treatment Providers have been verified in accordance with State requirements applicable to the Provider category.

Exhibit A, ATTACHMENT III

2.3 Utilization Management Program

2.3.1 Prior Authorizations and Review Procedures
2.3.2 Timeframes for Medical Authorization
2.3.3 Review of Utilization Data
2.3.4 Delegating Utilization Management Activities

2.3 Utilization Management Program

Contractor must develop, implement, update as needed (but at least annually), and improve its Utilization Management (UM) program to ensure appropriate processes are used to review and approve the provision of Medically Necessary Covered Services for its Members. Contractor must ensure that its UM program:

A. Includes a designated medical director or clinical director responsible for the UM process in accordance with Health & Safety Code (H&S) section 1367.01, and qualified staff responsible for the UM program.

B. Prohibits medical decisions to be influenced by fiscal and administrative management. Compensation of individuals or entities that conduct UM activities must not be structured to provide incentives to deny, limit, or discontinue Medically Necessary Covered Services.

C. Allows for a second opinion from a qualified health professional within the Network, if available. If a qualified health professional within the Network is not available, Contractor must authorize an out-of-Network Provider to provide the second opinion at no cost to the Member, in accordance with 42 Code of Federal Regulations (CFR) section 438.206.

D. Makes available to Network Providers all relevant UM policies and procedures upon request.

E. Makes available to Members all relevant UM policies and procedures upon request. Makes available to Members clinical criteria used by Contractor, Subcontractors, and Downstream Subcontractors, as applicable for assessing Medical Necessity for Covered Services.

F. Provides training to Network Providers on the procedures and services that require Prior Authorization for Medically Necessary Covered Services, and ensures that all Network Providers are aware of the procedures and timeframes necessary to obtain Prior Authorization for Medically Necessary Covered Services, within 30 calendar days of executing this Contract and within 30 calendar days of contracting with a Network Provider.

G. Has a Standing Referral process providing a determination within three Working Days from the date the request is made by the Member or the Member's Primary Care Providers (PCP) and all appropriate Medical Records and other items of information necessary to make the determination are provided. Once a determination is made, the referral must be made within four Working Days of the date that the proposed

treatment plan, if any, is submitted to Contractor's medical director or the medical director's designee, in accordance with H&S section 1374.16.

H. Has a specialty referral system to track and monitor referrals requiring Prior Authorization by Contractor. When Prior Authorization is delegated to Subcontractors and Downstream Subcontractors, Contractor must ensure that Subcontractors and Downstream Subcontractors have systems in place to track and monitor referrals requiring Prior Authorization and must furnish documentation of Subcontractor's and Downstream Subcontractor's referrals to DHCS upon request. Contractor's specialty referral systems must include authorized, denied, deferred, or modified referrals, and the timeliness of the referrals. Contractor's specialty referral systems must include information on requested out-of-Network services. Contractor must ensure that all Network Providers are aware of the specialty referral processes and tracking procedures.

I. Integrates UM activities into the Quality Improvement System (QIS) specified in Exhibit A, Attachment III, Section 2.2 (*Quality Improvement and Health Equity Transformation Program (QIHETP)*), including a process to integrate reports on the number and types of service requests, denials, deferrals, modifications, Appeals, and Grievances to the medical director or their designee.

J. Has timelines and processes that do not impose Quantitative Treatment Limitations (QTL) or Non-Quantitative Treatment Limitations (NQTL) more stringently on covered mental health and Substance Use Disorder (SUD) services than are imposed on medical/surgical services, in accordance with the parity in mental health and SUD requirements in 42 CFR section 438.900, et seq.

K. Makes Contractor's UM policies and procedures available to Members and Providers on Contractor's website and upon request. These policies and procedures must set out how Contractor authorizes, modifies, delays, or denies health care services via Prior Authorization, concurrent authorization, or Retrospective Review, under the services provided by Contractor in accordance with 42 CFR section 438.915.

1) Contractor must ensure that policies and procedures for authorization decisions are based on the Medical Necessity of a requested Covered Service and are consistent with criteria or guidelines supported by sound clinical principles and evidence-based practice.

2) Contractor must ensure that policies, processes, strategies, evidentiary standards, and other factors used for UM are consistently applied to medical/surgical, mental health, and SUD services and benefits.

3) Contractor must notify Network Providers, as well as Members and Potential Members upon request, of all services that require Prior Authorization, concurrent authorization, or Retrospective Review, and ensure that all Network Providers are aware of the procedures and timeframes necessary to obtain authorization for these services.

All UM activities must be performed in accordance with H&S sections 1363.5 and 1367.01 and 28 California Code of Regulations (CCR) section 1300.70(a)(3), (b)(2)(H), and (c).

2.3.1 Prior Authorizations and Review Procedures

Contractor must ensure that its Prior Authorization, concurrent review, and Retrospective Review authorization procedures meet the following minimum requirements, in accordance with H&S section 1367.01:

A. Contractor must consult with Providers as needed for Prior Authorization requests for the purposes of determining Medical Necessity for Covered Services unless doing so would lead to undue delay in care;

B. Decisions to deny or to authorize an amount, duration, or scope that is less than requested must be made by a qualified health care professional with appropriate clinical expertise in treating the medical or Behavioral Health condition and disease or Long-Term Services and Supports (LTSS) needs. Appropriate clinical expertise may be demonstrated by relevant specialty training, experience, or certification. Qualified health care professionals do not have to be an expert in all conditions and may use other resources to make appropriate decisions;

C. Qualified health care professionals must supervise the review of medical decisions, including service reductions, and must review all denials that are made, in whole or in part, based on Medical Necessity. Contractor is not responsible for the review of Prior Authorizations for physician administered drugs, medical supplies, enteral nutritional products, and covered outpatient Prescription Drugs provided by an outpatient pharmacy. Contractor must review Prior Authorizations for physician administered drugs which include Prescription Drugs administered by a health care professional in a clinic, physician’s office, or outpatient setting;

medical supplies; and enteral nutritional products. These Prescription Drugs and supplies are covered under the medical benefit and would be included in the medical claim or encounter;

D. Contractor must establish written criteria or guidelines for UM that are developed with practicing health care Providers. The written criteria or guidelines must be based on sound clinical practices and processes which are evaluated and updated when necessary, and at least annually, in accordance with H&S section 1363.5;

E. Contractor must provide a clear and concise written explanation of the reasons for denying, deferring, or modifying a service; a description of the criteria or guidelines used; and the clinical reasons for the decision based on Medical Necessity. Any written communication to a Provider of a denial, delay, or modification of a request must include the name and telephone number of Contractor's health care professional responsible for the denial, delay, or modification;

F. Contractor must notify Members regarding denied, deferred or modified referrals as specified in Exhibit A, Attachment III, Subsection 5.1.5, (*Notices of Action for Denial, Deferral, or Modification of Prior Authorization Requests*). Contractor must publish on its website an Appeals procedure for both Providers and Members;

G. Decisions and Appeals must be made in a timely manner and not be unduly delayed when Member's medical condition requires time sensitive services;

H. Prior Authorization requirements must not be applied to Emergency Services, family planning services, preventive services, basic prenatal care, sexually transmitted disease services, Human Immunodeficiency Virus (HIV) testing, or initial mental health and SUD assessments;

I. Records relating to Prior Authorization requests, including any Notices of Action (NOA), must meet the retention requirements described in Exhibit E, Section 1.22 (*Inspection and Audit of Records and Facilities*);

J. Contractor must notify the requesting Provider of any decision to deny, approve, modify, or delay a service authorization request, a request by a Member or a Member's Provider for the provision of a Covered Service, or when authorizing a service in an amount, duration, or scope that is less than requested. The notice to the Provider may be oral or in writing; and

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

2.3.2 Timeframes for Medical Authorization

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

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

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

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

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

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

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

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

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

I. Physician Administered Drugs: Contractor must respond to requests for medical authorization of Medically Necessary physician administered drugs billed on a medical or institutional claim within 24 hours of receipt of the request, in accordance with 42 USC section 1396r-8, 42 CFR sections 438.210 and 438.3, and W&I section 14185. If the physician administered drug is a "covered outpatient drug," as defined in 42 USC section 1396r-8(k)(2) and (k)(3), Contractor cannot obtain an extension of time to respond. However, if the physician administered drug is not a "covered outpatient drug," Contractor may obtain an extension of time to respond, as set forth in 42 CFR section 438.210.

2.3.3 Review of Utilization Data

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

B. Contractor must monitor utilization data to appropriately identify Members eligible for Enhanced Care Management (ECM) and applicable

Community Supports as specified in Exhibit A, Attachment III, Subsection 4.4.6 (*Member Identification for Enhanced Care Management)* and Subsection 4.5.6 (*Identifying Members for Community Supports)*.

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

2.3.4 Delegating Utilization Management Activities

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

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Exhibit A, ATTACHMENT III

3.0 Providers, Network Providers, Subcontractors, and Downstream Subcontractors

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

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

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

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

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

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

3.1.1 Overview of Contractor's Duties and Obligations

A. Contractor is fully responsible for all duties and obligations set forth in this Contract. However, Contractor may enter into agreements with other individuals, groups, or entities to fulfill its obligations and duties under the Contract, including Network Provider Agreements and Subcontractor Agreements. Some individuals, groups, or entities may be a combination of Network Provider, Subcontractor, and/or Downstream Subcontractor, in which case they would need to comply with the requirements for Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements, as applicable. Subcontractors and Downstream Subcontractors may enter into agreements to fulfill their obligations and duties under the Contract, in which case they would need to comply with the requirements of Downstream Subcontractor Agreements or Network Provider Agreements, as applicable.

B. Contractor must ensure that all Subcontractors and Downstream Subcontractors comply with all Contract requirements related to the delegated functions undertaken by each Subcontractor or Downstream Subcontractor. Contractor remains fully responsible for the performance of all duties and obligations it delegates to Subcontractors and Downstream Subcontractors. To ensure Subcontractor's and Downstream Subcontractor's compliance, Contractor must, at a minimum, do the following:

1) Include all Contract duties and obligations relating to the delegated duties in the Subcontractor Agreement;

2) Ensure Subcontractor includes all Contract obligations relating to the delegated duties in all Downstream Subcontractor Agreements;

3) Provide policies and procedures to Subcontractors applicable to the delegated functions and ensure Subcontractor provides the relevant policies and procedures as applicable to delegated functions;

   Monitor and oversee all delegated functions, including those that may flow down to Downstream Subcontractors; and

4) Provide to DHCS a delegation reporting and compliance plan, as set forth in Exhibit A, Attachment III, Subsection 3.1.3 (*Contractor's*

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Duty to Disclose All Delegated Relationships and to Submit Delegation Reporting and Compliance Plan).

C. Contractor must ensure that Network Providers comply with all applicable Contract requirements and all requirements set forth in their Network Provider Agreements (See Exhibit A, Attachment III, Subsection 3.1.5.A (*Network Provider Agreement Requirements).*

3.1.2 DHCS Approval of Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements

A. Submission and Approval of Network Provider Agreements Templates

1) Contractor must submit to DHCS all Network Provider Agreement templates, and any proposed amendments thereto, for review and approval before use. The contents of the Network Provider Agreement templates are set forth in All Plan Letter (APL) 19-001.

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

B. Submission and Approval of Subcontractor Agreements and Downstream Subcontractor Agreements Templates

1) Contractor must submit to DHCS all Subcontractor Agreement and Downstream Subcontractor Agreement templates, and any amendments thereto, as follows:

a) For Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors, Contractor must submit all Subcontractor Agreement and Downstream Subcontractor Agreement templates and any amendments thereto, to DHCS for review and approval before use. Contractor must also file with DHCS all executed Subcontractor Agreements with Fully Delegated Subcontractors and all executed

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Downstream Subcontractor Agreements with Downstream Fully Delegated Subcontractors.

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

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

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

A. Content of Delegation Reporting and Compliance Plan

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

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

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

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

B. Timing of Submission

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

1) During the operational readiness period;

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

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

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

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

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

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

A. Network Provider Agreement Requirements

Network Provider Agreements must contain the following provisions:

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

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

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

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

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

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

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

8) Network Provider will make all of its premises, facilities, equipment, books, records, contracts, and computer and other electronic systems pertaining to the Covered Services ordered, referred, or rendered under the terms of the Network Provider Agreement, available for the purpose of an audit, inspection, evaluation, examination or copying, including but not limited to Access Requirements and State's Right to Monitor, as set forth in Exhibit E, Section 1.22 (*Inspection and Audit of Records and Facilities*), as follows:

   a) In accordance with inspections and audits, as directed by DHCS, The Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services

(DHHS) Inspector General, the Comptroller General, Department of Justice (DOJ), the Department of Managed Health Care (DMHC), or their designees; and

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

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

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

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

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

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

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

15) Contractor must inform Network Provider of prospective requirements added by State or federal law or DHCS related to this Contract that impact obligations undertaken through the Network

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Provider Agreement before the requirement would be effective, and agreement by Network Provider to comply with the new requirements within 30 calendar days of the effective date, unless otherwise instructed by DHCS;

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

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

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

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

20) Confirmation of Network Provider's right to all protections afforded them under the Health Care Providers' Bill of Rights, including, but not limited to Network Provider's right to access Contractor's dispute resolution mechanism and submit a Grievance pursuant to H&S section 1367(h)(1).

21) Network Provider must execute the California Health and Human Services Data Exchange Framework data sharing agreement pursuant to H&S section 130290.

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B. Subcontractor and Downstream Subcontractor Agreement Requirements

Subcontractor Agreements and Downstream Subcontractor Agreements must contain the following provisions, as applicable to the specific obligations and functions that Contractor delegates in the Subcontractor Agreement or that the Subcontractor or Downstream Subcontractor delegates in the Downstream Subcontractor Agreement:

1) Specification of Contractor's obligations and functions undertaken by the Subcontractor or Downstream Subcontractor;

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

3) Full disclosure of the method and amount of compensation or other consideration to be received by Subcontractor or Downstream Subcontractor per unit of service;

4) Specification that the Subcontractor Agreement or Downstream Subcontractor Agreement and amendments as set forth in this Exhibit A, Subsection 3.1.2 (*DHCS Approval of Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements*);

5) Subcontractor's assignment or delegation of an obligation or responsibility under a Subcontractor Agreement to any Downstream Subcontractor is void unless prior written approval is obtained from DHCS;

6) Downstream Subcontractor's assignment or delegation of an obligation or responsibility under a Downstream Subcontractor Agreement to any Downstream Subcontractor is void unless prior written approval is obtained from DHCS;

7) Specification that the Subcontractor Agreement or Downstream Subcontractor Agreement is governed by and construed in accordance with all applicable laws and regulations governing the Contract, including but not limited to 42 CFR section 438.230; KKA, H&S section 1340 *et seq*. (unless otherwise excluded under this Contract); 28 CFR section 1300.43 *et seq.*; W&I sections 14000 and 14200 *et seq.*; and 22 CCR sections 53800 *et seq.*, 22 CCR sections 53900 *et seq*;

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8) Subcontractor and Downstream Subcontractors must comply with all applicable requirements of the DHCS Medi-Cal Managed Care Program, pertaining to the obligations and functions undertaken pursuant to the Subcontractor Agreement or Downstream Subcontractor Agreement, including but not limited to, all applicable federal and State Medicaid and Medi-Cal laws, regulations, sub-regulatory guidance, APLs, and the provisions of this Contract;

9) Language comparable to Exhibit A, Attachment III, Subsection 3.3.16 (*Emergency Services and Post-Stabilization Care Services*), for those Subcontractors or Downstream Subcontractors obligated to reimburse Providers of Emergency Services;

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

11) Subcontractor and Downstream Subcontractors must comply with all monitoring provisions of this Contract and any monitoring requests by DHCS;

12) Subcontractor and Downstream Subcontractors must maintain and make available to DHCS, upon request, copies of all contracts it enters into related to the performance of the obligations and functions it undertakes pursuant to the Subcontractor Agreement, and to ensure that such contracts are in writing;

13) Subcontractor and Downstream Subcontractors must make all of their premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining to the obligations and functions undertaken pursuant to the Subcontractor Agreement or Downstream Subcontractor Agreement, available for the purpose of an audit, inspection, evaluation, examination or copying, including but not limited to Access Requirements and State's Right to Monitor, as set forth in Exhibit E, Section 1.22 (*Inspection and Audit of Records and Facilities*), as follows:

    a) In accordance with inspections and audits, as directed by DHCS, CMS, U.S. DHHS Inspector General, the Comptroller General, DOJ, DMHC, or their designees; and

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

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

15) Subcontractor and Downstream Subcontractors must timely gather, preserve, and provide to DHCS, CMS, DMFEA, and any authorized State or federal regulatory agencies, any records in Subcontractor's possession, in accordance with Exhibit E, Section 1.27 (*Litigation Support*).

16) Subcontractor and Downstream Subcontractors must assist Contractor as applicable in the transfer of the Member's care as needed, and in accordance with Exhibit E, Section 1.17 (*Phaseout Requirements*), in the event of Contract termination, or in the event of termination of the Subcontractor Agreement or Downstream Subcontractor Agreement for any reason;

17) Subcontractor and Downstream Subcontractors must notify DHCS in the event the Subcontractor Agreement or any Downstream Subcontractor Agreement is amended or terminated for any reason;

18) Subcontractor and Downstream Subcontractors must hold harmless both the State and Members in the event Contractor, or another Subcontractor or Downstream Subcontractor as applicable, cannot or will not pay for the obligations and functions undertaken pursuant to the Subcontractor Agreement or Downstream Subcontractor Agreement;

19) Subcontractor and Downstream Subcontractors must participate and cooperate in Contractor's Quality Improvement System as applicable;

20) If Subcontractor or Downstream Subcontractors takes on Quality Improvement activities, the Subcontractor Agreement or Downstream Subcontractor Agreement must include those provisions stipulated in Exhibit A, Attachment III, Subsection 2.2.5

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(*Subcontractor and Downstream Subcontractor Quality Improvement Activities*);

21) To the extent Subcontractor or Downstream Subcontractor undertakes coordination of care obligations and functions for Members, an agreement to share with Subcontractor and Downstream Subcontractor any utilization data that DHCS has provided to Contractor, and agreement by the Subcontractor and Downstream Subcontractors to receive the utilization data provided and use it solely for the purpose of Member Care Coordination;

22) Contractor must inform Subcontractor of prospective requirements added by federal or State law or DHCS related to this Contract that impact obligations and functions undertaken pursuant to the Subcontractor Agreement before the requirement is effective, and Subcontractor's agreement to comply with the new requirements within 30 calendar days of the effective date, unless otherwise instructed by DHCS;

23) Subcontractor or Downstream Subcontractors must inform the Downstream Subcontractor taking on delegated functions of prospective requirements added by federal or State law or DHCS related to this Contract that impact obligations and functions undertaken pursuant to the Downstream Subcontractor Agreement before the requirement is effective, and the agreement of the Downstream Subcontractor taking on delegated functions to comply with the new requirements within 30 calendar days of the effective date, unless otherwise instructed by DHCS;

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

25) Subcontractor and Downstream Subcontractors must provide interpreter services for Members and comply with language assistance standards developed pursuant to H&S section 1367.04;

26) Subcontractor and Downstream Subcontractors must notify Contractor within ten Working Days of any suspected Fraud, Waste, or Abuse and a provision that allows Contractor to share such information with DHCS in accordance with Exhibit A,

Attachment III, Subsection 1.3.2.D (*Contractor's Reporting Obligations*) and Subsection 1.3.2.D.6) (*Confidentiality*);

27) Subcontractor and Downstream Subcontractors must report directly to Contractor, or through the Subcontractor or Downstream Subcontractor, as applicable, when it has received an overpayment; return the overpayment to Contractor within 60 calendar days after the date the overpayment was identified; and notify Contractor in writing of the reason for the overpayment in accordance with Exhibit A, Attachment III, Subsection 1.3.6 *(Treatment of Overpayment Recoveries) and* 42 CFR section 438.608(d)(2);

28) Subcontractor and Downstream Subcontractors must perform the obligations and functions of Contractor undertaken pursuant to the Subcontractor Agreement or Downstream Subcontractor Agreement, including but not limited to reporting responsibilities, in compliance with Contractor's obligations under this Contract in accordance with 42 CFR section 438.230(c)(1)(ii); and

29) Express agreement and acknowledgement by Subcontractor and Downstream Subcontractors that DHCS is a direct beneficiary of the Subcontractor Agreement or Downstream Subcontractor Agreement with respect to all obligations and functions undertaken pursuant to the Subcontractor Agreement or Downstream Subcontractor Agreement, and that DHCS may directly enforce any and all provisions of the Subcontractor Agreement or Downstream Subcontractor Agreement.

30) Subcontractors and Downstream Subcontractors must execute the California Health and Human Services Data Exchange Framework data sharing agreement, if applicable, pursuant to H&S section 130290.

31) Specification of Subcontractors', including Downstream Subcontractors', MLR reporting and remittance obligations pursuant to 42 CFR sections 438.8 and 438.230(c) and Paragraph 11 of the 1915(b) CalAIM Special Terms and Conditions (STCs), which include, but are not limited to, the requirements in:

    a) Exhibit A, Attachment III, Subsection 1.2.5.A.2 (*Medical Loss Ratio*) for the CalAIM 1915(b) STC downstream requirements and four-part test;

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b) Exhibit A, Attachment III, Subsection 1.2.5.B (*Medical Loss Ratio*) for the MLR Experience Defined;

c) Exhibit A, Attachment III, Subsections 1.2.5. C and D (*Medical Loss Ratio*) for the Materiality Threshold;

d) Exhibit A, Attachment III, Subsection 1.2.5. E (*Medical Loss Ratio*) for the MLR numerator and incurred claims for Subcontractors and Downstream Subcontractors;

e) Exhibit A, Attachment III, Subsection 1.2.5.E.1.b.iii (*Medical Loss Ratio*) for remittances received by Subcontractors and Downstream Subcontractors must be deducted from incurred claims;

f) Exhibit A, Attachment III, Subsection 1.2.5.E.1.e.iii (*Medical Loss Ratio*) for remittances paid by Subcontractors and Downstream Subcontractors must be excluded from incurred claims;

g) Exhibit A, Attachment III, Subsection 1.2.5.F (*Medical Loss Ratio*) for MLR denominator;

h) Exhibit A, Attachment III, Subsection 1.2.5.G (*Medical Loss Ratio*) for Subcontractor and Downstream Subcontractor allocation of expenses;

i) Exhibit A, Attachment III, Subsection 1.2.5.H (*Medical Loss Ratio*) for Subcontractor and Downstream Subcontractor credibility adjustments;

j) Exhibit A, Attachment III, Subsection 1.2.5.I (*Medical Loss Ratio*) for materiality threshold;

k) Exhibit A, Attachment III, Subsection 1.2.5.J (*Medical Loss Ratio*) for Subcontractor and Downstream Subcontractor MLR reporting at Subcontractor or Downstream Subcontractor arrangement level by county or rating region;

l) Exhibit A, Attachment III, Subsection 1.2.5.K (*Medical Loss Ratio*) for general MLR reporting requirement imposed on Subcontractors and Downstream Subcontractors;

m) Exhibit A, Attachment III, Subsection 1.2.5.K.4 (*Medical Loss Ratio*) for Subcontractor and Downstream Subcontractor reporting requirements on downstream entities that accept financial risk;

n) Exhibit A, Attachment III, Subsection 1.2.5.K.5 (*Medical Loss Ratio*) for Subcontractor and Downstream Subcontractor MLR submission accuracy attestation;

o) Exhibit A, Attachment III, Subsection 1.2.5.K.6 (*Medical Loss Ratio*) for requirements for Subcontractor and Downstream MLR submissions and oversight requirements;

p) Exhibit A, Attachment III, Subsection 1.2.5.M (*Medical Loss Ratio*) for newer experience exemptions for Subcontractors and Downstream Subcontractors;

q) Exhibit A, Attachment III, Subsection 1.2.5.O (*Medical Loss Ratio*) for Subcontractor and Downstream Subcontractor re-reporting requirements following a retroactive change to the Capitation Payments for a MLR reporting year;

r) Exhibit A, Attachment III, Subsection 1.2.5.P (*Medical Loss Ratio*) for Subcontractor and Downstream Subcontractor remittance requirements; and

s) Exhibit A, Attachment III, Subsection 1.2.5.Q (*Medical Loss Ratio*) for Subcontractor and Downstream Subcontractor audit and record retention requirements.

3.1.6 Financial Viability of Subcontractors, Downstream Subcontractors, and Network Providers

Contractor must maintain a system to evaluate and monitor the financial viability of all Network Providers, Subcontractors, and Downstream Subcontractors that accept financial risk for the provision of Covered Services including, but not limited to, Medi-Cal managed care plans, independent Physician/Provider associations, medical groups, hospitals, risk-bearing organizations as defined by 28 CCR section 1300.75.4(b), Federal Qualified Health Centers (FQHC), and other clinics.

3.1.7 Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements with Federally Qualified Health Centers and Rural Health Clinics

Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements with FQHCs, Rural Health Clinics (RHCs), and other clinics must meet the requirements of Exhibit A, Attachment III, Subsections 3.1.5.A and B (*Network Provider Agreement Requirements* and *Subcontractor and Downstream Subcontractor Agreement Requirements*), above, and the reimbursement requirements set forth in Exhibit A, Attachment III, Subsection 3.3.7 (*Federally Qualified Health Center, Rural Health Center, and Indian Health Care Provider)*. Network Provider Agreements, Subcontractor Agreements, or Downstream Subcontractor Agreements with FQHCs, RHCs, and other clinics also must contain a provision stating that any negotiated and agreed-upon rate with an FQHC, RHC, or other clinic constitutes complete reimbursement and payment in full for the Covered Services rendered to a Member.

3.1.8 Network Provider Agreements with Safety-Net Providers

A. Except as provided in subdivisions (1), (2), or (3), Contractor must offer a Network Provider Agreement to, and maintain a Network Provider Agreement with, any Safety-Net Provider physically located and operating within Contractor's contracted geographic service areas if the Safety-Net Provider agrees to provide its applicable scope of services under the same terms and conditions that Contractor requires of other similar Providers.

1) If a Safety-Net Provider is no longer willing to accept a Network Provider Agreement on the same terms and conditions required of other similar Providers, and Contractor elects to terminate or not renew the Network Provider Agreement as a result, Contractor must notify DHCS of its intent to terminate or not renew that Network Provider Agreement with the applicable Safety-Net Provider at least 60 calendar days prior to the effective date of the intended Network Provider Agreement termination or non-renewal.

2) If Contractor determines that the Safety-Net Provider has engaged in Fraud, Waste, or Abuse of the Medi-Cal program; that there are quality of care concerns relating to the Safety-Net Provider's services; or that the Safety-Net Provider has materially breached its Network Provider Agreement, and Contractor elects to terminate or not renew the Network Provider Agreement as a result, Contractor must notify DHCS of its intent to terminate or not renew that Network Provider Agreement with the applicable Safety-Net

Provider at least 60 calendar days prior to the effective date of the intended Network Provider Agreement termination or non-renewal.

3) If DHCS or Contractor determines that the health or welfare of a Medi-Cal Member is threatened by the Provider, Contractor may terminate or not renew the Network Provider Agreement with the applicable Safety-Net Provider immediately, but Contractor must notify DHCS and the Safety-Net Provider of the termination or non-renewal concurrently.

4) If the license of the Safety-Net Provider is revoked or suspended, Contractor must terminate the Network Provider Agreement with the applicable Safety-Net Provider immediately upon discovery of such revocation or suspension, but Contractor must notify DHCS and the Safety-Net Provider of the termination concurrently.

3.1.9 Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements with Local Health Departments

A. Contractor must negotiate in good faith and execute Network Provider Agreements and Subcontractor Agreements, as appropriate, with the Local Health Department (LHD) in each county within Contractor's Service Area for the following public health services:

1) Family Planning Services, as specified in Exhibit A, Attachment III, Subsection 3.3.9 (*Non-Contracting Family Planning Providers*);

2) Sexually Transmitted Disease (STD) services, as specified in Exhibit A, Attachment III, Subsection 3.3.10 (*Sexually Transmitted Disease*), including diagnosis and treatment of the following: syphilis, gonorrhea, chlamydia, herpes simplex, chancroid, trichomoniasis, human papilloma virus, non-gonococcal urethritis, lymphogranuloma venereum, and granuloma inguinal;

3) Human Immunodeficiency Virus (HIV) testing and counseling as specified in Exhibit A, Attachment III, Subsection 3.3.11 (*Human Immunodeficiency Virus Testing and Counseling*); and

4) Immunizations as specified in Exhibit A, Attachment III, Subsection 3.3.12 (*Immunizations*).

B. Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements with LHDs must specify the scope and responsibilities of both parties in the provision of services to

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Members, billing and reimbursements, reporting responsibilities, and how services are to be coordinated between the LHD and Contractor, including exchange of medical information as necessary. Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements must also meet the requirements described in Exhibit A, Attachment III, Subsection 3.1.5 (*Requirements for Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements*).

3.1.10 Nondiscrimination in Provider Contracts

Contractor must not discriminate against Providers, in connection with the participation, reimbursement, or indemnification of any Provider, who is acting within the scope of practice of their license or certification under applicable State law, solely on the basis of that license or certification. If Contractor declines to include individual or groups of Providers in its Network, it must give the affected Providers written notice of the reason for its decision. Contractor's Provider selection policies must not discriminate against Providers that serve high-risk populations or specialize in conditions requiring costly treatment. Upon request, Contractor must provide to DHCS its selection of Providers chosen to meet the need of Contractor's Members. This section will not be construed to require Contractor to contract with Providers beyond the number necessary to meet the needs of Contractor's Members, preclude Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty, or preclude Contractor from establishing measures that are designed to maintain quality of services and control costs and is consistent with Contractor's responsibilities to Members.

3.1.11 Public Records

To the extent DHCS receives Contractor's Network Provider Agreements, Subcontractor Agreements, or Downstream Subcontractor Agreements, these agreements and all information received in accordance with these agreements will be public records on file with DHCS, except as specifically exempted in statute. The names of the officers and owners of the Network Provider, Subcontractor or Downstream Subcontractor; stockholders owning more than 5 percent of the stock issued by the Network Provider, Subcontractor or Downstream Subcontractor; and major creditors holding more than 5 percent of the debt of the Network Provider, Subcontractor, or Downstream Subcontractor must be attached to the Network Provider Agreement, Subcontractor Agreement, or Downstream Subcontractor Agreement at the time that agreement is submitted to DHCS.

3.1.12 Requirement to Post

Contractor must post on its website a summary of its delegation model that outlines how it delegates obligations and duties of this Contract to Fully Delegated Subcontractors, Partially Delegated Subcontractors, Downstream Fully Delegated Subcontractors, and Downstream Partially Delegated Subcontractors.

Exhibit A, ATTACHMENT III

3.2 Provider Relations

3.2.1 Exclusivity
3.2.2 Provider Dispute Resolution Mechanism
3.2.3 Out-of-Network Provider Relations
3.2.4 Contractor's Provider Manual
3.2.5 Network Provider Training
3.2.6 Emergency Department Protocols
3.2.7 Prohibited Punitive Action Against the Provider
3.2.8 Submittal of Inpatient Days Information

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3.2 Provider Relations

3.2.1 Exclusivity

Contractor must not, by use of any exclusivity provision, clause, agreement, nor in any other way, prohibit any Network Provider from providing services to other persons enrolled in Medi-Cal who are not Contractor's Members.

3.2.2 Provider Dispute Resolution Mechanism

In accordance with Health and Safety Code (H&S) section 1367(h)(1), Contractor must have a fast, fair, and cost-effective Provider Dispute Resolution Mechanism in place for Network Providers and out-of-Network Providers to submit disputes.

A. Contractor must have a formal procedure to accept, acknowledge, and resolve Network Provider and out-of-Network Provider disputes. The Provider Dispute Resolution Mechanism must occur in accordance with the timeframes set forth in H&S sections 1371 and 1371.35 for both Network Providers and out-of-Network Providers. Any Provider of Medi-Cal services may submit a dispute to Contractor regarding:

   1) The authorization or denial of a service;

   2) The processing of a payment or non-payment of a claim by Contractor; or

   3) The timeliness of the reimbursement on an uncontested Clean Claim and any interest Contractor is required to pay on claims reimbursement per APL-23-020.

B. Contractor's Provider Dispute Resolution Mechanism must be set forth in all Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements.

C. Contractor must inform all Network Providers, out-of-Network Providers, Subcontractors, and Downstream Subcontractors ~~that provide services to Contractor's Members~~ of its Provider Dispute Resolution Mechanism, regardless of contracting status.

D. Contractor must resolve Network Provider and out-of-Network Provider disputes within the timeframes set forth in H&S section 1371.35 of receipt of the dispute, including supporting documentation.

E. Contractor must submit a Provider Dispute Resolution Mechanism report annually to DHCS which includes information on the number of Providers who utilized the Provider Dispute Resolution Mechanism and a summary of the disposition of those disputes, in accordance with H&S section 1367(h)(3). This report must be delineated by Network Providers and out-of-Network Providers, and by Contractor, Subcontractor, or Downstream Subcontractor.

F. On an annual basis, Contractor must assess the Network Providers and out-of-Network Providers that utilize the Provider Dispute Resolution Mechanism to identify trends and systemic issues. Contractor must submit the results of its annual assessment to DHCS with discussion on how it is addressing trends and systemic issues identified based on the assessment.

3.2.3 Out-of-Network Provider Relations

A. Contractor must develop and maintain protocols for payment of claims to out-of-Network Providers, and for communicating and interacting with out-of-Network Providers regarding services and claims payment.

B. Contractor must provide its clinical protocols and evidence-based practice guidelines governing Prior Authorization, Utilization Management (UM) and Retrospective Review to all out-of-Network Providers providing services to its Members. Contractor must arrange to provide these protocols and guidelines at the time that Contractor enters into an agreement with an out-of-Network Provider or anytime an out-of-Network Provider submits a claim for services provided to Contractor's Members.

3.2.4 Contractor's Provider Manual

Contractor must issue a Provider manual to Network Providers, Subcontractors, and Downstream Subcontractors that includes information regarding Medi-Cal Covered Services and responsibilities for the provision of services including Basic Population Health Management (Basic PHM); Care Coordination for Excluded Services; policies and procedures; quality assurance; improvement and monitoring; clinical protocols governing Prior Authorization and UM; timeliness standards; Credentialing; prohibited claims; statutes; regulations; telephone access; special requirements; data reporting; and the Member Grievance, Appeal, and State Hearing process. Contractor must ensure the most updated Provider manual is available through Provider portals, the internet, or upon request. When updates are made to the Provider manual, Contractor must notify Network Providers, Subcontractors, and Downstream Subcontractors.

Contractor must solicit feedback from Contractor committees including but not limited to the Community Advisory Committee (CAC) and Quality Improvement Committee (QIC), to inform the development of Contractor Provider manual and clarify new and revised policies and procedures contained therein.

Contractor must conduct an annual review of its Provider manual and document that the review has been conducted by the appropriate Contractor committees including the QIC. Contractor must update its Provider manual annually or at any time to ensure that the information reflects current requirements.

Contractor's Provider manual must include and inform Network Providers, Subcontractors, and Downstream Subcontractors of the following Member rights information, as set forth in Exhibit A, Attachment III, Section 5.1 (*Member Services*):

A. Member's right to file Grievances and Appeals, and the requirements and timeframes for filing, including the right to have the Member's Medical Record and to have an Authorized Representative (AR) or Provider appeal on the Member's behalf, with written consent from the Member;

B. Availability of assistance in filing a Grievance, Appeal, or State Hearing;

C. Toll-free numbers to file oral Grievances and Appeals;

D. Member's right to request continuation of benefits during an Appeal or State Hearing;

E. Member's right to a State Hearing, how to obtain a State Hearing, and representation rules at a State Hearing; and

F. Member's right to an Independent Medical Review (IMR), if applicable.

3.2.5 Network Provider Training

Contractor must ensure that all Network Providers receive training regarding the Medi-Cal Managed Care program to ensure they operate in full compliance with the Contract and all applicable federal and State statutes, regulations, All Plan Letters (APLs), and Policy Letters (PLs). Contractor must conduct training for all Network Providers. Contractor must start training within ten Working Days and complete training within 30 Working Days after Contractor places a newly contracted Network Provider on active status. Contractor may conduct Network Provider training online or in-person. Contractor must maintain records of attendance to validate that Network Providers received training on a bi-annual basis.

A. Contractor must ensure that Network Provider training includes education on Covered Services, policies and procedures for clinical protocols governing Prior Authorization and UM, and carved out services including, how to refer to and coordinate care with agencies, programs and third parties with which Contractor has a Memorandum of Understanding (MOU) as required under this Contract.

B. Contractor must conduct ongoing training, at least once every two years, for Network Providers on required preventive healthcare services, including Early Periodic Screening, Diagnosis and Testing (EPSDT) services for Members less than 21 years of age; appropriate medical record documentation; and coding requirements. This must include training on existing Contractor data collection and reporting requirements and Quality Improvement programs to ensure required preventive services are offered and provided. This training also must include, but is not limited to, training on Population Health Management (PHM) program requirements (i.e., care management services) including referrals, health education resources, and Provider and Member incentive programs.

C. Contractor must immediately notify Network Providers when changes to its existing policies and procedures impact Network Providers' provision of Medi-Cal Covered Services to Members and not wait until the next biennial mandatory training.

D. Contractor's training must educate Network Providers on Member access, including compliance with appointment waiting time standards and ensuring telephone, translation, and language access is available for Members during hours of operation. Training must also include education on secure methods for sharing information between Contractor, Network Providers, Subcontractors, Downstream Subcontractors, Members, and other healthcare professionals. This must include training on ensuring Providers have accurate contact information for the Member and all Network Providers involved in the Member's care. Contractor must also provide training on how to refer and coordinate care for Members who need access to Excluded Services.

E. Contractor must ensure that Network Provider biennial mandatory training includes information on all Member rights specified in Exhibit A, Attachment III, Section 5.1 (*Member Services*), and diversity, equity and inclusion training (sensitivity, diversity, communication skills, and cultural competency/humility training) as specified in Exhibit A, Attachment III, Subsection 5.2.11.C. (*Cultural and Linguistic Programs and Committees*). This process must also include an educational program for Network Providers regarding health needs to include but not be limited to, the

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Seniors and Persons with Disabilities (SPD) population, Members with chronic conditions, Members with Specialty Mental Health Service (SMHS) needs, Members with Substance Use Disorder (SUD) needs, Members with intellectual and Developmental Disabilities (DDs), and Children and Youth with Special Health Care Needs (CYSHCN). Trainings must include Social Drivers of Health (SDOH) and disparity impacts on Members' health care. Attendance records must be reviewed and maintained by Contractor's Health Equity officer.

F. Trainings must be reviewed by the appropriate Contractor committees, including Contractor's board of director's compliance and oversight committee and QIC, routinely, but not less than biennially, to ensure consistency and accuracy with current requirements and Contractor's policies and procedures.

G. In compliance with 42 Code of Regulations (CFR) section 438.236(b), Contractor must ensure that practice guidelines are based on valid and reliable clinical evidence or a consensus of Providers in that particular field, consider the needs of Contractor's Members, are adopted in consultation with Network Providers, and are reviewed and updated periodically as appropriate. In addition to Network Provider training, Contractor must disseminate their practice guidelines to all affected Providers.

3.2.6 Emergency Department Protocols

Contractor must develop and maintain protocols for communicating and interacting with emergency departments in and out of its Service Area. Contractor's protocols must be distributed to all emergency departments in the Service Area and must include, at a minimum, the following:

A. All information on telephone or other secure methods of communicating with Contractor's triage and advice systems;

B. Contact information for Contractor's designated contact person responsible for coordinating Emergency Services who is available 24 hours a day for the coordination of Emergency Services and Post-Stabilization Care Services;

C. Written referral procedures (including after-hours instruction) that emergency department personnel can provide to Members who present at the emergency department for Non-Emergency services;

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D. Procedures for emergency departments to report Contractor's system and/or protocol failures and Contractor's processes for correcting deficiencies when failures occur;

E. Procedures for the authorization and payment of Medically Necessary Post-Stabilization Care Services consistent with 42 CFR section 438.114, APL 19-008, and APL 23-009;

F. Procedures for screening and referral of Members who meet Enhanced Care Management (ECM) Population**s** of Focus **(POF)** eligibility criteria, especially the Individuals at risk for avoidable hospital or Emergency Department utilization ~~Population of Focus~~**POF**; and

G. Procedures for screening and referral of Members who meet medical necessity eligibility criteria for Community Health Workers CHW services.

3.2.7 Prohibited Punitive Action Against the Provider

Contractor is prohibited from taking punitive action against a Provider who either requests an expedited resolution or supports a Member's Appeal. Further, Contractor may not prohibit, or otherwise restrict, a health care professional acting within their lawful scope of practice, from advising, or advocating on behalf of, a Member about:

A. The Member's health status, medical care, treatment options, or alternative treatment options (including any alternative treatment that may be self-administered), including obtaining any information the Member needs in order to decide among all relevant treatment options;

B. The risks, benefits, and consequences of treatment or non-treatment; or

C. The Member's right to participate in decisions regarding their health care, including the right to refuse treatment and to express preferences about future treatment decisions.

3.2.8 Submittal of Inpatient Days Information

Contractor must report hospital inpatient days to DHCS as required by Welfare and Institutions Code (W&I) section 14105.985(b)(2). Upon DHCS' written request, Contractor must also provide these reports for the time period and in the form and manner specified in DHCS' request, within 30 calendar days of receipt of the request. Contractor must submit additional reports to DHCS, as requested, for the administration of the Disproportionate Share Hospital program.

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Exhibit A, ATTACHMENT III

3.3 Provider Compensation Arrangements

3.3.1 Compensation and Value Based Arrangements
3.3.2 Capitation Arrangements
3.3.3 Provider Financial Incentive Program Payments
3.3.4 Identification of Responsible Payor
3.3.5 Claims Processing
3.3.6 Prohibited Claims
3.3.7 Federally Qualified Health Center, Rural Health Center, and Indian Health Care Provider
3.3.8 Non-Contracting Certified Nurse Midwife, Nurse Practitioner, and Licensed Midwife Providers
3.3.9 Non-Contracting Family Planning Providers
3.3.10 Sexually Transmitted Disease
3.3.11 Human Immunodeficiency Virus Testing and Counseling
3.3.12 Immunizations
3.3.13 Community Based Adult Services
3.3.14 Organ and Bone Marrow Transplants
3.3.15 Long-Term Care Services
3.3.16 Emergency Services and Post-Stabilization Care Services
3.3.17 Provider-Preventable Conditions
3.3.18 Prohibition Against Payment to Excluded Providers
3.3.19 Compliance with Directed Payment Initiatives and Related Reimbursement Requirements

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3.3 Provider Compensation Arrangements

3.3.1 Compensation and Value Based Arrangements

A. Except as otherwise specified in this Contract, Contractor may compensate Providers as Contractor and Provider negotiate and agree.

B. DHCS encourages Contractor to utilize value-based and alternative payment models to compensate Network Providers, especially for Primary Care Covered Services, in ways that ensure Provider accountability for both quality and total cost of care with a focus on population health management. Contractor must monitor and must report, within 90 calendar days of DHCS' request, the number or amount, and percent, of Contractor's Members, Network Providers, and medical expenditures that are made under such payment models, separately for hospital services, professional services, and other services at a minimum.

C. Payment to support Networks based on value: To continue to build and strengthen Networks based on value, Contractors must support their Providers through value-based payment models that promote high-quality, affordable, and equitable care.

On an annual basis, as specified by DHCS, Contractor must report on its Network payment models using the Health Care Payment Learning and Action Network Alternative Payment Model (HCP LAN APM) framework categories as outlined.

D. Effective Primary Care: Contractor must support effective Primary Care and integrated care through use of alternative payment models, such as population-based payment and shared savings. Specifically, Contractor must:

1) Ensure investment in Primary Care service delivery

a) Contractor must report on total Primary Care spend, as defined by the Integrated Healthcare Association (IHA), and the percent of spend within each HCP LAN APM Framework Category. Contractor must report the percentage of spend within each HCP LAN APM Framework Category as a percentage of its total spend.

b) Contract must stratify the reporting of Primary Care spend (and as a percentage of total spend) by age (Children and

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

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

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

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

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

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

3.3.2 Capitation Arrangements

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

3.3.3 Provider Financial Incentive Program Payments

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

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

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

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

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

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

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

3.3.4 Identification of Responsible Payor

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

3.3.5 Claims Processing

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

A. Contractor must comply with 42 United States Code (USC) section 1396u-2(f) and Health and Safety Code (H&S) sections 1371 - ~~1371.36~~ **1371.39**

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and their implementing regulations**, including 42 CFR sections 447.45 - 447.46 and 28 CCR section 1300.71**. Contractor must be subject to any penalties and sanctions, including interest at the rate of 15 percent per annum, provided by law if Contractor fails to meet the standards specified in this section.

B. Contractor is expected to pay Clean Claims within 30 calendar days of receipt. ~~For the purpose of establishing compliance thresholds,Contractor must pay at least 90 percent of all Clean Claims from Providers within 30 calendar days of the date of receipt and 99 percent of all Clean Claims within 90 calendar days. For purposes of calculation, the date of receipt is considered the date Contractor receives the claim, as indicated by its date stamp on the claim, and the date of payment is considered be the date of the check or other form of payment.~~ Pursuant to H&S section 1371(a), if Contractor does not pay a Clean Claim within 45 Working Days of receipt, it will owe the Provider interest at the rate of 15 percent per annum beginning on the first day after a 45 Working Day period. For the purposes of calculating interest, the first day is considered to be the first calendar day after 45 Working Days following the receipt of the claim. Contractor must automatically include all accrued interest in any late payment. **Pursuant to 42 USC section 1396a(a)(37)(A) and 42 CFR section 447.45(d), Contractor must pay at least 90 percent of all Clean Claims from Providers within 30 calendar days of the date of receipt and 99 percent of all Clean Claims within 90 calendar days. For purposes of calculation, the date of receipt is considered the date Contractor receives the claim, as indicated by its date stamp on the claim, and the date of payment is considered the date of the check or other form of payment.**

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

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

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

F. Contractor must maintain sufficient claims processing, tracking, and payment systems capability to comply with applicable State and federal law, regulations, and Contract requirements, to determine the status of received claims and to provide an Incurred but Not Reported Claim Estimate as specified by 28 CCR sections 1300.77.1 and 1300.77.2.

3.3.6 Prohibited Claims

A. Contractor must comply with 22 CCR sections 53866, 53220, and 53222 regarding the submission and recovery of claims for services provided under this Contract. Contractor must ensure that its Subcontractors and Downstream Subcontractors also comply with 22 CCR sections 53866, 53220, and 53222.

B. Contractor must hold harmless and indemnify Members for Contractor's debt to Providers for services rendered and billed to Members.

3.3.7 Federally Qualified Health Center, Rural Health Center, and Indian Health Care Provider

A. Reimbursement of Non-Contracting Federally Qualified Health Centers (FQHCs) and Rural Health Center (RHCs)

If FQHC and RHC services are not available in Contractor’s Network in a particular county of Contractor’s Service Area, Contractor must reimburse non-contracting FQHCs and RHCs for Covered Services in that county provided to Members at a level and amount of payment that is not less than the level and amount of payment which the entity would make for the services if the services were furnished by a Provider which is not a FQHC or RHC.

B. Required Terms and Conditions for Network Provider Agreements with FQHCs and RHCs

1) Contractor must submit to DHCS, within 30 calendar days of a request and in the form and manner specified by DHCS, documentation of the services provided, the reimbursement level, and amount for each of Contractor’s FQHC and RHC Network Provider Agreements.

2) Contractor must certify in writing to DHCS within 30 calendar days of DHCS' written request that, pursuant to Welfare and Institutions Code (W&I) sections 14087.325(b) and (d), Contractor's Network Provider Agreement terms and conditions with FQHCs and RHCs are the same as those offered to other Network Providers providing similar services, and that reimbursement is not less than the level and amount of payment which the entity would make for the services if the services were furnished by a Provider which is not a FQHC or an RHC.

3) Contractor is not required to pay FQHCs and RHCs the Medi-Cal per-visit rate for that clinic.

4) Contractor must fully cooperate with any DHCS review and audit of Contractor's operations and records related to FQHC and RHC reimbursement to ensure compliance with State and federal law.

5) Contractor must submit any FQHC and RHC Network Provider Agreements to DHCS for approval in accordance with W&I section 14087.325.

6) To the extent that an Indian Health Care Provider (IHCP) Facility chooses to participate as an FQHC or RHC, the above requirements in this Paragraph B must apply to a Network Provider Agreement with an IHCP. Moreover, Contractor must pay any non-contracted IHCP that qualifies as an FQHC or RHC an amount equal to what Contractor would pay a contracted FQHC or RHC, and DHCS must make any additional payment needed to comply with 42 CFR section 438.14(c).

7) Contractor or its Subcontractors and Downstream Subcontractors may enter into financial incentive payment arrangements with FQHC and RHC Network Providers provided such agreements meet all applicable conditions of federal and State law and of APL 19-005 including, but not limited to, the following:

    a) Contractor must establish and maintain clear, objective criteria for the financial incentive payments and the conditions under which payments will be made.

    b) The financial incentive payment arrangement must enumerate specific metrics and/or performance terms for the FQHC or RHC to attain the financial incentive payment.

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c) Contractor must have written agreements in place with the FQHC or RHC prior to the start of the financial incentive payment arrangement, including the methodology used to determine the total incentive payment amount.

d) The financial incentive payments must be similar to, and not less in amount than, other financial incentive payments Contractor makes to non-FQHC or non-RHC Network Providers who are providing similar services.

e) Financial incentive payment arrangements must not result in payments that are less than the payments made by Contractor to non-FQHC or non-RHC Network Providers who are providing similar services.

f) Contractor must evaluate the effectiveness of the financial incentive payments and adjust or discontinue them if they are determined ineffective upon evaluation.

g) Contractor must provide to DHCS, upon request, written agreements for, as well as policies and procedures for oversight and monitoring of, such financial incentive payments.

C. Indian Health Care Providers

1) Contractor must attempt to contract with each IHCP in its Service Area as set forth in 22 CCR sections 55120 - 55180. Contractor must reimburse an IHCP that qualifies as a FQHC but is not a Network Provider as set forth in 42 CFR section 438.14(c)(1).

2) For services provided to Members who are qualified to receive services from an IHCP pursuant to the California Medicaid State Plan, Supplement 6, Attachment 4.19-B, regardless of whether the IHCP is a Network Provider:

a) Contractor must reimburse IHCP at the most current and applicable outpatient per-visit rate published in the Federal Register by the Indian Health Service (IHS) in accordance with APL 17-020 and APL 21-008.

b) Contractor must ensure compliance with any retroactive changes to the outpatient per-visit rates published in the

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Federal Register by the IHS by appropriately reimbursing IHCPs in accordance therewith.

c) Contractor must reimburse IHCPs at the Medi-Cal Fee-For-Service (FFS) Rate for services that, pursuant to the California Medicaid State Plan, Supplement 6, Attachment 4.19-B, are not eligible for the outpatient per-visit rate published in the Federal Register by the IHS.

3.3.8 Non-Contracting Certified Nurse Midwife, Nurse Practitioner, and Licensed Midwife Providers

In accordance with 22 CCR section 51345 *et seq*. and APL 18-022, if there are no non-contracting Certified Nurse Midwife (CNM), Nurse Practitioner (NP), or Licensed Midwife (LM) Providers in Contractor's Network, Contractor must reimburse non-contracting CNMs, NPs, or LMs for services provided to Members at no less than the applicable Medi-Cal FFS Rates. For hospitals, the requirements of Exhibit A, Attachment III, Subsection 3.3.16.A.3 (*Emergency Services*), if applicable, apply. For Free Standing Birthing Centers, Contractor must reimburse non-contracting Free Standing Birthing Centers at no less than the applicable Medi-Cal FFS Rate. If an appropriately licensed non-contracting Free Standing Birthing Center is used, Contractor also must pay the Center's facility fee.

3.3.9 Non-Contracting Family Planning Providers

Pursuant to federal law, including but not limited to 42 USC sections 1396a(a)(23) and 1396n(b) and 42 CFR section 431.51, Contractor must reimburse non-contracting family planning Providers at no less than the appropriate Medi-Cal FFS Rate, for services listed in Exhibit A, Attachment III, Subsection 5.2.8 (*Specific Requirements for Access to Programs and Covered Services*), provided to Members of childbearing age to temporarily or permanently prevent or delay pregnancy.

3.3.10 Sexually Transmitted Disease

Pursuant to federal law, including but not limited to 42 USC sections 1396a(a)(23) and 1396n(b) and 42 CFR section 431.51, Contractor must reimburse non-contracted family planning Providers, including local health departments, at no less than the Medi-Cal FFS Rate for the diagnosis and treatment of a Sexually Transmitted Disease (STD) episode, as defined in Policy Letter (PL) 96-09. Contractor must provide reimbursement only if the STD treatment Provider provides treatment records or documentation of the Member's refusal to release Medical Records to Contractor along with billing information.

3.3.11 Human Immunodeficiency Virus Testing and Counseling

Pursuant to federal law, including but not limited to 42 USC sections 1396a(a)(23) and 1396n(b) and 42 CFR section 431.51, Contractor must reimburse non-contracting family planning Providers, including local health departments, at no less than the Medi-Cal FFS Rate for Human Immunodeficiency Virus (HIV) testing and counseling in accordance with PL 97-08. Contractor must provide reimbursement only if such non-contracting family planning Providers make reasonable efforts to report confidential test results to Contractor in accordance with applicable laws and regulations, including but not limited to H&S section 121025 *et seq*.

3.3.12 Immunizations

Contractor must reimburse local health departments for the administration fee for immunizations given to Members, in accordance with the terms set forth in APL 18-004, who are not already immunized as of the date of the immunization. The local health department must provide immunization records when immunization services are billed to Contractor. Other than local health departments, Contractor is not obligated to reimburse Providers for immunizations under this provision unless the Provider enters into an agreement with Contractor.

3.3.13 Community Based Adult Services

Contractor must reimburse Network Providers for Community Based Adult Services (CBAS) pursuant to a reimbursement structure that must include an all-inclusive per-Member, per-day of attendance rate, or otherwise be reflective of the acuity and/or level of care of the Member population served by Network Providers of CBAS. In accordance with W&I section 14184.201(d)(4), Contractor must reimburse Network Providers of CBAS the amount the Provider could collect if the Member accessed those services in the FFS delivery system, as defined by DHCS in the California Medicaid State Plan and other applicable guidance, including but not limited to guidance issued pursuant to W&I section 14184.102(d), unless Contractor and the Network Provider mutually agree to reimbursement in a different amount. Contractor may include incentive payment adjustments and performance and/or quality standards in its rate structure in paying Network Providers of CBAS.

3.3.14 Organ and Bone Marrow Transplants

In accordance with W&I section 14184.201(d), and for applicable dates of service, Contractor must reimburse a Provider furnishing organ or bone marrow transplant surgeries to a Member the amount the Provider could collect for those same services if the Member accessed those services in the FFS delivery

system, as defined by DHCS in the California Medicaid State Plan, a Directed Payment Initiative, and other applicable guidance, including but not limited to guidance issued pursuant to W&I section 14184.102(d).

3.3.15 Long-Term Care Services

In accordance with W&I sections 14184.201(b) and (c), and for applicable dates of service, Contractor must reimburse a Network Provider furnishing institutional Long-Term Care LTC services to a Member the amount the Provider could collect if the Member accessed those services in the FFS delivery system, as defined by DHCS in the California Medicaid State Plan, a Directed Payment Initiative, and other applicable guidance, including but not limited to guidance issued pursuant to W&I section 14184.102(d). As used in this provision, "institutional LTC services" has the same meaning as set forth in the California Advancing and Innovating Medi-Cal (CalAIM) Terms and Conditions and, subject to W&I section 141814.201(g), includes, at a minimum, all of the following services: Skilled Nursing Facility (SNF) services; subacute facility services; pediatric subacute facility services; and Intermediate Care Facility for the Developmentally Disabled (ICF/DD), ICF/DD-Habilitative (ICF/DD-H), and ICF/DD-Nursing (ICF/DD-N) services.

3.3.16 Emergency Services and Post-Stabilization Care Services

A. Emergency Services

1) Subject to 42 CFR section 422.113(b), Contractor is responsible for coverage and payment of Emergency Services and must cover and pay for Emergency Services regardless of whether the Provider that furnishes the services has a contract with Contractor. Contractor must not deny payment for treatment obtained when a Member had an Emergency Medical Condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in 42 CFR section 438.114(a)(i) – (iii). Further, Contractor must not deny payment for treatment obtained when a representative of Contractor instructs the Member to seek Emergency Services. Emergency Services must not be subject to Prior Authorization by Contractor.

2) Contractor must not limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms or refuse to reimburse Emergency Services based on the emergency room Provider, hospital, or fiscal agent not notifying the Member's Primary Care Providers, Contractor, or DHCS of the Member's screening and treatment for Emergency Services. A Member who

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has an Emergency Medical Condition must not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the Member.

3) Contractor must reimburse Providers for Emergency Services received by a Member from out-of-Network Providers. Payments to non-contracting Providers must be for the treatment of the Emergency Medical Condition, including Medically Necessary inpatient services rendered to a Member until the Member's condition has stabilized sufficiently to permit referral and transfer in accordance with instructions from Contractor or the Member is stabilized sufficiently to permit discharge. The treating Provider is responsible for determining when the Member is sufficiently stabilized for transfer or discharge and that determination is binding on Contractor. Emergency Services must not be subject to Prior Authorization by Contractor.

4) At a minimum, Contractor must reimburse the non-contracting emergency department and, if applicable, its affiliated Providers for physician services at the lowest level of the emergency department evaluation and management physician's Current Procedural Terminology (CPT) codes, unless a higher level is clearly supported by documentation, and for the facility fee and diagnostic services such as laboratory and radiology.

5) For all non-contracted Emergency Services Providers, reimbursement by Contractor or by a Subcontractor or Downstream Subcontractor who is at risk for out-of-Network Emergency Services for properly documented claims for services rendered by out-of-Network Provider pursuant to this provision must be made in accordance with Exhibit A, Attachment III, Subsection 3.3.5 (*Claims Processing*) above and 42 USC section 1396u-2(b)(2)(D).

B. Post-Stabilization Care Services

1) Except for the response time periods set forth in 42 CFR section 422.113(c)(2)(ii) and (iii)(A), Post-Stabilization Care Services must be covered by and paid for in accordance with 42 CFR section 422.113(c) and APL 23-009. Applicable response time periods involving Post-Stabilization Care Services is governed by Exhibit A, Attachment III, Subsection 2.3.2(B) (*Timeframes for Medical Authorization*) of this Contract and APL 23-009. Contractor is financially responsible for Post-Stabilization Care Services obtained

within or outside Contractor's Network that are authorized by Contractor, Subcontractor, or Downstream Subcontractor.

2) In accordance with 28 CCR section 1300.71.4, Contractor must approve or disapprove a request for Post-Stabilization Care Services made by a Provider on behalf of a Member within 30 minutes of the request. If Contractor fails to approve or disapprove authorization within the required timeframe, the authorization is deemed approved.

3) Contractor is also financially responsible for Post-Stabilization Care Services obtained within or outside Contractor's Network that are not authorized by Contractor, Subcontractor, or Downstream Subcontractor, but administered to maintain, improve, or resolve the Member's stabilized condition if Contractor, Subcontractor, or Downstream Subcontractor does not respond to a request for authorization within 30 minutes; Contractor, Subcontractor, or Downstream Subcontractor cannot be contacted; or Contractor, Subcontractor, or Downstream Subcontractor and the treating Provider cannot reach an agreement concerning the Member's care. In this situation, the treating Provider may continue with care of the Member until Contractor, Subcontractor, or Downstream Subcontractor is reached and assumes responsibility for the Member's care or one of the criteria of 42 CFR section 422.113(c)(3) is satisfied.

4) Contractor's financial responsibility for Post-Stabilization Care Services it has not authorized ends when a Network Provider with privileges at the treating hospital assumes responsibility for the Member's care; a Network Provider assumes responsibility for the Member's care through transfer; Contractor's Representative and the treating Provider reach an agreement concerning the Member's care; or the Member is discharged.

5) Consistent with 42 CFR sections 438.114(e), 422.113(c)(2), and 422.214, Contractor is financially responsible for payment of Post-Stabilization Care Services, following an emergency admission, at the hospital's Medi-Cal FFS Rate for general acute care inpatient services rendered by a non-contracting, Medi-Cal certified hospital, unless a lower rate is agreed to in writing and signed by the hospital.

   a) For the purposes of this Subsection 3.3.16 (*Emergency Services and Post-Stabilization Care Services*), the FFS

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payment amounts for dates of service when the Post-Stabilization Care Services were rendered must be the FFS payment method known as diagnosis-related groups, which for the purposes of this Paragraph 5 must apply to all acute care hospitals, including public hospitals that are reimbursed under the certified public expenditure basis methodology (W&I section 14166 *et seq.*), less any associated direct or indirect medical education payments to the extent applicable.

b) Payment made by Contractor to a hospital that accurately reflects the payment amounts required by this Paragraph 5 must constitute payment in full and must not be subject to subsequent adjustments or reconciliations by Contractor, except as provided by Medicaid law and regulations. A hospital's tentative and final cost settlement processes required by 22 CCR section 51536 must not have any effect on payments made by Contractor pursuant to this Paragraph 5.

C. Disputed claims involving Emergency Services and/or Post-Stabilization Care Services may be submitted for resolution under provisions of W&I section 14454 and 22 CCR section 53620 *et seq.* (except section 53698) to:

Department of Health Care Services
Office of Administrative Hearings and Appeals
3831 North Freeway Blvd, Suite 200
Sacramento, CA 95834

Contractor agrees to implement DHCS' determination and reimburse the out-of-Network Provider within 30 calendar days of the effective date of a decision that Contractor is liable for payment of a claim and must provide proof of reimbursement in such form as DHCS directs. Failure to reimburse the out-of-Network Provider within 30 calendar days must result in capitation offsets in accordance with W&I sections 14454(c) and 14115.5 and 22 CCR section 53702 and may subject Contractor to sanctions pursuant to W&I section 14197.7.

3.3.17 Provider-Preventable Conditions

Contractor, Subcontractor, or Downstream Subcontractor, or Network Provider must not pay any Provider claims nor reimburse a Provider for a Provider-Preventable Condition (PPC) in accordance with 42 CFR section 438.3(g).

Contractor must report and require any and all of its Network Providers, Subcontractors, and Downstream Subcontractors to report PPCs in the form and frequency required by APL 17-009.

3.3.18 Prohibition Against Payment to Excluded Providers

In accordance with 42 USC section 1396b(i)(2), Contractor must not pay any amount for any services or items, other than Emergency Services, to an Excluded Provider as defined in Exhibit A, Attachment III, Subsection 1.3.4.A, (*Tracking Suspended, Excluded, and Ineligible Providers*) of this Contract. This prohibition applies to non-emergent services furnished by a Provider at the medical direction or prescribed by an Excluded Provider when the Provider knew or had a reason to know of the exclusion or prescribed by an Excluded Provider to whom DHCS has failed to suspend payment while pending an investigation of a credible allegation of Fraud.

3.3.19 Compliance with Directed Payment Initiatives and Related Reimbursement Requirements

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

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Exhibit A, ATTACHMENT III

4.0 Member

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

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

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

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

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

4.1 Marketing

4.1.1 Training and Certification of Marketing Representatives
4.1.2 Marketing Plan

4.1 Marketing

4.1.1 Training and Certification of Marketing Representatives

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

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

B. Training Program

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

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

2) The Medi-Cal scope of services;

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

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

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

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

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

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

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

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

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

4.1.2 Marketing Plan

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

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

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

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

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

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

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

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

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

7) Documentation of all agreements between Contractor and the organizations with which it is undertaking Marketing activities.

8) All Marketing Materials Contractor will use, including those for English-speaking populations, non-English speaking populations, and alternative formats for people with disabilities (including Braille, large-size print font no smaller than 20-point, accessible electronic format, and audio format).

9) A description of the methods Contractor will use to distribute Marketing Materials in compliance with APLs, this Contract, and State and federal law, including, but not limited to, the Telephone Consumer Protection Act of 1991 (47 United States Code (USC) section 227).

10) Copies of a sample Marketing identification badge and business card clearly identifying Marketing Representatives as Contractor's employees. Marketing identification badges and business cards must not resemble those of a government agency.

11) Written formal procedures for monitoring the performance of Contractor's Marketing Representatives to ensure Marketing integrity, pursuant to Welfare and Institutions Code (W&I) section 14408(c).

12) All sites for proposed Marketing activities, such as annual health fairs and community events in which Contractor proposes to participate.

13) All other information requested by DHCS to assess Contractor's Marketing program.

C. If Contractor wishes to conduct a Marketing activity not included in the approved Marketing plan, Contractor must submit a written request and obtain prior written approval for that Marketing activity from DHCS. Contractor must submit the written request, a copy of the proposed Marketing Materials, and all other required documentation at least 30 calendar days prior to the Marketing activity, unless DHCS agrees to a shorter review period.

D. At least 30 calendar days before Contractor's participation in any proposed Marketing events, Contractor must notify its designated DHCS Contract Manager in writing and provide required documentation for DHCS review and approval. In cases where Contractor learns of a

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Marketing event less than 30 calendar days before the event, Contractor must immediately provide written notification and required documentation to DHCS for review and approval. In no instance may notification be less than two Working Days before the Marketing event.

E. At least 30 calendar days before Contractor's participation in any proposed Marketing events, Contractor must submit a community event Marketing agreement for DHCS review and approval. Along with the community event Marketing agreement, there must be an attestation from the event organization stating that:

1) Contractor will not distribute Marketing Materials or conduct Marketing presentations at a Network Provider, Subcontractor, Downstream Subcontractor, or out-of-Network Provider site, including hospitals and their property; and

2) There are trained Marketing staff at the Marketing event and, if the Marketing event is educational, there are trained health educators at the Marketing event.

F. Contractor must obtain prior DHCS approval before performing in-home Marketing presentations and must provide strict accountability, including documentation from the Potential Member requesting an in-home Marketing presentation or a telephone log entry documenting the Potential Member's request.

G. Contractor must submit any advertisement intended for Marketing purposes to DHCS for prior approval. Such advertisements include, but are not limited to, mass media, magazines, newspapers, radio, telephonic Marketing, TV, billboards, bus sides, and any mobile advertisements.

H. Contractor must not position any mobile advertisements at any Network Provider, Subcontractor, Downstream Subcontractor, or non-contracted Provider sites, including hospitals and their property.

I. When conducting Marketing, Contractor must comply with W&I sections 10850(b), 14407.1, 14408, 14409, 14410, and 14411 and 22 California Code of Regulations (CCR) sections 53880 and 53881.

J. Contractor must not engage in door-to-door, telephone, e-mail, texting, or other Cold-Call Marketing for the purpose of enrolling Potential Members, or for any other purpose.

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K. Contractor must not distribute Marketing Materials or conduct Marketing presentations at any Network Provider, Subcontractor, Downstream Subcontractor, or out-of-Network Provider sites, including hospitals and their property.

L. Contractor must not seek to influence Enrollment in conjunction with the sale or offering of any private insurance.

M. Contractor's Marketing Materials must not contain any statements that suggest Enrollment is necessary to obtain or to avoid losing Medi-Cal benefits, or that Contractor is endorsed by DHCS, Center for Medicare & Medicaid Services (CMS), or any other State or federal government entity.

N. All of Contractor's Marketing must be accurate and not mislead, confuse, or defraud Members, Potential Members, or the Medi-Cal program, pursuant to 42 Code of Federal Regulations (CFR) section 438.104.

Exhibit A, ATTACHMENT III

4.2 Enrollments and Disenrollments

4.2.1 Enrollment
4.2.2 Disenrollment

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4.2 Enrollments and Disenrollments

4.2.1 Enrollment

Contractor must cooperate with the DHCS Enrollment processes and the DHCS Enrollment contractor in enrolling all Potential Members into Medi-Cal managed care health plans. DHCS and its Enrollment contractor will verify eligibility status and notify the Potential Member of the available Medi-Cal managed care health plans in their County. Contractor must ensure mandatory and voluntary Potential Members residing in its Service Area, are properly enrolled pursuant to the requirements of this provision.

A. Non-Discrimination in Enrollment

Contractor must accept as Members all Potential Members who select or are assigned to Contractor without regard to sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, pre-existing medical condition(s), genetic information, health status, marital status, gender, gender identity, sexual orientation, existing or prior involvement in the justice system, or identification with any other persons or groups defined in California Penal Code section 422.56.

B. Enrollment Processing Criteria

1) Contractor must accept as Members all Potential Members who meet the Enrollment criteria in 22 California Code of Regulations (CCR) section 53845, as follows:

a) Potential Members with a Mandatory aid code unless they qualify for an exemption from Enrollment pursuant to 22 CCR section 53887 or meet the criteria in 22 CCR section 53891(c).

b) Potential Members with a Mandatory aid code who are default enrolled because they did not select a Medi-Cal managed care plan during the choice timeframe.

c) Potential Members with a Justice Involved aid code who are default enrolled per the Justice Involved Reentry Initiative, as described in the Policy and Operational Guide for Planning and Implementing CalAIM Justice-Involved Reentry Initiative.

d) Potential Members with a Voluntary aid code who select Contractor as their Medi-Cal managed care plan.

C. Enrollment Process

1) Contractor will receive an effective Enrollment date from DHCS that is no later than 90 calendar days from the date that Medi-Cal Eligibility Data System (MEDS) lists the individual as meeting the required Enrollment criteria contained in 22 CCR section 53845(a).

2) DHCS or its Enrollment contractor will assign Potential Members meeting the Enrollment criteria contained in 22 CCR section 53845(a) to Medi-Cal Managed Care Health Plans in accordance with 22 CCR section 53884, if the Potential Member fails to select a plan after receiving notice that they are required to enroll in Medi-Cal Managed Care.

3) Notwithstanding any other provision in this Contract, Paragraphs 1) and 2) above do not apply to Potential Members without a current valid deliverable address or with an address designated as a county post office box for homeless Members.

D. Enrollment Disputes

1) Contractor must notify DHCS of Enrollment disputes, pursuant to the requirements and procedures contained in Exhibit E, Section 1.21 (*Contractor's Dispute Resolution Requirements*).

2) DHCS has 120 calendar days from the date of DHCS' receipt of Contractor's Enrollment dispute notice (the "cure period") to make necessary Enrollment corrections or adjustments, identified in Contractor's dispute notice, without incurring any financial liability to Contractor. For purposes of this Provision, DHCS will be deemed to have corrected or adjusted any issues identified in Contractor's notice if, within the cure period, any of the following occurs:

a) Mandatory plan Members receive an effective Member Assignment date that is within the cure period; or

b) DHCS corrects or adjusts an Enrollment issue by redirecting Enrollment from Contractor to another Contractor within the cure period; or

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c) Within the cure period, DHCS changes the distribution of Member Assignment, subject to the requirements of 22 CCR section 53845, to the maximum extent new Members are available to be assigned, to adjust for the number of incorrectly assigned Members.

3) If it is necessary to redirect Enrollment or change the distribution of Member Assignment and such change varies from the requirements of 22 CCR section 53884(b)(5) or (b)(6), Contractor agrees it will neither seek legal nor equitable relief for such variance or the results of such variance if DHCS resumes assignment consistent with 22 CCR sections 53884(b)(5) or (b)(6) after any necessary Enrollment correction or adjustment.

4) DHCS will not be financially liable to Contractor for any Enrollment dispute, in an affected county (on a county-by-county basis) if Contractor's loss of mandatory plan Members, in a month in which a dispute occurs, is less than 5 percent of Contractor's total Members in that affected county. The parties acknowledge that the above referenced 5 percent threshold will apply on a county-by-county basis, not in the aggregate. DHCS' financial liability must not exceed 15 percent of Contractor's monthly Capitation Payment.

E. Coverage

1) Member coverage begins at 12:01 a.m. on the first day of the calendar month for which the Potential Member's name is included on the list of new Members assigned to Contractor. The term of Enrollment continues indefinitely until this Contract expires, is terminated, or the Member is disenrolled pursuant to the conditions described in Exhibit A, Attachment III, Subsection 4.2.2 (*Disenrollment*) below.

2) Contractor must authorize and provide coverage for Medically Necessary Covered Services to a Child born to a Member for the month of birth and the following month. No additional Capitation Payment is owed Contractor for the services provided to the newborn Child for month of birth and the month following birth.

F. Temporary Exemption from Mandatory Enrollment

A Member in a mandatory aid code category who currently has a DHCS approved medical exemption request pursuant to 22 CCR section 53887

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will not be assigned to Contractor until the medical exemption expires or the medical exemption is subsequently denied by DHCS.

G. Mandatory Assignment Restrictions

Assignment will continue on a monthly basis unless restricted by DHCS. DHCS will impose assignment restrictions and provide written notice to Contractor at least ten calendar days prior to the start of the restriction period. DHCS will notify Contractor at least ten calendar days before the end of the restriction period.

4.2.2 Disenrollment

DHCS or its agent will process a Member's disenrollment from Contractor under the following conditions, in accordance with the provisions of 22 CCR section 53891:

A. Disenrollment from Contractor is mandatory when:

1) The Member requests disenrollment with a request for Enrollment in the competing Medi-Cal managed care plan pursuant to 22 CCR section 53891(c), subject to any lock in restrictions on disenrollment under the federal lock in option, if applicable, or when the Member enrolls in a Medicare Advantage plan that is affiliated with a competing Medi-Cal managed care plan.

2) The Member is no longer eligible for Enrollment with Contractor because they lost Medi-Cal eligibility, including the death of a Member.

3) Contractor's contract is terminated or Contractor no longer participates in the Medi-Cal Program.

4) Enrollment was in violation of 22 CCR section 53891(a)(2), or requirements of this Contract regarding Marketing.

5) The Member requests disenrollment in accordance with Welfare and Institutions Code (W&I) section 14303.1, following a merger with other organizations, or W&I section 14303.2, following a reorganization or merger, with a parent or subsidiary corporation. In these circumstances, Contractor must give Members the option to disenroll for any cause, and request Enrollment in another Medi-Cal managed care plan within 60 calendar days following the date of

the reorganization or merger. Contractor must not disenroll the Member to Fee-For-Service (FFS).

6) A Member's change of residence is outside of Contractor's Service Area.

Mandatory disenrollment from Contractor will be effective on the first day of the next month after DHCS receives all documentation it determines are necessary to process the disenrollment, provided disenrollment was requested at least 30 calendar days prior to that date.

B. Except as provided in above Paragraph A.6) of this Subsection, Enrollment terminates no later than midnight on the last day of the first calendar month after DHCS receives the Member's disenrollment request and all required supporting documentation for Enrollment in a competing plan. On the first day after Enrollment ceases, Contractor is relieved of all obligations to provide Covered Services to the Member under the terms of this Contract. Contractor agrees in turn to return to DHCS any Capitation Payment forwarded to Contractor for Members no longer enrolled with Contractor under this Contract.

C. Contractor must implement and maintain procedures to ensure that all Members requesting disenrollment are provided an explanation of the Member's right to disenroll at any time, with the requirement that the Member enroll in the competing Medi-Cal managed care plan in the county, subject to the requirements in 22 CCR section 53891(c), and any restricted disenrollment period. Additionally, Contractor must immediately refer Members requesting disenrollment from Contractor to the DHCS Enrollment contractor so the Member may be enrolled in another Medi-Cal managed care plan or disenrolled because they require a carved-out service.

Exhibit A, ATTACHMENT III

4.3 Population Health Management and Coordination of Care

4.3.1 Population Health Management Program Requirements
4.3.2 Population Needs Assessment
4.3.3 Data Integration and Exchange
4.3.4 Medi-Cal Connect (DHCS' PHM Service)
4.3.5 Population Risk Stratification and Segmentation, and Risk Tiering
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4.3.23 Justice Involved Reentry Coordination
4.3.24 Managed Care Liaisons

4.3 Population Health Management and Coordination of Care

4.3.1 Population Health Management Program Requirements

A. Contractor must develop and maintain a Population Health Management (PHM) program that ensures all Members have equitable access to necessary wellness and prevention services, Care Coordination and care management. Contractor must assess Member needs across the continuum of care based on Member preferences, data-driven risk stratification, identified gaps in care and standardized assessment processes at both the individual Member level, and at the community level. Contractor must maintain a PHM program that seeks to improve the health outcomes of all Members consistent with the requirements set forth in this Section and DHCS guidance. Contractor must report on PHM program operations, effectiveness, and outcomes based on DHCS guidance specified in the PHM Policy Guide, as noted in All Plan Letter (APL) 22-024.

B. Contractor must ensure its PHM program meets, at a minimum, all National Committee for Quality Assurance (NCQA) PHM standards as well as applicable federal and State requirements as set forth in APL 22-024. As described in Exhibit A, Attachment III, Subsection 4.3.2 (*Population Needs Assessment*) and in accordance with APL 23-021, Contractor must fulfill its Population Needs Assessment (PNA) requirement by meaningfully participating in the local health jurisdiction (LHJ) Community Health Assessment (CHA)/ Community Health Implementation Plan (CHIP) process in the Service Area county(ies) in which it operates, and submit a PHM Strategy, informed by PNA findings, to DHCS. PHM Strategy submission documentation will include an NCQA-approved PHM strategy for accredited Plans. Contractor that has not yet obtained NCQA accreditation is still responsible for submitting PHM Strategy documentation prepared for near-future NCQA submission in line with NCQA Health Plan Accreditation standards, inclusive of population assessment documentation informing PHM Strategy and accreditation application process if Contractor is without current accreditation, upon DHCS request.

4.3.2 Population Needs Assessment

A. Contractor must conduct a Population Needs Assessment (PNA) by participating in the CHA/CHIP processes led by Local Health Departments (LHDs) in the Service Area county(ies) where Contractor operates, as defined further in APL 23-021 and the PHM Policy Guide.

B. Contractor operating in multiple LHD jurisdictions must participate in the CHA/CHIP process for each jurisdiction in which it operates.

C. Contractor must submit an annual PHM Strategy that demonstrates that Contractor is responding to community needs and provides PHM updates as specified and, in the format prescribed by DHCS.

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

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

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

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

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

3) Wellness and prevention programs.

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

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

I. Additional operational details on the PNA and PHM Strategy are located in the PHM Policy Guide. Any future updates will also be communicated to Contractor via the PHM Policy Guide.

4.3.3 Data Integration and Exchange

In accordance with the Centers for Medicare & Medicaid Services (CMS) Interoperability and Patient Access final rule (CMS-9115-F) and applicable federal and State data exchange requirements, Contractor must integrate its PHM data by expanding its Management Information System (MIS) capabilities outlined in Exhibit A, Attachment III, Section 2.1 (*Management Information System*), as follows:

A. Integrate additional data sources in accordance with all NCQA PHM standards to ensure the ability to assess the needs and characteristics of all Members;

B. Enhance interoperability of its MIS to allow for data exchange with Health Information Technology (HIT) systems and Health Information Exchange (HIE) networks as specified by the DHCS;

C. Enhance interoperability of the PHM Service, in support of population health principles, integrated care, and Care Coordination across delivery systems;

D. Provide DHCS with administrative, clinical, and other data requirements as specified by the DHCS; and

E. Comply with all data sharing agreements, including data exchange policies and procedures, as defined by the California Health and Human Services Data Exchange Framework in accordance with Health & Safety Code (H&S) section 130290.

F. Comply with the CMS Interoperability and Patient Access Final Rule set forth at CMS-9115-F.

4.3.4 Medi-Cal Connect (DHCS' PHM Service)

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

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

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

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

D. Support Member engagement and education activities.

4.3.5 Population Risk Stratification and Segmentation, and Risk Tiering

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

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

2) Comply with NCQA PHM standards;

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

a) Upon each Member's Enrollment;

b) Annually after each Member's Enrollment;

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

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

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

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

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

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

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

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

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

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

4.3.6 Screening and Assessments

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

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

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

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

4.3.7 Care Management Programs

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

Enhanced Care Management

Enhanced Care Management (ECM) is a whole-person, interdisciplinary approach to comprehensive care management that addresses the clinical and non-clinical needs of high need and/or high-cost Members**.** ECM provides systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered. This benefit is intended for the highest risk Medi-Cal managed care health plan Members who meet the Populations of Focus **(POF)** criteria. ECM is described in Exhibit A, Attachment III, Section 4.4 (*Enhanced Care Management*).

Complex Care Management

Complex Care Management (CCM) (which equates to “Complex Case Management” as defined by NCQA) is an approach to comprehensive care management that meets differing needs of high and medium rising-risk Members through both ongoing, chronic Care Coordination and interventions for episodic, temporary needs. The overall goal of CCM is to help Members regain optimum health or improved functional capability, in the right setting, and in a cost-effective manner. Contractor must consider CCM to be an opt-out program, i.e. Members have the right to participate or to decline to participate.

Both ECM and CCM are inclusive of Basic PHM, which Contractor must provide to all Members, at minimum. Care Managers conducting ECM or CCM must integrate all elements of Basic PHM into their ECM or CCM approach.

A. Care Management Programs

Contractor must operate and administer the following care management programs:

1) ECM as described in Exhibit A, Attachment III, Section 4.4 (*Enhanced Care Management*).

2) CCM

   a) Contractor must operate and administer CCM in accordance with all NCQA CCM standards and requirements, and coordinate services for high and medium/rising-risk Members through Contractor's CCM approach. To the extent NCQA's standards are updated, Contractor must comply with most recent standards. Contractor must maintain and provide DHCS with policies and procedures that, at a minimum, include the following details regarding its CCM program:

      i. Contractor's CCM program must be designed and implemented to help Members gain or regain optimum health or improved functional capability in the right setting;

      ii. Contractor's CCM program must include comprehensive assessment of the Member's condition; determination of available benefits and resources; and development and implementation of a CMP with performance goals, monitoring and follow-up;

      iii. Contractor's CCM program must have an opt-out method under which Members meeting criteria for CCM have the right to decline to participate;

      iv. Contractor's CCM program must include a variety of interventions for Members that meet the differing needs of high and medium/rising-risk populations, including longer-term chronic Care Coordination and interventions for episodic, temporary needs;

      v. Contractor's CCM program must incorporate disease-specific management programs (including, but not limited to, asthma and diabetes) that include self-management support and health education;

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vi. For Members under age 21, Contractor's CCM program must include Early Periodic Screening, Diagnosis and Testing (EPSDT); all Medically Necessary services, including those that are not necessarily covered for adult Members, must be provided as long as they could be Medi-Cal-services.

b) Contractor must assess Members for the need for Community Supports as part of its CCM program to eligible Members.

c) A description of the CCM program must be included, in a manner to be prescribed by DHCS, in Contractor's annual PHMS for DHCS review and approval, outlining all the components of its CCM program, including all those listed in this Subsection.

B. CCM Care Manager Role

1) Assignment of CCM Care Manager

a) Contractor must identify and assign a CCM Care Manager for every Member receiving CCM. Following NCQA requirements, Contractor may delegate CCM to Network Providers or other entities that are NCQA-certified. PCPs may be assigned as CCM Care Managers when they are able to meet all the requirements specified in this Subsection.

b) When a CCM Care Manager other than the Member's PCP is assigned, Contractor must provide the Member's PCP with the identity of the Member's assigned CCM Care Manager, and a copy of the Member's CMP.

c) When multiple Providers perform separate aspects of Care Coordination for a Member, Contractor must:

i. Identify a lead CCM Care Manager and communicate the identity of the Care Manager to all treating Providers and the Member; and

ii. Maintain policies and procedures to ensure compliance and non-duplication of Medically Necessary services and delegation of responsibilities

between Contractor and the Member's Providers in meeting all care management requirements.

2) CCM Care Manager Responsibilities

a) Contractor is responsible for ensuring CCM Care Managers comply with all of the Basic PHM requirements in Exhibit A, Attachment III, Subsection 4.3.8 (*Basic Population Health Management*) and all NCQA CCM standards.

b) Contractor must ensure that the CCM Care Manager performs the following duties:

i. Conduct Member assessments as needed to identify and close any gaps in care and address the Member's physical, mental health, Substance Use Disorder (SUD), developmental, oral health, dementia, palliative care, chronic disease, and LTSS needs as well as needs due to SDOH;

ii. Complete a CMP for all Members receiving CCM, consistent with the Member's goals in consultation with the Member. The CMP must:

a. Address a Member's health and social needs, including needs due to SDOH;

b. Be reviewed and updated at least annually, upon a change in Member's condition or level of care, or upon request of the Member;

c. Be in an electronic format and a part of the Member's Medical Record, and document all of the Member's services and treating Providers;

d. Be developed using a person-centered planning process that includes identifying, educating, and training the Member's parents, family members, legal guardians, Authorized Representatives (ARs), caregivers, or authorized support persons, as needed; and

e. Include referrals to community-based social services and other resources even if they are not Covered Services under this Contract.

iii. Ensure continuous information sharing and communication with the Member and their treating Providers; and

iv. Specify the responsibility of each Provider that provides services to the Member.

c) Ensure Members receive all Medically Necessary services, including Community Supports, to close any gaps in care and address the Member's mental health, SUD, developmental, physical, oral health, dementia, palliative care needs as well as needs due to SDOH;

d) Support and assist the Member in accessing all needed services and resources, including across the physical and Behavioral Health delivery systems;

e) Communicate to Members' parents, family members, legal guardians, ARs, caregivers, or authorized support persons all Care Coordination provided to Members, as appropriate;

f) Provide referrals to Community Health Workers (CHWs), peer counselors, and other community-based social services including, but not limited to, personal care services, LTSS, Community Supports and local community organizations and other programs or services offered by other agencies and third-party entities with which Contractor has or will have a MOU;

g) Assess the Member's understanding of the referral instructions and follow-up to determine whether the referral instructions were completed or whether the Member needs further assistance to access the services, and if so, provide such assistance;

h) Review and/or modification of Member's CMP, when applicable, to address unmet service needs;

i) Facilitate and encourage the Member's adherence to recommended interventions and treatment; and

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j) Ensure timely authorization of services to meet the Member's needs in accordance with the Member's CMP.

4.3.8 Basic Population Health Management

A. Contractor must provide Basic PHM to all Members, in accordance with 42 CFR section 438.208. Contractor must maintain policies and procedures that meet the following Basic PHM requirements, at a minimum:

1) Ensure that each Member has an ongoing source of care that is appropriate, ongoing and timely to meet the Member's needs;

2) Ensure Members have access to needed services including Care Coordination, navigation and referrals to services that address Members' developmental, physical, mental health, SUD, dementia, LTSS, palliative care, and oral health needs;

3) Ensure that each Member is engaged with their assigned PCP and that the Member's assigned PCP plays a key role in the Care Coordination functions described in this Subsection, in partnership with Contractor;

4) Ensure each Member receives all needed preventive services in partnership with the Member's assigned PCP;

5) Ensure efficient Care Coordination and continuity of care for Members who may need or are receiving services and/or programs from out-of-Network Providers;

6) Ensure Members are provided with resources and education about how to access the various programs and services offered by agencies and third-party entities with whom Contractor has or will have an executed MOU;

7) Review Member utilization reports to identify Members not using Primary Care; stratify such reports, at minimum, by race and ethnicity to identify Health Disparities that result from differences in utilization of outpatient and preventive services; and develop strategies to address differences in utilization;

8) Facilitate access to care for Members by, at a minimum, helping to make appointments, arranging transportation, ensuring Member health education on the importance of Primary Care for Members who have not had any contact with their assigned Medical

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Home/PCP or have not been seen within the last 12 months, particularly Members less than 21 years of age;

9) Ensure all services are delivered in a culturally and linguistically competent manner that promotes Health Equity for all Members;

10) Coordinate health and social services between settings of care, across other Medi-Cal managed care health plans, delivery systems, and programs (e.g., Targeted Case Management, Specialty Mental Health Services), with external entities outside of Contractor's Network, and with Community Supports and other community-based resources, even if they are not Covered Services under this Contract, to address Members' needs and to mitigate impacts of SDOH;

11) Coordinate referrals to ensure Care Coordination with public benefits programs, including without limitation, as required by this Contract under the requirements set forth for Memorandums of Understanding (MOUs) in Exhibit A, Attachment III, Section 5.6 (*MOUs with Local Government Agencies, County Programs, and Third Parties*);

12) Assist Members, Members' parents, family members, legal guardians, ARs, caregivers, or authorized support persons with navigating health delivery systems, including Contractor's Subcontractor and Downstream Subcontractor Networks, to access Covered Services as well as services not covered under this Contract;

13) Provide Members with resources to address the progression of disease or disability, and improve behavioral, developmental, physical, and oral health outcomes;

14) Communicate to Members' parents, family members, legal guardians, ARs, caregivers, or authorized support persons all Care Coordination provided to Members, as appropriate;

15) Ensure that Providers furnishing services to Members maintain and share, as appropriate, Members' Medical Records in accordance with professional standards and State and federal law;

16) Facilitate exchange of necessary Member Information in accordance with any and all State and federal privacy laws and regulations, including data exchange policies and procedures, as

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defined by the California Health and Human Services Data Exchange Framework in accordance with H&S section 130290, specifically pursuant to 45 CFR parts 160 and 164 subparts A and E, to the extent applicable; and

17) Maintain processes to ensure no duplication of services occurs.

B. Wellness and Prevention Programs

1) Contractor must provide wellness and prevention programs that meet NCQA PHM standards, including for the provision of evidence-based self-management tools;

2) Contractor must ensure that the wellness and prevention programs align with the DHCS Comprehensive Quality Strategy;

3) Contractor must provide wellness and prevention programs in a manner specified by DHCS, and in collaboration with LGAs as appropriate, that include the following, at a minimum:

a) Identification of specific, proactive wellness initiatives and programs that address Member needs;

b) Evidence-based disease management programs including, but not limited to, programs for diabetes, cardiovascular disease, asthma, and depression that incorporate health education interventions, target Members for engagement, and seek to close care gaps for Members participating in these programs;

c) Initiatives, programs, and evidence-based approaches to improving access to preventative health visits, developmental screenings and services for Members less than 21 years of age, as described in Exhibit A, Attachment III, Subsection 5.3.4 (*Services for Members Less Than 21 Years of Age*);

d) Initiatives, programs, and evidence-based approaches on improving pregnancy outcomes for women, including through 12 months post-partum;

e) Initiatives, programs, and evidence-based approaches on ensuring adults have access to Preventive Care, as described in Exhibit A, Attachment III, Subsection 5.3.5

(*Services for Adults*) and in compliance with all applicable State and federal laws;

f) A process for monitoring the provision of wellness and preventive services by PCPs as part of Contractor's Site Review process, as described in Exhibit A, Attachment III, Subsection 5.2.14 (*Site Review*);

g) Health education materials, in a manner that meets Members' health education and cultural and linguistic needs, in accordance with Exhibit A, Attachment III, Subsection 5.3.7 (*Services for All Members*); and

h) Initiatives and programs that implement evidence-based best practices that are aimed at helping Members set and achieve wellness goals.

4) Contractor must ensure that its wellness and prevention programs are submitted to DHCS for review and approval in a form and method prescribed by DHCS.

5) Contract must report annually through the PHMS on how community-specific information and stakeholder input from the PNA is used to design and implement evidence-based wellness and prevention strategies.

4.3.9 Other Population Health Requirements for Children

For Members less than 21 years of age, Contractor must provide as part of care management and Basic PHM the following services for Children:

A. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Case Management Responsibilities

Contractor must provide case management to assist Members less than 21 years of age in gaining access to all Medical Necessary medical, Behavioral Health, dental, social, educational, and other services, as defined in 42 United States Code (USC) sections 1396d(a), 1396d(r), and 1396n(g)(2), and Welfare and Institutions Code (W&I) section 14059.5(b). Case management services for Members less than 21 years of age also include the data exchange necessary for the provision of services as well as the coordination of non-covered services such as social support services. Additionally, Contractor must provide EPSDT case management services as Medically Necessary services for Members less than 21 years

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of age, as required in Exhibit A, Attachment III, Subsection 5.3.4 (*Services for Members Less Than 21 Years of Age*), and must ensure that all Medically Necessary services for Members less than 21 years of age are initiated within timely access standards whether or not the services are Covered Services under this Contract.

B. Children and Youth with Special Health Care Needs

Contractor must develop and implement policies and procedures to provide services for CYSHCN. Contractor must ensure that the policies and procedures include the following information, at a minimum, to encourage CYSHCN Member participation:

1) Methods for ensuring and monitoring timely access to pediatric Specialists, sub-Specialists, ancillary therapists, transportation, and Durable Medical Equipment (DME) and supplies. These may include assignment to a Specialist as PCP, Standing Referrals, or other methods.

2) Methods for monitoring and improving the quality, Health Equity and appropriateness of care for CYSHCN.

3) Methods for ensuring Care Coordination with Department of Developmental Services (DDS), local health departments and local California Children's Services (CCS) Programs, as appropriate and as required under any applicable MOUs between Contractor and local health departments and DDS for the CCS Program.

C. Early Intervention Services

Contractor must develop and implement systems to identify Members who may be eligible to receive services from the Early Start program and refer them to the local Early Start program. These Members include those with a condition known to lead to developmental delay, those in whom a developmental delay is suspected, or whose early health history places them at risk for delay. Contractor must collaborate with the local RC or local Early Start program in determining the Medically Necessary diagnostic and preventive services and treatment plans for Members. Contractor must provide case management and Care Coordination to the Member to ensure the provision of all Medically Necessary Covered Services identified in the Individualized Family Service Plan (IFSP) developed by the Early Start program, with PCP participation.

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4.3.10 Transitional Care Services

Contractor must provide Transitional Care Services (TCS) to all Members transferring from one setting, or level of care, to another in accordance with 42 CFR section 438.208, other applicable federal and State laws and regulations, APL 22-024, and the PHM Policy Guide. Transferring from one setting, or level of care, to another includes, but is not limited to, discharges from hospitals, institutions, acute care facilities, and Skilled Nursing Facilities (SNFs) to home or community-based settings, Community Supports, post-acute care facilities, or Long-Term Care (LTC) settings.

Contractor must identify every Member undergoing a transition as high-risk or lower-risk according to the criteria in the PHM Policy Guide.

For all identified high-risk Members, Contractor must ensure a Member has a single point of contact for the duration of the transition. If a Member identified as high risk is not receiving CCM or ECM, Contractor must identify a care manager who is a single point of contact responsible for ensuring the completion of all Transitional Care Services, including making referrals and ensuring no gaps in care. For Members identified as lower risk, a single point of contact is not required, but there must be a dedicated care management team available, as described further in the PHM Policy Guide.

Contractor must ensure that TCS processes meet the requirements of A-C below, for both high and lower risk Members. The PHM Policy Guide describes in further detail how the requirements below apply to high and lower risk Members.

Additional guidance is forthcoming on the specific TCS requirements for different populations.

A. General Requirements for Transitional Care Applicable to All Members in Transition, including High- and Lower-Risk Members

Contractor must implement transitional care processes that meet the following further requirements as specified in the PHM Policy Guide, at minimum:

1) Ensure each Member is evaluated for all care settings appropriate to the Member's condition, needs, preferences and circumstances. Members must not be discharged to a setting that does not meet their medical and/or LTSS needs;

2) Ensure that permission is obtained from Members, Members' parents, legal guardians, or ARs, as appropriate to share

information with Providers to facilitate transitions, in accordance with federal and State privacy laws and regulations;

3) Ensure referrals to Community Supports and coordination with county social service agencies and waiver agencies for In-Home Supportive Services (IHSS) and other Home and Community-Based Services (HCBS) for Members who may be eligible for such services, and **as applicable,** in accordance with any MOU executed between Contractor and such agencies;

4) Ensure referrals to ECM and Community Supports for Members identified as having unstable housing, experiencing homelessness, or needing nursing facility care, for whom transition to home/assisted living facility or short term post hospitalization/recuperative care are alternatives;

5) Ensure all Prior Authorizations required for the Member's discharge are processed within timeframes consistent with the urgency of the Member's condition, not to exceed five Working Days for routine authorizations, or 72 hours for expedited authorizations, in accordance with Exhibit A, Attachment III, Subsection 2.3.2 (*Timeframes for Medical Authorization*). Prior Authorizations should be complete prior to discharge. This includes Prior Authorizations for therapy, home care, medical supplies, prescription medications for which Contractor is responsible, and DME that are processed in accordance with 42 CFR section 438.210, H&S section 1367.01, and Exhibit A, Attachment III, Section 2.3 (*Utilization Management Program*) of this Contract;

6) Ensure all Network Provider hospitals, institutions, and facilities educate their Discharge Planning staff on the services, supplies, medications, and DME needing Prior Authorization;

7) Ensure that mutually agreed-upon policies and procedures for Discharge Planning and Transitional Care Services exist between Contractor and each of its Network Provider and out-of-Network Provider hospitals within its Service Area;

8) Prevent delayed discharges of a Member from a hospital, institution, or facility due to circumstances such as, but not limited to, Contractor authorization procedures or transitions to a lower level of care, by determining and addressing the root causes of why delays occur;

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9) Require all of its contracted hospitals, and all SNFs with electronic health records, to send Admission, Discharge, and Transfer (ADT) notifications to Contractor for each of its assigned Members in accordance with Interoperability and Patient Access Final Rule set forth at CMS-9115-F, and in accordance with the California Health and Human Services Data Exchange Framework set forth in H&S section 130290, and as further specified in the PHM Policy Guide; and

10) Ensure all Members being discharged from discharging facilities, including SNFs, have a PCP who can provide follow-up care, as appropriate, and that the discharging facilities have contact information for PCPs.

B. Responsibility to Ensure Completion of Facility's Discharge Planning Process, Including Member Engagement for All Members, Including Both High and Lower Risk Members.

Contractor must ensure the discharging facility completes a Discharge Planning process that engages Members, Members' parents, legal guardians, or Authorized Representatives, as appropriate, when being discharged from a hospital, institution or facility. Contractor must ensure that the facility's process is consistent with CMS Conditions of Participation, State regulations, and Joint Commission Requirements, as applicable, including as follows:

1) Contractor must ensure the discharging facility focuses on the Member's goals and treatment preferences during the discharge process, and that they are documented in the Medical Record. Contractor must ensure the discharging facility uses a consistent assessment process and/or assessment tools to identify Members who are likely to suffer adverse health consequences upon discharge in the absence of adequate discharge planning.

a) For high-risk Members, Contractor must ensure the facility shares this information with the care manager. Contractor must also ensure the discharging facility has processes and procedures in place to refer Members to ECM or Community Supports as needed.

b) For lower risk Members, Contractor must ensure the hospital has processes and procedures to leverage this assessment to identify Members who may benefit from services and refer

Members to Contractor for high risk TCS, ECM, or Community Supports.

2) For discharge instructions, Contractor must ensure that the Member and their designated caregiver are informed of the continuing health care requirements following discharge from the facility. This information must include, but is not limited to, education and counseling about the Member's medications, including dosing and proper use of medication delivery devices, when applicable. The information must be provided in a culturally and linguistically appropriate format to the Member and caregiver, and must include the opportunity for the caregiver to ask questions about the post-hospital needs of the Member per H & S section 1262.5.

3) For discharge coordination, Contractor must ensure discharging facility has process in place for coordinating care with the following:

a) For Member's designated family caregiver, Contractor must ensure the discharging facility has processes to ensure Member's designated family caregiver is notified of the Member's discharge or transfer to another facility per H&S section 1262.5.

b) For post-discharge Providers, Contractor must ensure discharging facility provides necessary clinical information to the appropriate post-discharge Providers, including the discharge summary per 42 CFR section 482.43.

C. Transitional Care Services for High and Lower Risk Members

1) Contractor must identify every Member undergoing a transition as high risk or lower-risk. For the criteria for high and lower-risk, and detailed requirements for each, refer to the PHM Policy Guide.

2) For Members identified as high risk, Contractor must ensure the Member has a single point of contact for the duration of the transition who is responsible for ensuring a successful transition. If the Member is receiving CCM or ECM, Contractor must ensure that the Member's assigned care manager provides all TCS. The single point of contact is responsible for:

a) Outreach to Member;

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b) Assessing Member's risk for adverse outcomes to inform needed TCS and identify Members that may require ECM, CCM (if not already enrolled), or Community Supports, using the discharging facility data and Member engagement;

c) Reviewing facility discharge summary;

d) Ensuring Member receives appropriate discharge instructions;

e) Ensuring follow up Providers receive appropriate clinical information;

f) Ensuring medication reconciliation is complete post discharge;

g) Ensuring Members with SUD and mental health needs receive treatment for those conditions upon discharge;

h) Ensuring the completion of all recommended follow-up, including any needed specialty or primary care follow-up, any SUD or mental health treatment, or any needed community or home-based services.

3) For Members identified as lower risk, Contractor must, in addition to meeting all general requirements in Paragraphs A and B above:

a) Ensure Member has, at minimum, telephonic access to a dedicated TCS team for at least 30 days from the discharge. The team must:

i. Be able to access the Member's discharge documents to be able to assist Member with questions, including but not limited to medication changes;

ii. Assist Member with any TCS needs identified by Member, including but not limited to access to ambulatory care, appointment scheduling, referrals, arranging Non-Emergency Medical Transport (NEMT);

iii. Provide escalation to meet any TCS needs as needed, including connecting Members with a

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licensed Provider, if necessary; and

iv. Place and coordinate referrals to longer term care management programs such as ECM/CCM, and/or Community Supports for eligible Members at any point in the transition.

b) Ensure Member can access the TCS team through a dedicated phone number as follows:

i. During business hours, Contractor must ensure Members can connect with live TCS team member within no more than one automated phone selection option.

ii. Outside of business hours, Members must be able to be referred to Emergency Services as needed and be able to leave a message. TCS team must respond to Members within one Working Day of message.

iii. Contractor must ensure the Member is notified of the TCS support team and phone line directly, and make best efforts to ensure Member is notified directly within 24 hours of discharge.

c) Ensure Member completes follow-up with ambulatory PCP, Specialist, or advanced practice Provider that has prescribing authority within 30 calendar days to ensure medication reconciliation. For a Member who has not had a visit with their assigned PCP within the last 12 months, ensure the Member completes PCP follow-up in addition to any necessary non-primary care ambulatory visits within 30 calendar days.

d) Use data from discharges to assess and identify Members that may newly qualify for ECM/CCM or Community Supports.

D. Nursing Facility Transitions

1) For diversion from the need for a nursing facility with supports, Contractor must evaluate all Members who have been identified as requiring nursing facility care for Community Supports. This includes the following, as appropriate: short term post-

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hospitalization, recuperative care, and respite services; day habilitation services; Community Supports supporting transitions to home, or a Residential Care Facility for the Elderly/ Adult Residential Facility, and personal care/homemaker services; as well as for ECM, IHSS, and/or waiver programs that may allow the Member to live at home or in alternative settings with support, as aligned with the Member's goals.

2) When transitioning Members to and from SNFs, Contractor must comply with APL 23-004. Contractor must ensure timely Member transitions that do not delay or interrupt any Medically Necessary services or care by meeting the following requirements, at a minimum:

   a) Coordinate with facility discharge planners, care or Case Managers, or social workers to provide case management and Transitional Care Services during all transitions;

   b) Assist Members being discharged or Members' parents, legal guardians, or ARs by evaluating all medical needs and care settings available including, but not limited to, discharge to a home or community setting, and referrals and coordination with IHSS, Community Supports, LTSS, and other HCBS programs;

   c) Maintain contractual requirements for SNFs to share Minimum Data Set (MDS) Section Q, have appropriate systems to import and store MDS Section Q data and incorporate MDS Section Q data into transition assessments;

   d) Ensure all Members being discharged from nursing facilities, have a PCP that can provide follow-up care, as appropriate, and that the discharging facilities have contact information for PCPs;

   e) Ensure Member outpatient appointment(s) or other immediate follow-ups are scheduled prior to discharge;

   f) Verify with facilities or at-home settings that Members arrive safely at the agreed upon care setting and have their medical needs met; and

   g) Follow-up with Members, Members' parents, legal

guardians, or ARs, as appropriate, regarding the new care setting to ensure compliance with Transitional Care Services requirements.

4.3.11 Targeted Case Management Services

A. Contractor must identify the target populations for Targeted Case Management (TCM) programs within their Service Area, and maintain procedures to refer Members to TCM services. If upon notification from DHCS that Members are receiving TCM services Contractor is not already aware of, Contractor must reach out to LGAs to coordinate care, as appropriate.

B. Contractor must coordinate with LGAs to provide Care Coordination for all Medically Necessary Covered Services identified by TCM Providers in their Member care plans, including referrals and Prior Authorization for out-of-Network medical services. Coordination with LGAs must continue for Members receiving TCM services until the LGA notifies Contractor that TCM services are no longer needed for the Member.

C. Because TCM can be a direct duplication of services such as, but not limited to, Basic PHM, CCM, ECM, and Community Supports, Contractor must have processes to ensure Members receiving TCM are not receiving duplicative services. For specific guidance on ECM overlap with county-based TCM, see the ECM Policy Guide.

D. Contractor must designate a representative responsible for coordinating TCM services with LGAs for the Member. Contractor representative's responsibilities include, but are not limited to, sharing the appropriate Member Provider(s) information and PCP and/or Care Manager assignment with LGAs and resolving all related operational issues.

E. Contractor must also notify Members' PCPs and/or Care Managers when Members are receiving TCM services and provide them with the appropriate LGA contact information.

F. For Members less than 21 years of age, Contractor must ensure that all Medically Necessary services are provided timely as required in Exhibit A, Attachment III, Subsection 5.3.4 (*Services for Members Less Than 21 Years of Age)*. Notwithstanding medical services recommended in TCM care plans or arranged by LGAs or TCM Providers for Members less than 21 years of age, Contractor remains responsible for the provision of the EPSDT benefit, as described in Exhibit A, Attachment III, Section 5.3 (*Scope of Services*).

4.3.12 Mental Health Services

A. Contractor must use DHCS-approved standardized screening tools as identified in APL 22-028 to ensure Members seeking mental health services who are not currently receiving Non-**S**~~s~~pecialty Mental Health Services (NSMHS) or Specialty Mental Health Services (SMHS) receive referrals to the appropriate delivery system for mental health services, either in Contractor's Network or the **Mental Health Plan (**MHP**)** network, in accordance with the No Wrong Door policies set forth in W&I section 14184.402(f) and specified in Exhibit A, Attachment III, Section 5.5 (*Mental Health and Substance Use Disorder Benefits*).

1)~~A.~~ Non-**S**~~s~~pecialty Mental Health Services

a) Contractor must provide timely NSMHS for Members consistent with the No Wrong Door policies even when:

i.~~1)~~ NSMHS were provided:

a.~~a)~~ During the assessment process;

b.~~b)~~ Prior to determination of a diagnosis; or

c.~~c)~~ Prior to determination of whether NSMHS criteria set forth in W&I section 14184.402(b)(2) are met;

ii.~~2)~~ NSMHS were not included in a Member's individual treatment plan;

iii.~~3)~~ Member has a co-occurring mental health condition and SUD; or

iv.~~4)~~ NSMHS are provided to a Member concurrently with SMHS, if those services are not duplicative and coordinated between Contractor and the MHP.

2)~~B.~~ Specialty Mental Health Services

a~~1~~) Contractor must maintain policies and procedures to refer Members who meet the criteria for SMHS to the MHP in accordance with the No Wrong Door policies.

b~~2~~) Contractor must also enter into a MOU with the MHP in accordance with Exhibit A, Attachment III, Subsection 5.6.1 (*MOU Purpose*) to ensure services for its Members are properly coordinated and provided in a timely and non-duplicative manner.

c~~3~~) If a Member receiving NSMHS is determined to meet the criteria for SMHS due to a change in the Member's condition, Contractor must use DHCS-approved standardized transition tools in accordance with Exhibit A, Attachment III, Subsection 5.5.2 (*Non-**S**~~s~~pecialty Mental Health Services and Substance Use Disorder Services*), and continue to provide NSMHS to the Member concurrently receiving SMHS when those services are not duplicative and coordinated between Contractor and the MHP.

3)~~C.~~ Mental Health Services Disputes

a~~1~~) Disputes between Contractor and MHP must not delay the provision of Medically Necessary services by Contractor or MHP.

b~~2~~) If Contractor and MHP cannot agree on the appropriate place of care, disputes must be resolved pursuant to APL 21-013, and as specified in Exhibit A, Attachment III, Subsection 5.5.5 (*Mental Health and Substance Use Disorder Services Disputes*). Specifically, as set forth in APL 21-013, Contractor and MHPs must complete the plan level dispute resolution process within 15 Working Days of identifying the dispute.

c~~3~~) Contractor and MHP may seek to enter into an expedited dispute resolution process if a Member has not received a disputed service(s) and Contractor and/or MHP determine that the routine dispute resolution process timeframe would result in serious jeopardy to the Member's life, health, or ability to attain, maintain, or regain maximum function. Under this expedited process, Contractor and MHP will have one Working Day after identification of a dispute to attempt to resolve the dispute at the plan level. All terms and requirements established in APL 21-013 apply to disputes between Contractor and MHP.

B. Contractor must create and update annually both a Member and Primary Care Provider (PCP) Non-Specialty Mental Health Services (NSMHS) Outreach and Education Plan, as specified by APL 24-012. Contractor must publicly post on their website the DHCS approved NSMHS outreach and education plans and utilization assessment annually.

4.3.13 Alcohol and Substance Use Disorder Treatment Services

A. Contractor must identify and refer Members requiring alcohol and/or SUD treatment services to the County Department responsible for alcohol and SUD treatment, other community resources when services are not available through the County Department, or to outpatient heroin and other opioid detoxification Providers available through the Medi-Cal Fee-For-Service (FFS), as appropriate. Contractor must assist Members in locating available treatment service sites. To the extent that alcohol and/or SUD treatment services are not available within Contractor's Service Area, Contractor must coordinate with the County Department responsible for SUD treatment to refer Members to available treatment outside of Contractor's Service Area.

B. Contractor must have MOUs with each County Department responsible for alcohol and SUD treatment services within Contractor's Service Area in accordance with the MOU requirements in Exhibit A, Attachment III, Section 5.6 (*MOUs with Local Government Agencies, County Programs, and Third Parties*). The MOU must delineate the roles and responsibilities between Contractor and County Departments for coordinating care, and ensuring non-duplication of services and timeliness of care for the Members.

C. For Members receiving alcohol and SUD treatment services through County Departments, Contractor must continue to provide all Medically Necessary Covered Services and coordination and referral of services between its Network Providers and other treatment programs for the Member.

D. Prescribing and medication management of buprenorphine and other prescribed medications for SUD treatment (also known as medication-assisted treatment or MAT) are the responsibility of Contractor when they are provided in Primary Care offices, departments, hospitals, or other contracted medical facilities.

E. Contractor must enter into a data sharing agreement with the County Department responsible for alcohol and SUD treatment, other community

resources when services are not available through the County Department, or to outpatient opioid disorder treatment. Contractor's data sharing agreement with such County Departments must also require such County Departments, and all Part 2 programs contracting with such County Departments that provide services to Members, to use authorization forms that align with DHCS data sharing and authorization guidance for the disclosure of information that
provide the following:

1) Comply with 42 CFR part 2;

2) Name both Contractor and DHCS as potential recipients of the data being disclosed;

3) Indicate that Contractor and DHCS are permitted to use such data for payment and health care operations purposes, as defined by HIPAA; and

4) If 42 CFR Part 2 is modified to permit such a practice, include a statement indicating that any information disclosed to a covered entity or business associate may be redisclosed to the extent permitted by the HIPAA privacy rule, except for uses and disclosures for civil, criminal, administrative, and legislative proceedings against the patient.

4.3.14 California Children's Services

A. Notwithstanding any other provisions in W&I section 14094.4 *et seq*. for Contractors operating in COHS counties, Contractor must maintain policies and procedures to identify and refer Members with a potential California Children's Services (CCS)-Eligible Conditions to the local CCS Program for determination of CCS eligibility. These policies and procedures must include the following, at a minimum:

1) The requirement that Network Providers complete the appropriate baseline health assessments and diagnostic evaluations, which provide sufficient clinical detail to establish, or raise a reasonable suspicion, that a Member has a potential CCS-Eligible Condition;

2) The requirement that Contractor supports CCS program referral pathways in the non-Whole Child Model counties including but not limited to identifying children who may be eligible for the CCS program through internal reports, Provider directed referrals, or direct referrals from Contractor;

3) Instruct Network Providers that CCS reimburses only CCS-paneled Providers and CCS-approved hospitals within Contractor's Network, and that reimbursement is only from the date of referral;

4) The requirement that Network Providers complete the initial referrals of Members with suspected CCS-Eligible Conditions same day using modalities accepted by the local CCS Program. The initial referral must be followed by submission of supporting medical documentation sufficient to allow for CCS eligibility determination by the local CCS Program;

5) Instruct Network Providers of their requirement to continue to provide all Covered Services to the Member until CCS Program eligibility is confirmed;

6) The requirement that once eligibility for the CCS Program is established for a Member, Contractor must continue to provide all Covered Services that are not authorized by CCS Program and must ensure the coordination of services and joint case management between the Member's PCP, CCS Providers, and the local CCS Program. Contractor must continue to provide case management services to ensure all Covered Services authorized through the CCS Program are provided timely as required in Exhibit A, Attachment III, Subsection 5.3.4 (*Services for Members Less Than 21 Years of Age*). Without limitation, Contractor must, as necessary, including upon a Member's request, arrange for all in-home nursing hours authorized by the CCS Program that a Member desires to utilize, as required by APL 20-012; and

7) The requirement that Contractor ensure all Medically Necessary Covered Services are provided to the Member if the local CCS Program does not approve CCS Program eligibility. If the local CCS Program denies authorization for any service, Contractor remains responsible for providing and reimbursing for the cost of the ser vice if it is determined to be Medically Necessary.

B. Authorization for payment must be retroactive to the date the CCS Program was informed about the Member through an initial referral by Contractor or a Network Provider. In an emergency admission, Contractor or a Network Provider must be allowed until the next Working Day to inform the CCS Program about the Member.

C. Contractor must maintain policies and procedures for identifying CCS-eligible Members that are aging out of the CCS Program. Within 12

months of a CCS Member aging out of the program, Contractor must develop a Care Coordination plan to assist the Member in transitioning out of the CCS Program. The policies and procedures must include, the following, at a minimum:

1) Identifying the Member's CCS-Eligible Condition; and any other programs the Member may be eligible for based upon their CCS eligible condition;

2) Planning for the needs of the Member to transition from the CCS Program;

3) A communication plan with the Member in advance of the transition;

4) Identification and coordination of Primary Care and specialty care Providers appropriate to the Member's CCS-Eligible Condition(s); and

5) Continued assessment of the Member through first 12 months of the transition.

D. Contractor must have Memorandums of Understanding (MOUs) with each CCS Program within its Service Area that are in accordance with the MOU requirements in Exhibit A, Attachment III, Section 5.6 (*MOUs with Local Government Agencies, County Programs, and Third Parties*). The MOU must delineate the roles and responsibilities of Contractor and the CCS Program for coordinating care and ensuring the non-duplication of services.

4.3.15 Services for Persons with Developmental Disabilities

A. Contractor must maintain policies and procedures for identifying and tracking Members with Developmental Disabilities (DD), including all services they receive.

B. Contractor must designate its own liaison to coordinate with each RC operating within Contractor's Service Area to assist Members with DD in understanding and accessing services, and to act as a central point of contact for questions, access and care concerns, and problem resolution, as required by W&I section 14182(c)(10).

C. Contractor must refer Members with DD to a RC for evaluation and for access to non-medical services provided by the RC, including, but not

limited to, respite, out-of-home placement, and supportive living. Contractor must have an MOU in place as required in Exhibit A, Attachment III, Section 5.6 (*MOUs with Local Government Agencies, County Programs, and Third Parties*) to coordinate services for the Member with RC staff to ensure the non-duplication services and to create the individual developmental services plan required for all Members with DD, which includes identification of the Member's medical needs and the provision of Medically Necessary services such as medical care, NSMHS, and Behavioral Health Treatment (BHT).

D. Contractor must maintain policies and procedures to identify and refer eligible Members to the HCBS program administered by the Department of Developmental Services (DDS).

E. Contractor must refer to Exhibit A, Attachment III, Subsection 4.3.20 (*Home and Community-Based Services Programs*) for further coordination of care requirements related to providing HCBS programs through the HCBS-DD Waiver.

4.3.16 School-Based Services

A. Contractor must **negotiate in good faith and execute** ~~have an~~MOU**s** with all LEAs **and/or County Office of Education, as applicable, if agreed to by all stakeholders involved,** in its Service Area in accordance with Exhibit A, Attachment III, Section 5.6 (*MOUs with Third Parties*) to ensure there are processes that account for facilitating cooperation and collaboration between the Member's PCP and the LEA in the development of the Member's Individualized Education Plan (IEP) or the IFSP. Contractor must provide case management and Care Coordination to the Member, or the parent, legal guardian, or AR, to ensure the provision of all Medically Necessary Covered Services identified in the IEP developed by the LEA, with PCP participation.

B. Contractor must cover Medically Necessary mental health and SUD services as specified by DHCS when delivered by school-linked behavioral health providers to a Member who is 25 years of age or younger. Contractor must cover these services in accordance with DHCS guidance related to the Children and Youth Behavioral Initiative (CYBHI) and at the DHCS established fee schedule Contractor must execute agreements in accordance with DHCS guidance and in accordance with H&S section 1374.722 and W&I section 5963.4(c).

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C. By 2025, Contractor is required to provide Covered Services, including preventive services and adolescent health services provided in schools or by school-affiliated health providers.

D. Contractor must implement interventions that increase access to preventive, early intervention, and Behavioral Health Services by school-affiliated Behavioral Health Providers for Children in publicly funded childcare and preschool, and TK-12 Children in public schools, in accordance with the interventions, goals, and metrics set forth in W&I section 5961.3(b).

4.3.17 Dental

A. Contractor must cover and ensure that dental screenings and oral health assessments are included for all Members. Contractor must ensure that all Members are given referrals to appropriate Medi-Cal dental Providers. Contractor must provide Medically Necessary Federally Required Adult Dental Services (FRADS), fluoride varnish, and dental services that may be performed by a medical professional. Dental services that are exclusively provided by dental Providers are not covered under this Contract.

B. For Members less than 21 years of age, Contractor must ensure that a dental screening and an oral health assessment are performed as part of every periodic assessment, with annual dental referrals beginning with the eruption of the Member's first tooth or at 12 months of age, whichever occurs first.

C. Contractor must ensure the provision of Medically Necessary dental-related Covered Services that are not exclusively provided by dentists or dental anesthetists. Contractor must also have an identified Contractor liaison available to Medi-Cal dental Providers to assist with referring the Member to other Covered Services. Other Covered Services include, but are not limited to laboratory services, and pre-admission physical examinations required for admission to an outpatient surgical service center, or an in-patient hospitalization required for a dental procedure (including facility fees and anesthesia services for both inpatient and outpatient services). Contractor may require Prior Authorization for Medically Necessary Covered Services needed in support of dental procedures.

If Contractor requires Prior Authorization in support of dental procedures, Contractor must develop and publish the policies and procedures for obtaining Prior Authorization for dental services to ensure that services

are provided to the Member in a timely manner. Contractor must coordinate with DHCS Medi-Cal Dental Services Division in the development of their policies and procedures pertaining to Prior Authorization for dental services and must submit such policies and procedures to DHCS for review and approval.

4.3.18 Direct Observed Therapy for Treatment of Tuberculosis

Contractor must assess the risk of treatment resistance or noncompliance with drug therapy for each Member who requires placement on anti-tuberculosis drug therapy.

A. The following groups are at risk for treatment resistance or noncompliance for the treatment of Tuberculosis (TB):

1) Members with demonstrated resistance to Isoniazid and Rifampin;

2) Members whose treatment has failed or who have relapsed after completing a prior regimen;

3) Substance users;

4) Members with mental health conditions or SUD;

5) Elderly, Children and adolescent Members;

6) Members with unmet housing needs;

7) Members with language and/or cultural barriers; and

8) Members who have demonstrated noncompliance by failing to keep office appointments.

B. Contractor must refer Members with active TB and Members who have treatment resistance or non-compliance issue risks to the TB control officer of the LHD for Direct Observed Therapy (DOT). If a Provider finds that a Member is at risk for treatment resistance or noncompliance with treatment, Contractor must refer the Member to the LHD for DOT.

C. Contractor must have an MOU in place as required in Exhibit A, Attachment III, Section 5.6 (*MOUs with Local Government Agencies, County Programs, and Third Parties*) to ensure joint case management and Care Coordination with the LHD TB Control Officer. Contractor must

provide all Medically Necessary Covered Services to Members with TB on DOT.

4.3.19 Women, Infants, and Children Supplemental Nutrition Program

A. Women, Infants, and Children (WIC) services are not covered under this Contract. However, Contractor must maintain procedures to identify and refer eligible Members for WIC services. Contractor must also have an MOU in place as required in Exhibit A, Attachment III, Section 5.6 (*MOUs with Local Government Agencies, County Programs, and Third Parties*) to ensure referrals. As part of the referral process, Contractor must provide the WIC program with the Member's current hemoglobin or hematocrit laboratory value. Contractor must also document the laboratory values and the referral in the Member's Medical Record.

B. Contractor must refer, and document the referral of, Members who are pregnant, breastfeeding, or postpartum, or a legal guardian for a Member under the age of five, to the WIC program either as part of the initial evaluation of newly pregnant women pursuant to 42 CFR section 431.635(c) and PL 98-010.

4.3.20 Home and Community-Based Services Programs

A. DHCS administers, either directly or through another State entity, a number of Medi-Cal Home and Community-Based Services (HCBS) programs authorized under the Medi-Cal program. HCBS programs provide long-term community-based services and supports to eligible Members in the community setting of their choice instead of in an institution.

B. Contractor must continue to provide all Covered Services to a Member when that Member is enrolled in, or applying to enroll in, receiving, or applying to receive an HCBS program other than this Contract. Contractor must continuously collaborate and exchange Member health care and medical information with all third-party entities providing the Member with Medi-Cal HCBS or administering a Medi-Cal-funded HCBS program pursuant to the third-party entity's contractual or legal authority to administer Medi-Cal-funded HCBS programs and/or provide HCBS to the Member. Such third-party entities include, but are not limited to:

1) DHCS;

2) State departments that operate or administer Medi-Cal programs offering HCBS pursuant to legal authority and/or Inter-Agency

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Agreements with DHCS, including but not limited to, the California Department of Social Services; the California Department of Developmental Services, the California Department of Public Health (CDPH), and the California Department of Aging;

3) Home and Community Based Alternatives Waiver agencies;

4) Assisted Living Waiver Care Coordination agencies;

5) RCs;

6) Multipurpose Senior Services Program sites;

7) Medi-Cal Waiver Program agencies; and

8) California Community Transitions lead organizations.

C. Contractor must maintain procedures to identify Members who may benefit from Medi-Cal HCBS programs and refer Members to the third-party entity administrating the HCBS program. The HCBS programs include, but are not limited to HCBS programs authorized under the Social Security Act (SSA) at 42 USC section 1396n(c), the California Medicaid State Plan option authorized under 42 USC section 1396n(k), California Medicaid State Plan HCBS benefits authorized under 42 USC section 1396n(k), and other State and federally-funded Medi-Cal HCBS programs. If the Member is then authorized to receive Medi-Cal-funded HCBS program services, the Member must remain enrolled with Contractor and Contractor must continue to provide all services and benefits covered under this Contract to the Member.

D. Contractor's collaboration with third-party entities providing the Member with HCBS program services or administering a HCBS program pursuant to the third-party entity's contractual or legal authority to administer HCBS programs and/or provide HCBS program services to the Member, must include, but is not limited to:

1) Maintaining staff assigned to coordinate with such third-party entities that is sufficient to assist Members in understanding and accessing HCBS program services, and to act as a central point of contact for questions, access, and Care Coordination concerns.

2) Working in collaboration with such third-party entities' care managers and Providers to coordinate Covered Services, all HCBS program services, and any other relevant medical or supportive

services. Such coordination must include, but is not limited to, the timely exchange of information regarding the Member and their health care needs, services, and efforts to obtain and arrange for the provision of both Medi-Cal and non-Medi-Cal programs pursuant to DHCS guidance to Contractor and HCBS Providers.

3) As contracted delegates of the State, Contractor and such third-party entities administering HCBS programs and/or providing HCBS program services are authorized to share Member information with one another, including PHI/Personal Identifiable Information (PII) in accordance with the Health Insurance Portability and Accountability Act (HIPAA) and Exhibit G of this Contract, because both are under a contract with DHCS, are legally authorized to receive such information, and/or are responsible for administration of the Medi-Cal program, complying with the provisions within their respective Business Associate Agreements with the State, and sharing this information with each other as part of their contractual responsibilities pursuant to and in compliance with 45 CFR sections 164.502(a)(1)(ii), 164.502(a)(3), and 164.506(c).

4.3.21 In-Home Supportive Services

Contractor must maintain policies and procedures for identifying and referring eligible Members to the county IHSS program. Contractor's procedures must address the following requirements, at a minimum:

A. Processes for coordinating with the county IHSS agency that ensures Members do not receive duplicative services through ECM, Community Supports, and other services;

B. Track all Members receiving IHSS and continue coordinating services with the county IHSS agency for Members until IHSS notifies Contractor that IHSS is no longer needed for the Member;

C. Designate a person to serve, as the day-to-day IHSS liaison with county IHSS agency.

1) Contractor, in collaboration with county IHSS agency, must ensure Contractor's IHSS liaison is sufficiently trained on IHSS assessment and referral processes and providers, and how Contractor and Primary Care Providers can support IHSS eligibility applications and coordinate care across IHSS, medical services, and long-term services and supports. This includes training on IHSS referrals for Members in inpatient and Skilled Nursing Facility

settings as a part of Transitional Care Service requirements, to support safe and stable transitions to home and community-based settings.

2) The IHSS liaison functions may be assigned to the LTSS liaison as long as they meet the training requirements and have the expertise to work with the county IHSS liaison.

D. Outreach and coordinate with the county IHSS agency for any Members identified by DHCS as receiving IHSS;

E. Upon identifying Members receiving, referred to, or approved for IHSS, conduct a reassessment of Members' Risk Tier, per the population RSS and Risk Tiering requirements in this Section; and

F. Continue to provide Basic PHM and Care Coordination of all Medically Necessary services while Members receive IHSS.

4.3.22 Indian Health Care Providers

Contractor must have an identified tribal liaison dedicated to working with each Indian Health Care Provider (IHCP) in its Service Area and responsible for coordinating referrals and payment for services provided to Indian Members who are qualified to receive services from an IHCP, in accordance with the requirements in Exhibit A, Attachment III, Subsection 3.3.7 (*Federally Qualified Health Center, Rural Health Center, and Indian Health Care Provider*).

4.3.23 Justice Involved Reentry Coordination

Contractor must maintain policies and procedures for coordinating with Correctional Facilities and pre-release care managers in order to support Members who are leaving a Correctional Facility and reentering the community. Such policies and procedures must include all requirements as detailed in the Policy and Operational Guide for Planning and Implementing CalAIM Justice-Involved Initiative, including:

A. A designated Justice Involved liaison, as required in Exhibit A, Attachment III, Subsection 4.3.24 (*Managed Care Liaisons*);

B. Assigning ECM Providers to serve as pre-release care managers and/or as post-release ECM Providers for Justice Involved Individuals;

C. Coordinating the Member's transition from the pre-release to the post-release period, including any needed data sharing; and

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D. Ensuring the provision of any Medically Necessary Covered Services including ECM, physical and behavioral health services, Community Supports, NEMT, and Non-Medical Transportation (NMT).

4.3.24 Managed Care Liaisons

Contractor must designate an individual or set of individuals to serve as the day-to-day liaisons for specific services and programs as set forth in the list below to ensure services are closely coordinated with Member's other services and to ensure effective oversight and delivery of services.

Liaisons must receive training on the full spectrum of rules and regulations pertaining to the service they are coordinating, including referral requirements and processes, care management, and authorization processes.

Contractor must notify the other party, for which they are serving as a liaison, of any changes to the liaison as soon as reasonably practical but no later than the date of change and must notify DHCS within five (5) days of the change.

Pursuant to the obligations set forth in this section, Contractor must designate the following liaisons:

A. Tribal liaison as required in Exhibit A, Attachment III, Subsection 4.3.22 (*Indian Health Care Providers*)

B. Long-Term Services and Supports (LTSS) Liaison

LTSS Liaisons must receive training on the rules and regulations pertaining to Medi-Cal covered LTC, including payment and coverage policies; prompt claims payment requirements; Provider resolutions, policies and procedures; and care management, coordination and transition policies.

C. Transportation Liaison

Contractor must have a direct line for Providers and Members to receive real-time assistance directly from Contractor with unresolved transportation issues that can result in missed appointments. The liaison role may not be delegated to a transportation broker. Contractor must also have a process to triage urgent transportation calls when the Member or Provider communicates that they have attempted to work with the broker but the issue remains unresolved and is time sensitive.

D. California Children's Services Liaison

Contractor must have a CCS liaison(s) that serves as the primary point(s) of contact for the coordination of services between Contractor and county CCS Program to ensure the appropriate communication and care coordination are ongoing between the Contractor and county CCS Program, facilitate quarterly meetings, and provide updates to the county CCS Program as appropriate. CCS liaison(s) must receive training on the full spectrum of rules and regulations pertaining to the CCS Program, including referral requirements and processes, annual medical review processes with counties, care management and authorization processes for CCS Children.

E. County Child Welfare Liaison

1) Contractor must designate at least one individual to serve as the county child welfare liaison who will serve as a leader within Contractor to be the point of contact for child welfare departments and be the advocate on behalf of Members involved in county child welfare. Additional county child liaisons must be designated as needed to ensure the needs of Members involved with county child welfare are met.

2) Contractor's county child welfare liaison(s) will follow DHCS-issued standards and expectations as set forth in APLs or other similar instructions. Contractor's county child welfare liaison must:

a) Have expertise in Child welfare services, County Behavioral Health Services.

b) Ensure appropriate ECM staff, including the ECM Lead Care Manager whenever possible, attend meetings of the Child and family teams, in accordance W&I section 16501(a)(4), and ensure Covered services are closely coordinated with other services, including social services and Specialty Mental Health Care Services.

c) Act as a resource to ECM Providers providing services to Child welfare-involved Children and youth, provide technical assistance to Contractor and ECM Provider staff as needed, and serve as a point of escalation for care managers if they face operational obstacles when working with County and community partners.

d) Be sufficiently trained on County Care Coordination and assessment processes.

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e) Provide resources and support to Member's care manager about Medi-Cal managed care plan Enrollment and disenrollment when they are made aware that the Member will move to a different county.

F. Justice Involved Liaison

1) Contractor must have an assigned Justice Involved liaison for justice involved reentry coordination, which may be one individual or multiple identified individuals, and make available information related to the Justice Involved liaison's title, name, contact phone number and email address.

2) The Justice Involved liaison must be available to support Correctional Facilities, pre-release care management Providers, and/or ECM Providers in the reentry planning process as required in Exhibit A, Attachment III, Subsection 4.3.23 (*Justice Involved Reentry Coordination)* and further specified in the Policy and Operational Guide for Planning and Implementing CalAIM Justice Involved Initiative.

G. RC Liaison as required in Exhibit A, Attachment III, Subsection 4.3.15 (*Services for Persons with Developmental Disabilities*)

H. Dental Liaison as required in Exhibit A, Attachment III, Subsection 4.3.17 (*Dental*)

I. IHSS Liaison as required in Exhibit A, Attachment III, Subsection 4.3.21 (*In-Home Support Services*)

Exhibit A, ATTACHMENT III

4.4 Enhanced Care Management

4.4.1 Contractor's Responsibilities for Administration of Enhanced Care Management
4.4.2 Populations of Focus for Enhanced Care Management
4.4.3 Enhanced Care Management Providers
4.4.4 Enhanced Care Management Provider Capacity
4.4.5 Enhanced Care Management Model of Care
4.4.6 Member Identification for Enhanced Care Management
4.4.7 Authorizing Members for Enhanced Care Management
4.4.8 Assignment to an Enhanced Care Management Provider
4.4.9 Initiating Delivery of Enhanced Care Management
4.4.10 Discontinuation of Enhanced Care Management
4.4.11 Core Service Components of Enhanced Care Management
4.4.12 Data System Requirements and Data Sharing to Support Enhanced Care Management
4.4.13 Oversight of Enhanced Care Management Providers
4.4.14 Payment of Enhanced Care Management Providers
4.4.15 Enhanced Care Management Reporting Requirements
4.4.16 Enhanced Care Management Quality and Performance Incentive Program

4.4 Enhanced Care Management

4.4.1 Contractor's Responsibilities for Administration of Enhanced Care Management

A. Contractor must follow all provisions in the Enhanced Care Management (ECM) Policy Guide, in addition to provisions outlined in this Contract.

B. Contractor must take a whole-person approach to offering ECM, ensuring that ECM addresses the clinical and non-clinical needs of high-need and high-cost Members in distinct Populations of Focus **(POF)**, Exhibit A, Attachment III, Subsection 4.4.2 (*Populations of Focus for Enhanced Care Management*), through systematic coordination of services and comprehensive care management.

C. Contractor must ensure ECM is community-based, interdisciplinary, high-touch, and person-centered.

D. Contractor must ensure ECM is available throughout its Service Area.

E. Contractor must ensure ECM is offered primarily through in-person interaction where Members and their family members, legal guardians, Authorized Representatives (ARs), caregivers, and authorized support persons live, seek care, or prefer to access services in their local community. Contractor must ensure its ECM Providers focus on building relationships with Members, and in-person visits may be supplemented with secure teleconferencing and Telehealth, when appropriate and with the Member's consent.

F. In situations where Contractor is performing ECM functions using Contractor's own staff, Contractor must follow the same requirements as an ECM Provider that is a Network Provider or Subcontractor**,** specifically that all such services are community-based, interdisciplinary, high-touch and person-centered. All such situations require DHCS approval through the exemption process and plans must be also making demonstrable progress to moving these ECM functions to community-based providers.

G. Contractor must follow the appropriate processes to ensure Members who may benefit from ECM receive ECM as defined in this Contract.

H. Contractor must ensure ECM provided to each Member encompasses the ECM core service components described in Exhibit A, Attachment III, Subsection 4.4.11 (*Core Service Components of Enhanced Care Management*).

I. Contractor must ensure a Member receiving ECM is not receiving duplicative case management services from other sources, including but not limited to county-specific Targeted Case Management (TCM) services administered by Local Governmental Agencies (LGAs).

J. For Members who are dually eligible for Medicare and Medi-Cal and enrolled in a Medicare Advantage Plan, Contractor must coordinate with the Medicare Advantage Plan for the provision of ECM for those Members.

K. Contractor must develop Member-facing written material about ECM for use across its network of ECM Providers. The written material must be submitted for DHCS review and approval prior to use. This material must include the following, at a minimum:

1) Explain ECM and how a Member may to request it;

2) Maintain a list of ECM Providers as part of its Provider Directory, adherent to requirements established in the ECM Policy Guide;

3) Explain that ECM participation is voluntary and can be discontinued at any time;

4) Explain that the Member must authorize ECM-related data sharing;

5) Describe the process by which the Member may choose a different ECM Lead Care Manager or ECM Provider; and

6) Meet standards for culturally and linguistically appropriate communication Exhibit A, Attachment III, Subsection 5.2.11 (*Cultural and Linguistic Programs and Committees*) and in Exhibit A, Attachment III, Subsection 5.1.3 (*Member Information*).

4.4.2 Populations of Focus for Enhanced Care Management

A. Subject to the phase-in and Member transition requirements described in Exhibit A, Attachment III, Subsection 4.4.6 (*Member Identification for Enhanced Care Management*).

B. Contractor must provide ECM to Members that meet the eligibility criteria for at least one of the following ~~Populations of Focus~~**POF**, as described in the ECM Policy Guide:

1) Members experiencing homelessness

a) Members without dependent Children/youth living with them experiencing homelessness; and

b) Homeless families or unaccompanied Children/youth experiencing homelessness.

2) Members at risk for avoidable hospital or emergency department utilization;

3) Members with serious mental health and/or Substance Use Disorder (SUD) needs;

4) Members transitioning from incarceration;

5) Adult Members living in the community and at risk for Long-Term Care (LTC) institutionalization;

6) A Member residing in an adult nursing facility transitioning to the community;

7) Children enrolled in California Children's Services (CCS) or CCS Whole Child Model (WCM) with additional needs beyond the CCS condition;

8) Children involved in Child welfare; and

9) Birth equity ~~population of focus~~**POF**.

C. Contractor may offer ECM to Members who do not meet ~~Population of Focus~~**POF** criteria in full but may benefit from ECM.

D. Contractor must follow all applicable DHCS policies and guidance, including All Plan Letters (APLs) and the ECM Policy Guide, that further define the approach to ECM for each ~~Population of Focus~~**POF**, including the eligibility criteria for each ~~Population of Focus~~**POF** and the phase-in timeline for ~~Populations of Focus~~**POF**, and the JI Policy and Operations guide, that further define the approach to ECM for the Justice Involved ~~Population of Focus~~**POF**.

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:

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a) Multipurpose Senior Services Program (MSSP);

b) Assisted Living Waiver (ALW);

c) Home and Community-Based Alternatives (HCBA) Waiver;

d) Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) Waiver;

e) HCBS programs for Individuals with Developmental Disabilities (DD); and

f) Self-Determination Program for Individuals with intellectual and DD.

2) Fully integrated programs for Members dually eligible for Medicare and Medicaid including:

a) Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs);

b) Program for All-Inclusive Care for the Elderly (PACE);

c) Exclusively Aligned Enrollment (EAE) Dual Special Needs Plans (D-SNPs); and

d) Non EAE D-SNPs.

3) California Community Transitions (CCT) Money Follows the Person (MFTP)

4) Complex Care Management (CCM)

4.4.3 Enhanced Care Management Providers

A. Contractor must ensure ECM is provided primarily through in-person interaction in settings that are most appropriate for the Member, such as where the Member lives, seeks care, or prefers to access services in their local community.

B. ECM Providers may include, but are not limited to, the following entities:

1) Counties;

2) County Behavioral Health Providers;

3) Primary Care Provider (PCP) or Specialist or Physician groups;

4) Federally Qualified Health Centers (FQHCs);

5) Community health centers;

6) Community-based organizations;

7) Hospitals or hospital-based Physician groups or clinics (including public hospitals or district or municipal public hospitals);

8) Rural Health Clinics (RHCs) or Indian Health Care Providers (IHCP);

9) Local Health Departments (LHDs);

10) Behavioral Health entities;

11) Community mental health centers;

12) SUD treatment Providers;

13) Community Health Workers (CHW);

14) Organizations serving individuals experiencing homelessness;

15) Organizations serving justice-involved individuals;

16) CCS Providers; and

17) Other qualified Providers or entities that are not listed above, as approved by DHCS.

C. For the ~~Population of Focus~~**POF** for eligible individuals with Serious Mental Illness (SMI) or SUD and the ~~Population of Focus~~**POF** for eligible individuals with Contractor must prioritize county Behavioral Health staff or Behavioral Health Providers to serve in the ECM Provider role, provided they agree and are able to coordinate all services needed by those ~~Populations of Focus~~**POF**, not just their Behavioral Health Services.

D. Contractor must attempt to contract with each IHCP as set forth in 22 CCR sections 55110 through 55180 to provide ECM, when applicable, as

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described in Exhibit A, Attachment III, Subsection 3.3.7 (*Federally Qualified Health Center, Rural Health Center, and Indian Health Care Provider*).

E. Contractor must ensure ECM Providers meet the requirements set forth in APLs including but not limited to the requirements regarding the use of a care management documentation system.

F. Care management documentation systems may include certified electronic health record technology, or other documentation tools that can:

1) Document Member goals and goal attainment status;

2) Develop and assign care team tasks;

3) Define and support Member Care Coordination and Care Management needs; and

4) Gather information from other sources to identify Member needs and support care team coordination and communication; and support notifications regarding Member health status and transitions in care (e.g., discharges from a hospital, LTC facility, housing status).

G. Contractor must also comply with requirements on data exchange pursuant to Exhibit A, Attachment III, Subsection 4.4.12 (*Data System Requirements and Data Sharing to Support Enhanced Care Management*).

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

I. Contractor must not require eligible ECM Providers to be National Committee for Quality Assurance (NCQA) certified or accredited as a condition of entering into a Subcontractor Agreement or Network Provider Agreement, as appropriate.

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

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

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

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

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

4.4.4 Enhanced Care Management Provider Capacity

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

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

C. Contractor must meet DHCS' requirements regarding ECM Provider capacity separately from general Network adequacy; ECM Provider capacity does not alter the general Network adequacy provisions in Exhibit A, Attachment III, Section 5.2 (*Network and Access to Care*).

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

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

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

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

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

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

4) ECM Providers are unwilling to contract;

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

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

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

G. During an exception period approved by DHCS, Contractor must take steps to continually develop and increase its ECM Network capacity. After the expiration of an exception period, Contractor must submit a new

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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 **POF**~~Populations of Focus~~ in a community-based manner may result in imposition of Corrective Action proceedings, and may result in sanctions pursuant to Exhibit E, Section 1.19 (*Sanctions*).

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

4.4.5 Enhanced Care Management Model of Care

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

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

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

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

4.4.6 Member Identification for Enhanced Care Management

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

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

1) Members' health care utilization;

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

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

4) Long-Term Services and Supports needs.

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

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

a) Enrollment data;

b) Encounter Data;

c) Utilization/claims data;

d) Pharmacy data;

e) Laboratory data;

f) Screening or assessment data;

g) Clinical information on physical and Behavioral Health;

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

i) Risk stratification information for Children in County Organized Health System (COHS) counties with WCM programs;

j) Information about Social Drivers of Health, including standardized assessment tools including Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) and International Classification of Diseases, Tenth Revision (ICD-10) codes;

k) Results from any available Adverse Childhood Experience (ACE) screening; and

l) Other cross-sector data and information, including housing, social services, foster care, criminal justice history, and other information relevant to the ECM **POF**~~Populations of Focus~~ (e.g., Homeless Management Information System (HMIS), available data from the education system).

2) Receipt of requests from ECM Providers and other Providers or community-based entities.

a) Contractor must accept requests for ECM on behalf of Members from:

i. ECM Providers;

ii. Social service or other Providers; and

iii. Community-based entities, including those contracted to provide Community Supports, as described in Exhibit A, Attachment III, Subsection 4.5.3 (*Community Supports Providers)*.

b) Contractor must update its ECM referral forms and tools to reflect requirements in the *ECM Referral Standards and Form Templates.*

c) Contractor must not require nor request community partners or ECM Providers to submit supplemental eligibility checklists, outreach authorization forms, ICD-10 codes, additional proof of homelessness, Treatment Authorization Request (TAR) forms, or other supplemental information beyond the information

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provided in the ECM Referral Standards to confirm eligibility and authorize ECM.

d~~b~~) Contractor must designate an email and dedicated phone number that is widely available by which referrals can be made.

e~~c~~) Contractor must directly engage with and provide training to Network Providers, Subcontractors, Downstream Subcontractors, and county agencies to inform these entities of ECM, the ECM **POF**~~Populations of Focus~~, and how to request ECM for Members, with the goal of having the majority of ECM eligible Member referrals coming from Providers and community sources, rather than Contractor identification.

f~~d~~) Contractor must encourage ECM Providers to identify Members who meet the criteria for the ECM **POF**~~Populations of Focus~~, and must **use *ECM Referral Standards and Form Templates* to receive referral requests from** ~~develop a process for receiving and responding to requests from~~ ECM Providers.

3) Requests from Members

a) Contractor must have a process for allowing Members to request ECM and for Members' parents, family members, legal guardians, ARs, caregivers, and authorized support persons to request ECM on a Member's behalf.

b) Contractor must provide information to Members regarding the Member initiated ECM request and approval process.

4) For pre-release services under the Justice Involved Reentry Initiative, Contractor must have processes that:

a) Identify any Member who received pre-release services for presumptive eligibility and enrollment in ECM, including using the JI aid code for enrolled Members.

b) Receive notifications of pre-release services from Correctional Facilities or their contracted pre-release care managers through their JI liaison.

c) Receive notifications from the ECM Provider who is acting as the pre-release care manager or who has received a warm handoff.

4.4.7 Authorizing Members for Enhanced Care Management

A. Contractor must authorize ECM for each eligible Member identified through any of the pathways described in Exhibit A, Attachment III, Subsection 4.4.6 (*Member Identification for Enhanced Care Management*). If a Member meets ECM **POF**~~Population of Focus~~ eligibility requirements, Contractor must authorize ECM without additional requirements.

B. Contractor must develop policies and procedures that explain how it will authorize ECM for eligible Members in an equitable and non-discriminatory manner.

C. For requests from Providers and other external entities, Members, Member's parent, family member, legal guardian, AR, caregiver, or authorized support person:

1) Contractor must ensure that authorization or a decision not to authorize ECM occurs as soon as possible and in accordance with Exhibit A, Attachment III, Subsection 2.3.2 (*Timeframes for Medical Authorization*) and APL 21-011;

2) If Contractor does not authorize ECM, Contractor must ensure the Member and the requesting individual or entity who requested ECM on a Member's behalf, as applicable, are informed of the Member's right to Appeal and the Appeals process by way of the Notice of Action (NOA) process as described in Exhibit A, Attachment III, Subsection 5.1.5 (*Notices of Action for Denial, Deferral, or Modification of Prior Authorization Requests*), and Exhibit A, Attachment III, Section 4.6 (*Member Grievance and Appeal System*) and APL 21-011; and

3) Contractor must follow its standard Grievances and Appeals process outlined in Exhibit A, Attachment III, Section 4.6 (*Member Grievance and Appeal System*) and APL 21-011.

D. ~~Contractor may collaborate with its ECM Providers to develop a process and identify possible circumstances under which presumptive authorization or preauthorization of ECM may occur, where select ECM Providers may directly authorize ECM for a limited period of time until~~

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~~Contractor authorizes or denies ECM.~~**Contractor must develop policies and procedures to implement ECM Streamlined Authorization in alignment with the *ECM Policy Guide* with in-network ECM Providers serving below specified POF:**

1) Adults and Children Experiencing Homelessness POF: Street Medicine Providers; Community Supports Providers of the Housing Trio Services: Housing Transition Navigation Services, Housing Deposits, and Housing Tenancy and Sustaining Services; County-contracted and County-operated Specialty Behavioral Health Providers.

2) Adults and Children at risk for avoidable hospital or ED Utilization POF: Primary Care Practices.

3) Adults and Children with Serious Mental Health and/or SUD Needs POF: County-contracted and County-operated Specialty Behavioral Health Providers.

4) Adults Living in the Community and At Risk for LTC Institutionalization POF: Community Supports Providers of the Nursing Facility Transition/Diversion to Assisted Living Facilities and Community Transition Services; California Community Transitions (CCT) Lead Organizations.

5) Adult SNF Residents Transitioning to the Community POF: Community Supports Providers of the Nursing Facility Transition/Diversion to Assisted Living Facilities and Community Transition Services; California Community Transitions (CCT) Lead Organizations.

6) Children and Youth Enrolled in CCS/CCS WCM POF: CCS Paneled Providers and Local Health Department CCS Programs.

7) Children and Youth Involved in Child Welfare POF: County-Contracted and County-Operated Specialty Behavioral Health Providers; High Fidelity Wraparound Providers; Health Care Program for Children in Foster Care Providers; California Department of Social Services (DSS) Offices; Foster Family Agencies; Transitional Housing Programs for Current and Former Foster Youth.

8) Birth Equity POF: OBGYN Practices; Midwifery Practices; Entities that deliver the following services: Black Infant Health Program, Perinatal Equity Initiative, Indian Health Program, American Indian Maternal Support Services.

E. Contractor must implement ECM Streamlined Authorization arrangements that enable ECM Providers to initiate and be reimbursed for ECM services for a 30 calendar day timeframe. Contractors must allow network ECM Providers under ECM Streamlined Authorization to start billing for ECM services from the date the Member first receives ECM services. In a case where the Contractor subsequently denies the ECM authorization, the Contractor must reimburse the ECM Provider throughout the ECM Streamlined Authorization timeframe up until the end of the day that the Contractor makes an authorization determination and communicates the denial to the ECM Provider. Contractor has two exemptions for requirement for payment in the ECM Streamlined Authorization timeframe:

1) Contractors are not responsible for reimbursing for ECM services for individuals who are not Members of their Managed Care Plan during the time of ECM service delivery.

2) Contractors are not responsible for reimbursing for ECM services in cases when the Contractor determines that a Member has an existing, open ECM authorization with another ECM Provider.

F. Contractors must make Members' ECM authorization statuses accessible to ECM Providers via their Plan Portal or similar online system by January 1, 2025, to support ECM Providers in accessing a Member's existing ECM authorization information to support implementation of ECM Streamlined Authorization requirements.

G~~E~~. Contractor must authorize ECM services for all Members who were found eligible for pre-release services under the CalAIM Justice Involved Reentry Initiative. ECM services are authorized for 12 months per the Policy and Operational Guide for Planning and Implementing CalAIM Justice-Involved Reentry Initiative.

H~~F~~. To inform Members that ECM has been authorized-, Contractor must follow its standard notice process outlined in Exhibit A, Attachment III,

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Subsection 5.1.5 (*Notices of Action for Denial, Deferral, or Modification of Prior Authorization Requests*) and APL 21-011.

4.4.8 Assignment to an Enhanced Care Management Provider

A. Contractor must assign every Member authorized for ECM to an ECM Provider. Contractor may assign Members to Contractor itself only with a DHCS-approved exception to the ECM Provider contracting requirement as described in Exhibit A, Attachment III, Subsection 4.4.4 (*Enhanced Care Management Provider Capacity*).

B. Contractor must develop a process to disseminate information of assigned Members to ECM Providers on a regular basis.

C. Contractor must ensure communication of Member Assignment to the designated ECM Provider occurs within ten Working Days of authorization or on an agreed upon schedule.

D. Pursuant to the Policy and Operational Guide for Planning and Implementing CalAIM Justice-Involved Reentry Initiative, for Members eligible for pre-release services under the CalAIM Justice Involved Reentry 1115 Initiative, Contractor must, to the extent possible, assign an ECM Provider that was the pre-release care manager or the care manager who received a warm handoff from the Correctional Facility while the individual was incarcerated.

E. If a Member prefers a specific ECM Provider, Contractor must assign the Member to that Provider, to the extent practicable.

F. If a Member's assigned PCP is a contracted ECM Provider, Contractor must assign the Member to the PCP as the ECM Provider, unless the Member indicates otherwise or Contractor identifies a more appropriate ECM Provider given the Member's individual needs and health conditions.

G. If a Member receives services from a MHP for SED, SUD, or SMI and the Member's Behavioral Health Provider is a contracted ECM Provider, Contractor must assign that Member to that Behavioral Health Provider as the ECM Provider, unless the Member indicates otherwise or Contractor identifies a more appropriate ECM Provider given the Member's individual needs and health conditions.

H. If a Member is enrolled in CCS and the Member's CCS Case Manager is Affiliated with a contracted ECM Provider, Contractor must assign that Member to that CCS Case Manager as the ECM Provider, unless the

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Member or parent, legal guardian, or AR has indicated otherwise or Contractor identifies a more appropriate ECM Provider given the Member's individual needs and health conditions.

I. Contractor must notify the Member's PCP, if different from the ECM Provider, of the assignment to the ECM Provider, within ten Working Days of the date of assignment.

J. Contractor must document the Member's ECM Lead Care Manager in its system of record.

K. Contractor must permit Members to change ECM Providers at any time. Contractor must implement any Member's request to change their ECM Provider within 30 calendar days to the extent practicable.

4.4.9 Initiating Delivery of Enhanced Care Management

A. Contractor must not require Member authorization for ECM-related data sharing (whether in writing or otherwise) as a condition of initiating delivery of ECM, unless such authorization is required by federal law.

B. Contractor must develop policies and procedures for its network of ECM Providers that meet the following requirements, including but not limited to:

1) Where required by law, ECM Providers must obtain Member's authorization to share information with Contractor and all others involved in the Member's care to maximize the benefits of ECM; and

2) ECM Providers must provide Contractor with Member-level records of any obtained authorizations for ECM-related data sharing as required by federal law and to facilitate ongoing data sharing with Contractor.

C. Contractor must ensure that upon the initiation of ECM, each Member receiving ECM has an ECM Lead Care Manager with responsibility for interacting directly with the Member and the Member's family, legal guardians, ARs, caregivers, and other authorized support persons, as appropriate.

The assigned ECM Lead Care Manager is responsible for engaging with a multi-disciplinary care team to identify any gaps in the Member's care and, at a minimum, ensure effective coordination of all physical health care,

behavioral, developmental, oral health, LTSS, Community Supports, and other services to address Social Drivers of Health, regardless of setting.

D. Contractor must ensure accurate and up-to-date Member-level records related to the provision of ECM services are maintained for Members authorized for ECM.

4.4.10 Discontinuation of Enhanced Care Management

A. Contractor must ensure Members are able to decline or end ECM upon initial outreach and engagement, or at any other time.

B. Contractor must require the ECM Provider to notify Contractor to discontinue ECM for Members when any of the following circumstances are met:

1) The Member has met all care plan goals;

2) The Member is ready to transition to a lower level of care;

3) The Member no longer wishes to receive ECM or is unresponsive or unwilling to engage; or

4) The ECM Provider has not been able to connect with the Member after multiple attempts.

C. Contractor must develop processes to determine if the Member is no longer authorized to receive ECM and, if so, to notify the ECM Provider to initiate discontinuation of services in accordance with the NOA process described in Exhibit A, Attachment III, Subsection 5.1.5 (*Notices of Action for Denial, Deferral, or Modification of Prior Authorization Requests*); Exhibit A, Attachment III, Section 4.6 (*Member Grievance and Appeal System*); and APL 21-011.

D. Contractor must develop processes for transitioning Members from ECM to other levels of care management to provide coordination of ongoing Member needs.

E. Contractor must notify the ECM Provider when ECM has been discontinued by Contractor.

F. Contractor must notify the Member of the discontinuation of the ECM benefit and ensure the Member is informed of their right to Appeal and the Appeals process by way of the NOA process as described in Exhibit A,

Attachment III, Subsection 5.1.5 (*Notices of Action for Denial, Deferral, or Modification of Prior Authorization Requests*), and Exhibit A, Attachment III, Section 4.6 (*Member Grievance and Appeal System*) and APL 21-011.

4.4.11 Core Service Components of Enhanced Care Management

Contractor must ensure all Members receive all of the following seven ECM core service components, as further defined in APLs:

A. Outreach and engagement;

B. Comprehensive assessment and Care Management Plan (CMP);

C. Enhanced coordination of care;

D. Health promotion;

E. Comprehensive transitional care;

F. Member and family supports; and

G. Coordination of and referral to community and social support services.

4.4.12 Data System Requirements and Data Sharing to Support Enhanced Care Management

A. Contractor must have an IT infrastructure and data analytic capabilities to support ECM, including the capabilities to:

1) Consume and use claims and Encounter Data, as well as other data types listed in Exhibit A, Attachment III, Subsection 4.4.6 (*Member Identification for Enhanced Care Management*);

2) Assign Members to ECM Providers;

3) Keep records of Members receiving ECM and authorizations necessary for sharing PHI and PI between Contractor and ECM and other Providers, among ECM Providers and family member(s) and/or support person(s), whether obtained by ECM Provider or by Contractor;

4) Securely share data with ECM Providers and other Providers in support of ECM;

5) Receive, process, and send Encounter Data from ECM Providers to DHCS;

6) Receive and process supplemental reports from ECM Providers;

7) Send ECM supplemental reports to DHCS; and

8) Open, track, and manage referrals to Community Supports Providers.

B. To support ECM, Contractor must follow DHCS guidance on data sharing and provide the following information to all ECM Providers:

1) Member Assignment files, defined as a list of Medi-Cal Members authorized for ECM and assigned to the ECM Provider;

2) Encounter Data and claims data;

3) Physical, behavioral, administrative, and Social Drivers of Health data (e.g., HMIS data) for all Members assigned to the ECM Provider; and

4) Reports of performance on quality measures and metrics, as requested.

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

4.4.13 Oversight of Enhanced Care Management Providers

A. Contractor must perform oversight of ECM Providers, holding them accountable to all ECM requirements contained in this Contract, DHCS policies and guidance, APLs, and Contractor's MOC.

1) Contractor must evaluate the prospective Subcontractor's and Downstream Subcontractor's ability to perform services as described in Exhibit A, Attachment III, Subsection 3.1.4 (*Contractor's Duty to Ensure Subcontractor, Downstream Subcontractor, and Network Provider Compliance*);

2) Contractor must ensure the Subcontractor's and Downstream Subcontractor's capacity is sufficient to serve all **POF**~~Populations of Focus~~;

3) Contractor must report to DHCS the names of all Subcontractors, Network Providers, and Downstream Subcontractors by Subcontractor and Downstream Subcontractor type and service(s) provided, and identify the county or counties in which Members are served as described in Exhibit A, Attachment III, Subsection 3.1.3 (*Contractor's Duty to Disclose All Delegated Relationships and to Submit Delegation Reporting and Compliance Plan*); and

4) Contractor must make all Subcontractor Agreements or Network Provider Agreements, as appropriate, available to DHCS upon request. Such agreements must contain minimum required information specified by DHCS, including method and amount of compensation as described in Exhibit A, Attachment III, Subsection 3.1.5.B (*Subcontractor and Downstream Subcontractor Agreement Requirements*).

B. Contractor may hold ECM Providers responsible for the same reporting requirements as those Contractor has with DHCS to support data collection and reporting.

1) Contractor must not impose mandatory reporting requirements that differ from or are additional to those required for Encounter and supplemental reporting; and

2) Contractor may collaborate with other Medi-Cal Managed Care Health Plans within the same county on oversight of ECM Providers.

C. Contractor must not utilize tools developed or promulgated by NCQA to perform oversight of ECM Providers, unless by mutual consent with the ECM Provider.

D. Contractor must provide ECM training and technical assistance to ECM Providers, including in-person sessions, webinars, or calls, as necessary, in addition to Network Provider training requirements, as applicable, described in Exhibit A, Attachment III, Subsection 3.2.5 (*Network Provider Training).*

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E. Contractor must ensure the Subcontractor Agreement and Downstream Subcontractor Agreement mirrors the requirements set forth in this Contract and in accordance with APLs, as applicable to Subcontractor.

Contractor may collaborate with its Subcontractors and Downstream Subcontractors on the approach to administration of ECM to minimize divergence in how ECM will be implemented between Contractor and its Subcontractors and Downstream Subcontractors, and to ensure a streamlined, seamless experience for ECM Providers and Members.

4.4.14 Payment of Enhanced Care Management Providers

A. Contractor must pay ECM Providers for the provision of ECM in accordance with Subcontractor Agreements or Network Provider Agreements established between Contractor and each ECM Provider.

B. Contractor must ensure that ECM Providers are eligible to receive payment when ECM is initiated for any given Member, as described in Exhibit A, Attachment III, Subsection 4.4.9 (*Initiating Delivery of Enhanced Care Management*).

C. Contractor may tie ECM Provider payments to value, including payment strategies and arrangements that focus on achieving outcomes related to high-quality care and improved health status.

D. Contractor must utilize the claims timeline as described in Exhibit A, Attachment III, Subsection 3.3.5 (*Claims Processing*).

4.4.15 Enhanced Care Management Reporting Requirements

A. Contractor must submit the following data and reports to DHCS to support DHCS' oversight of ECM:

1) Encounter Data:

a) Contractor must submit all ECM Encounter Data to DHCS using national standard specifications and code sets to be defined by DHCS.

b) Contractor must submit to DHCS all Encounter Data for ECM services to its Members, regardless of the number of levels of delegation and/or sub-delegation between Contractor and the ECM Provider.

c) In the event the ECM Provider is unable to submit ECM Encounter Data to Contractor using the national standard specifications and code sets to be defined by DHCS, Contractor is responsible for converting the ECM Provider's Encounter Data information into the national standard specifications and code sets, for submission to DHCS.

2) ECM supplemental reports, on a schedule and in a format to be defined by DHCS.

B. Contractor must track and report to DHCS, on a schedule and in a format specified by DHCS, information about outreach efforts related to Potential Members to be enrolled in ECM.

C. In the event of underperformance by Contractor in relation to its administration of ECM, DHCS may impose sanctions as described in Exhibit E, Section 1.19 (*Sanctions*).

4.4.16 Enhanced Care Management Quality and Performance Incentive Program

A. Contractor must meet all quality management and Quality Improvement requirements in Exhibit A, Attachment III, Section 2.2 (*Quality Improvement and Health Equity Transformation Program (QIHETP)*) and any additional quality requirements set forth in associated guidance from DHCS for ECM.

B. Contractor may participate in a performance incentive program related to building Provider capacity for ECM, related health care quality and outcomes, and other performance milestones and measures, in accordance with APL 23-003 or other technical guidance.

Exhibit A, ATTACHMENT III

4.5 Community Supports

4.5.1 Contractor's Responsibility for Administration of Community Supports
4.5.2 DHCS Pre-Approved Community Supports
4.5.3 Community Supports Providers
4.5.4 Community Supports Provider Capacity
4.5.5 Community Supports Model of Care
4.5.6 Identifying Members for Community Supports
4.5.7 Authorizing Members for Community Supports and Communication of Authorization Status
4.5.8 Referring Members to Community Supports Providers for Community Supports
4.5.9 Data System Requirements and Data Sharing to Support Community Supports
4.5.10 Contractor's Oversight of Community Supports Providers
4.5.11 Delegation of Community Supports Administration to Network Providers, Subcontractors, or Downstream Subcontractors
4.5.12 Payment of Community Supports Providers
4.5.13 Community Supports Reporting Requirements
4.5.14 Community Supports Quality and Performance Incentive Program

4.5 Community Supports

For the purposes of this Section 4.5 (*Community Supports*), "California Medicaid State Plan Covered Service or Setting" means any health service or care environment approved and funded under the California Medicaid State Plan, such as inpatient services, nursing facilities, or home health care.

4.5.1 Contractor's Responsibility for Administration of Community Supports

A. Contractor may provide DHCS pre-approved Community Supports as described in Exhibit A, Attachment III, Subsection 4.5.2 (*DHCS Pre-Approved Community Supports*).

This Section (Section 4.5) refers only to Community Supports that Contractor may choose to offer, unless otherwise specified.

B. In accordance with 42 Code of **F**ederal Regulations (CFR) section 438.3(e)(2), and the Member rights and protections defined within, all applicable All Plan Letters (APLs), and the Community Supports Policy Guide, Contractor may select and offer Community Supports from the list of Community Supports pre-approved by DHCS as medically appropriate and cost-effective substitutes for Covered Services or settings under the California Medicaid State Plan. See Exhibit A, Attachment III, Subsection 4.5.2 (*DHCS Pre-Approved Community Supports*) below for the list.

1) Contractor must ensure medically appropriate California Medicaid State Plan services are available to the Member regardless of whether the Member has been offered Community Supports, is currently receiving Community Supports, or has received Community Supports in the past.

2) Contractor must not require a Member to utilize Community Supports. Members always retain their right to receive the California Medicaid State Plan services on the same terms as would apply if Community Supports was not an option in accordance with regulatory requirements.

3) Contractor must not use Community Supports to reduce, discourage, or jeopardize Members' access to California Medicaid State Plan services.

4) Contractor may submit a request to DHCS to offer Community Supports in addition to the pre-approved Community Supports.

C. With respect to pre-approved Community Supports, Contractor must adhere to DHCS guidance on service definitions, eligible populations, code sets, potential Community Supports Providers, and parameters for each Community Support that Contractor chooses to provide, as referenced in APL 21-017 and the Community Supports Policy Guide.

1) Contractor is not permitted to extend Community Supports to Members beyond those for whom DHCS has determined the Community Supports will be cost-effective and medically appropriate.

2) Contractor may not adopt a more narrowly defined eligible population for Community Supports than outlined in Exhibit A, Attachment III, Subsection 4.5.2 (*DHCS Pre-Approved Community Supports*). That Subsection details (i) the name and definition of each Community Support; (ii) the Covered Services or settings under the California Medicaid State Plan that each Community Support may replace; (iii) the target populations for each Community Support; (iv) Member rights and protections; and (v) the requirement to use State-designated codes in Encounter Data for each Community Support.

D. If Contractor elects to offer one or more pre-approved Community Supports, it need not offer the Community Supports in each county it serves. Contractor must report to DHCS the counties in which it intends to offer the Community Supports. Contractor must provide Community Supports in a county selected by Contractor in accordance with the requirements set forth in Exhibit A, Attachment III, Subsection 4.5.4 (*Community Supports Provider Capacity*).

E. Contractor must identify Members for whom Community Supports will be a medically appropriate alternative to Covered Services, and accept requests for Community Supports from Members and Members' Providers and organizations that serve them, including community-based organizations as described in Exhibit A, Attachment III, Subsection 4.5.6 (*Identifying Members for Community Supports*).

F. Contractor must authorize Community Supports for Members deemed eligible in accordance with Exhibit A, Attachment III, Subsection 4.5.7 (*Authorizing Members for Community Supports and Communication of Authorization Status*).

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

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Supports does not preclude Contractor from offering value-added services.

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

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

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

4.5.2 DHCS Pre-Approved Community Supports

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

1) Housing transition navigation services

a. Housing transition navigation services assist Members with obtaining housing through supports such as a housing assessment, individualized planning, application assistance, and landlord engagement.

b. Members must meet at least one of the following sets of eligibility criteria (i, ii, or iii):

i. Members who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless coordinated entry system or similar system designed to use information to identify highly vulnerable individuals who meet at least one of the following sets of criteria (a, b, c, d, or e):

a. Have disabilities;

b. Have one or more serious chronic conditions;

c. Have a Serious Mental Illness (SMI);

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d. Are at risk of institutionalization or requiring residential services because of a Substance Use Disorder (SUD); or

e. Are exiting incarceration.

ii. Members who meet the United States Department of Housing and Urban Development (HUD) definition of "homeless" as defined in 24 CFR section 91.5 (including those exiting institutions but not including any limits on the number of days in the institution) and who meet at least one of the following sets of criteria (a, b, c, or d):

a. Are receiving Enhanced Care Management (ECM);

b. Have one or more serious chronic conditions;

c. Have a SMI; or

d. Are at risk of institutionalization or requiring residential services as a result of a SUD. Qualifying institutions include hospitals, Correctional Facilities, mental health residential treatment facilities, SUD residential treatment facilities, recovery residences, Institutions for Mental Diseases (IMD), and state hospitals.

iii. Members who meet the HUD definition of "at risk of homelessness" as defined in 24 CFR section 91.5 and have significant barriers to housing stability and meet at least one of the following sets of criteria (a, b, c, d, e, or f):

a. Are receiving ECM;

b. Have one or more serious chronic conditions;

c. Have a SMI;

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d. Are at risk of institutionalization or overdose or are requiring residential services because of a SUD;

e. Have a Serious Emotional Disturbance (SED) (children and adolescents); or

f. Are a transition-age Youth (aged 16 to 25 years) with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, having a SMI, having a SED, or having been a victim of trafficking or domestic violence.

c) Housing transition navigation services may serve as an immediate alternative to a California Medicaid State Plan covered service or setting, or as a replacement over a longer timeframe. Housing transition navigation services may potentially substitute the following California Medicaid State Plan covered services or settings: emergency department services, emergency transport services, inpatient services, outpatient hospital services, outpatient mental health, rehabilitation center outpatient services, Skilled Nursing Facility (SNF) services, and transitional inpatient care services.

d) Contractor must document the Encounter for the housing transition navigation services rendered using the standard Healthcare Common Procedure Coding System (HCPCS) code(s) and associated modifier(s) set by the State, located at https://www.dhcs.ca.gov/Documents/MCQMD/Coding-Options-for-ECM-and-Community-Supports.pdf.

2) Housing deposits

a) Housing deposits assist with identifying, coordinating, securing, or funding one-time services and modifications necessary to enable a Member to establish a basic household that do not constitute room and board, such as first and last month's rent as required by a landlord for occupancy, security deposits, utility set up fees/deposits, or service access and utility arrearages. Housing deposits are available once per California Advancing and Innovating

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Medi-Cal (CalAIM) demonstration period. Once a Member is determined eligible for and authorized for housing deposits, they are authorized to receive the service at any time during a 12-month period from when authorization occurs.

b) Members must meet at least one of the following sets of eligibility criteria (i, ii, or iii):

i. Members who received the housing transition navigation services Community Support in counties that offer housing transition navigation services;

a. While all Members who receive housing transition navigation services are eligible for housing deposits, Contractor must not require that Members receive housing transition navigation services to be eligible for housing deposits.

ii. Members who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless coordinated entry system or similar system designed to use information to identify highly vulnerable individuals who meet at least one of the following sets of criteria (a, b, c, d, or e):

a. Have disabilities;

b. Have one or more serious chronic conditions;

c. Have a SMI;

d. Are at risk of institutionalization or requiring residential services because of a SUD;

e. Are exiting incarceration.

iii. Members who meet the HUD definition of “homeless” as defined in 24 CFR section 91.5 (including those exiting institutions but not including any limits on the

number of days in the institution) and meet at least one of the following sets of criteria (a, b, c, or d):

a. Are receiving ECM;

b. Have one or more serious chronic conditions;

c. Have a SMI; or

d. Are at risk of institutionalization or requiring residential services as a result of a SUD. Qualifying institutions include hospitals, Correctional Facilities, mental health residential treatment facilities, SUD residential treatment facilities, recovery residences, IMDs, and state hospitals.

c) Housing deposits may serve as an immediate alternative to a California Medicaid State Plan covered service or setting, or as a replacement over a longer timeframe. Housing deposits may potentially substitute the following California Medicaid State Plan covered services or settings: emergency department services, emergency transport services, inpatient services, outpatient hospital services, outpatient mental health, rehabilitation center outpatient services, SNF services, and transitional inpatient care services.

d) Contractor must document the Encounter for housing deposit services rendered using the standard HCPCS code(s) and associated modifier(s) set by the State, located at https://www.dhcs.ca.gov/Documents/MCQMD/Coding-Options-for-ECM-and-Community-Supports.pdf.

3) Housing tenancy and sustaining services

a) Housing tenancy and sustaining services provide support to Members in maintaining a safe and stable tenancy once housing is secured. Support may include education on tenant and landlord rights and responsibilities, reducing the risk of eviction, coordinating updates to housing support and

crisis plans, and assistance with lease compliance. Services are available for a single duration in the Member's lifetime.

b) Members must meet at least one of the following sets of eligibility criteria (i, ii, iii, or iv):

i. Any Member who received the housing transition navigation services Community Support in counties that offer housing transition navigation services;

a. While all Members who receive housing transition navigation services are eligible for housing tenancy and sustaining services, Contractor must not require that Members receive housing transition navigation services to be eligible for housing tenancy and sustaining services.

ii. Members who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless coordinated entry system or similar system designed to use information to identify highly vulnerable individuals who meet at least one of the following sets of criteria (a, b, c, d, or, e):

a. Have disabilities;

b. Have one or more serious chronic conditions;

c. Have a SMI;

d. Are at risk of institutionalization or requiring residential services because of a SUD; or

e. Are exiting incarceration.

iii. Members who meet the HUD definition of "homeless" as defined in of 24 CFR section 91.5 (including those exiting institutions but not including any limits on the number of days in the institution) and meet at least one of the following sets of criteria (a, b, c, or d):

a. Are receiving ECM;

b. Have one or more serious chronic conditions;

c. Have a SMI; or

d. Are at risk of institutionalization or requiring residential services as a result of a SUD. Qualifying institutions include hospitals, Correctional Facilities, mental health residential treatment facilities, SUD residential treatment facilities, recovery residences, IMDs, and state hospitals.

iv. Members who meet the HUD definition of "at risk of homelessness" as defined in 24 CFR section 91.5, have significant barriers to housing stability, and meet at least one of the following sets of criteria (a, b, c, d, e, or f):

a. Have one or more serious chronic conditions;

b. Have a SMI;

c. Are at risk of institutionalization or overdose or are requiring residential services because of a SUD;

d. Have a SED (Children and adolescents);

e. Are receiving ECM; or

f. Are a transition-age Youth (aged 16 to 24 years) with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, having a SMI, having a SED, or having been a victim of trafficking or domestic violence.

c) Housing tenancy and sustaining services may serve as an immediate alternative to a California Medicaid State Plan covered service or setting, or as a replacement over a longer timeframe. Housing tenancy and sustaining services may potentially substitute the following California Medicaid State Plan covered services or settings: emergency department

visit, emergency transport services, inpatient services, outpatient hospital services, outpatient mental health, rehabilitation center outpatient services, and transitional inpatient care services.

d) Contractor must document the Encounter for the housing tenancy and sustaining services rendered using the standard HCPCS code(s) and associated modifier(s) set by the State, located at https://www.dhcs.ca.gov/Documents/MCQMD/Coding-Options-for-ECM-and-Community-Supports.pdf.

4) Short-term post-hospitalization housing

a) Short-term post-hospitalization housing provides Members who do not have a residence and who have high medical or behavioral health needs with the opportunity to continue their medical, psychiatric, or SUD recovery immediately after exiting an inpatient acute, psychiatric, or chemical dependency and recovery hospital; residential SUD treatment or recovery facility; residential mental health treatment facility; correctional facility; nursing facility; or recuperative care ~~and to avoid utilization of California Medicaid State Plan covered services or settings~~. Short-term post-hospitalization services are available once in a Member's lifetime and are not to exceed a duration of six months.

b) To receive short-term post-hospitalization services, Members must have medical or behavioral health needs such that experiencing homelessness upon discharge from an inpatient acute, psychiatric, or chemical dependency and recovery hospital; residential SUD treatment or recovery facility; residential mental health treatment facility; correctional facility; nursing facility; or recuperative care would likely result in Emergency Department utilization, hospitalization, ~~-~~or institutional admission. Members must also meet at least one of the following sets of eligibility criteria (i or ii):

i. Members exiting recuperative care; or

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ii. Members exiting an inpatient acute, psychiatric, or chemical dependency and recovery hospital stay; residential SUD treatment or recovery facility; residential mental health treatment facility; correctional facility; or nursing facility and who meet at least one of the following sets of criteria (a or b):

a. Members who meet the HUD definition of "homeless" as defined in 24 CFR section 91.5 (including those exiting institutions but not including any limits on the number of days in the institution) and meet at least one of the following sets of criteria (1, 2, 3, or 4). If exiting an institution, individuals are considered homeless if they were homeless immediately prior to entering that institutional stay, regardless of the length of the institutionalization. The timeframe for an individual or family who will imminently lose housing is extended from fourteen (14) days for individuals considered homeless to thirty (30) days:

1. Are receiving ECM;

2. Have one or more serious chronic conditions; or

3. Have a SMI; or

4. Are at risk of institutionalization or requiring residential services as a result of a SUD. Qualifying institutions include hospitals, Correctional Facilities, mental health residential treatment facilities, SUD residential treatment facilities, recovery residences, IMDs, and state hospitals.

b. Members who meet the HUD definition of "at risk of homelessness" as defined in 24 CFR section 91.5, have significant barriers to

housing stability, and meet at least one of the following sets of criteria (1, 2, 3, 4, 5, or 6):

1. Have one or more serious chronic conditions;

2. Have a SMI;

3. Are at risk of institutionalization or overdose or are requiring residential services because of a SUD;

4. Have a SED (Children and adolescents);

5. Are receiving ECM; or

6. Are a transition-age Youth (aged 16 to 24 years) with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, having a SMI, having a SED, and/or having been a victim of trafficking or domestic violence.

c) Short-term post-hospitalization housing services may serve as an immediate alternative to a California Medicaid State Plan covered service or setting, or as a replacement over a longer timeframe. Short-term post-hospitalization housing services may potentially substitute the following California Medicaid State Plan covered services or settings: emergency department services, emergency transport services, inpatient services, outpatient hospital services, post-acute care, and SNF services.

d) Contractor must document the Encounter for the short-term post-hospitalization housing services rendered using the standard HCPCS code(s) and associated modifier(s) set by the State, located at

https://www.dhcs.ca.gov/Documents/MCQMD/Coding-Options-for-ECM-and-Community-Supports.pdf.

5) Recuperative care (medical respite)

a) Recuperative care, also referred to as medical respite care, is short-term residential care for Members who no longer require hospitalization, but still need to heal from an injury or illness (including behavioral health conditions) and whose condition would be exacerbated by an unstable living environment. Recuperative care or medical respite care is allowable for no more than 90 days in continuous duration. This support does not include funding for building modification or building rehabilitation.

b) Members must meet at least one of the following sets of eligibility criteria (i, ii, iii, iv, or v):

i. Members who are at risk of hospitalization or are post-hospitalization;

ii. Members who live alone with no formal supports;

iii. Members who face housing insecurity or have housing that would jeopardize their health and safety without modification;

iv. Members who meet the HUD definition of “homeless” as defined in 24 CFR section 91.5 (including those exiting institutions but not including any limits on the number of days in the institution) and meet at least one of the following sets of criteria (1, 2, 3, or 4). If exiting an institution, individuals are considered homeless if they were homeless immediately prior to entering that institutional stay, regardless of the length of the institutionalization. The timeframe for an individual or family who will imminently lose housing is extended from fourteen (14) days for individuals considered homeless to thirty (30) days:

1. Are receiving ECM;

2. Have one or more serious chronic conditions;

3. Have a SMI; or

4. Are at risk of institutionalization or requiring residential services as a result of a SUD. Qualifying institutions include hospitals, Correctional Facilities, mental health residential treatment facilities, SUD residential treatment facilities, recovery residences, IMDs, and state hospitals.

v. Members who meet the HUD definition of "at risk of homelessness" as defined in 24 CFR section 91.5, have significant barriers to housing stability, and meet at least one of the following sets of criteria (1, 2, 3, 4, 5, 6, or 7):

1. Have one or more serious chronic conditions;

2. Have a SMI;

3. Are at risk of institutionalization or overdose or are requiring residential services because of a SUD;

4. Have a SED (Children and adolescents);

5. Are receiving ECM;

6. Are a transition-age Youth (aged 16 to 24 years) with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, having a SMI, having a SED, or having been a victim of trafficking or domestic violence; or

7. Are able to transition out of inpatient facility care, SNF care, or other health care facility, and recuperative care is medically appropriate and cost-effective.

c) Recuperative care or medical respite care may serve as an immediate alternative to a California Medicaid State Plan covered service or setting, or as a replacement over a longer

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timeframe. Recuperative care or medical respite care may potentially substitute the following California Medicaid State Plan covered services or settings: emergency department services, emergency transport services, inpatient services, outpatient hospital services, post-acute care, and SNF services.

d) Contractor must document the Encounter for the recuperative care or medical respite care rendered using the standard HCPCS code(s) and associated modifier(s) set by the State, located at https://www.dhcs.ca.gov/Documents/MCQMD/Coding-Options-for-ECM-and-Community-Supports.pdf.

6) Respite services

a) Respite services are provided to caregivers of Members who require intermittent temporary supervision. The services are provided on a short-term basis because of the absence or need for relief of those Members who normally care for or supervise them and are non-medical in nature. Respite services may attend to the Member's basic self-help needs and other Activities of Daily Living (ADL). In the home setting, these services, in combination with any direct care services the Member is receiving, may not exceed 24 hours per day of care. The service limit is up to 336 hours per calendar year. The service is inclusive of all in-home and in-facility services. Contractor can authorize exceptions to the 336 hour per calendar year limit when the caregiver experiences an episode, including medical treatment and hospitalization, that leaves a Member without their caregiver.

b) Members must meet at least one of the following eligibility criteria (i, ii, iii, iv, or v):

i. Members who live in the community and are compromised in their ADLs and are therefore dependent upon a qualified caregiver who provides most of their support, and who require caregiver relief to avoid institutional placement;

ii. Children who previously were covered for respite services under the pediatrics palliative care waiver;

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iii. Foster care program beneficiaries;

iv. Members enrolled in either CCS or the Genetically Handicapped Persons Program (GHPP); or

v. Members with Complex Care Needs, which means the multifaceted health and social support requirements of Members who face significant barriers to achieving and maintaining health and stability. This includes individuals with multiple chronic conditions, functional impairments, behavioral health challenges, or those requiring extensive care coordination due to social determinants of health.

c) Respite services may serve as an immediate alternative to a California Medicaid State Plan covered service or setting, or as a replacement over a longer timeframe. Respite services may potentially substitute the following California Medicaid State Plan covered services or settings: home health agency, home health aide, Intermediate Care Facility (ICF) services, ICF services for the developmentally disabled, ICF services for the developmentally disabled - habilitative, personal care services, SNF stay, and specialized rehabilitative services in SNFs and ICFs.

d) Contractor must document the Encounter for the respite services rendered using the standard HCPCS code(s) and associated modifier(s) set by the State, located at https://www.dhcs.ca.gov/Documents/MCQMD/Coding-Options-for-ECM-and-Community-Supports.pdf.

7) Day habilitation programs

a) Day habilitation programs are provided in a Member's home or an out-of-home, non-facility setting. The programs are designed to assist the Member in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to reside successfully in the Member's natural environment. These services include the use of public transportation and daily living skills (cooking, cleaning, shopping, and money management).

b) Members must meet at least one of the following eligibility criteria (i, ii, or iii):

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i. Members who are experiencing homelessness;

ii. Members who exited homelessness and entered housing in the last 24 months; or

iii. Members at risk of homelessness or institutionalization whose housing stability could be improved through participation in a day habilitation program.

c) Day habilitation programs may serve as an immediate alternative to a California Medicaid State Plan covered service or setting, or as a replacement over a longer timeframe. Day habilitation programs may potentially substitute the following California Medicaid State Plan covered services or settings: emergency department services, occupational therapy, outpatient hospital services, outpatient mental health, rehabilitation center outpatient services, and targeted case management services.

d) Contractor must document the Encounter for the day habilitation program services rendered using the standard HCPCS code(s) and associated modifier(s) set by the State, located at https://www.dhcs.ca.gov/Documents/MCQMD/Coding-Options-for-ECM-and-Community-Supports.pdf.

8) Nursing facility transition / diversion to assisted living facilities

a) Nursing facility transition / diversion services assist Members in transitioning to and living in an assisted living facility and in avoiding institutionalization when possible. These services may include assessing a Member's housing needs and presenting options, assisting in securing a facility residence, assessing the service needs of the Member to determine if the Member needs enhanced services onsite, and coordinating their move. These services also include ongoing assisted living services, such as support with ADLs and Instrumental ADLs (IADLs) as needed, companion services, and mediation oversight, that can be delivered up to 24 hours through direct care staff to meet unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety, and security.

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b) Members must meet at least one of the following eligibility criteria (i or ii):

i. For nursing facility transition:

a. Have resided 60 or more days in a nursing facility;

b. Are willing to live in an assisted living setting as an alternative to a nursing facility; and

c. Are able to reside safely in an assisted living facility with appropriate and cost- effective supports.

ii. For nursing facility diversion:

a. Are interested in remaining in the community;

b. Are willing and able to reside safely in an assisted living facility with appropriate and cost-effective supports and services; and

c. Are currently receiving Medically Necessary nursing facility level of care or meet the minimum criteria to receive nursing facility level of care services and in lieu of going into a facility, is choosing to remain in the community and continue to receive medically necessary nursing facility level of care services at an assisted living facility.

c) Nursing facility transition / diversion services may serve as an immediate alternative to a California Medicaid State Plan covered service or setting, or as a replacement over a longer timeframe. Nursing facility transition / diversion services may potentially substitute the following California Medicaid State Plan services or settings: emergency department visit, inpatient services, ICF services, ICF services for the developmentally disabled, ICF services for the developmentally disabled - habilitative, SNF stay, and specialized rehabilitative services in SNFs and ICFs.

d) Contractor must document the Encounter for the nursing facility transition / diversion services rendered using the standard HCPCS code(s) and associated modifier(s) set by the State, located at https://www.dhcs.ca.gov/Documents/MCQMD/Coding-Options-for-ECM-and-Community-Supports.pdf.

9) Community transition services / nursing facility transition to a home

a) Community transition services / nursing facility transition to a home services support Members with transitional care coordination from a licensed facility to a living arrangement in a private residence where the Member is directly responsible for their own living expenses. This service also covers set-up expenses necessary for a Member to establish a basic household, such as security deposits and utility set-up fees. Non-recurring set-up expenses are payable up to a total lifetime maximum amount of $7,500. The transitional coordination cost is excluded from this total lifetime maximum. These services do not include monthly rental or mortgage expenses, food, regular utility charges, or household appliances or items that are intended for purely diversionary or recreational purposes.

b) Members must meet all of the following sets of eligibility criteria (i, ii, iii, and iv):

i. Are currently receiving medically necessary nursing facility level of care services and, in lieu of remaining in the nursing facility or medical respite setting, is choosing to transition home and continue to receive medically necessary nursing facility level of care services;

ii. Has lived 60+ days in a nursing home and/or medical respite setting;

iii. Are interested in moving back to the community; and

iv. Are able to reside safely in the community with appropriate and cost-effective supports and services.

c) Community transition services / nursing facility transition to a home services may serve as an immediate alternative to a

California Medicaid State Plan covered service or setting, or as a replacement over a longer timeframe. Community transition services / nursing facility transition to a home services may potentially substitute the following California Medicaid State Plan covered services or settings: emergency department services, inpatient services, ICF services, ICF services for the developmentally disabled, ICF services for the developmentally disabled - habilitative, ICF services for the developmentally disabled - nursing, SNF stay, specialized rehabilitative services in SNFs and ICFs.

d) Contractor must document the Encounter for the community transition services / nursing facility transition to a home services rendered using the standard HCPCS code(s) and associated modifier(s) set by the State, located at https://www.dhcs.ca.gov/Documents/MCQMD/Coding-Options-for-ECM-and-Community-Supports.pdf.

10) Personal care and homemaker services

a) Personal care and homemaker services are for Members who need assistance with ADLs such as bathing, dressing, toileting, ambulation, or feeding. Personal care and homemaker services can also include assistance with IADLs, such as meal preparation, grocery shopping, and money management. Contractor cannot utilize these services in lieu of referring to the In-Home Supportive Services (IHSS) program. Contractor must refer Members to the IHSS program when they meet referral criteria.

b) Members must meet at least one of the following sets of eligibility criteria (i, ii, or iii):

i. Members at risk for hospitalization, or institutionalization in a nursing facility;

ii. Members with functional deficits and no other adequate support system; or

iii. Members approved for IHSS. IHSS eligibility criteria can be found at: http://www.cdss.ca.gov/In-Home-Supportive-Services.

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c) Personal care and homemaker services may serve as an immediate alternative to a California Medicaid State Plan covered service or setting, or as a replacement over a longer timeframe. Personal care and homemaker services may potentially substitute the following California Medicaid State Plan covered services or settings: home health agency services, home health aide services, inpatient services, ICF services, ICF services for the developmentally disabled, ICF services for the developmentally disabled - habilitative, SNF stay, and specialized rehabilitative services in SNFs and ICFs.

d) Contractor must document the Encounter for the personal care and homemaker services rendered using the standard HCPCS code(s) and associated modifier(s) set by the State, located at https://www.dhcs.ca.gov/Documents/MCQMD/Coding-Options-for-ECM-and-Community-Supports.pdf.

11) Environmental accessibility adaptations

a) Environmental accessibility adaptations are physical adaptations to a home that are necessary to ensure the health, welfare, and safety of the Member, or enable the Member to function with greater independence in the home, without which the Member would require institutionalization. These services include ramps and grab-bars to assist Members in accessing the home and doorway widening for Members who require a wheelchair.

b) Environmental accessibility adaptations are payable up to a total lifetime maximum of $7,500. The only exceptions to the $7,500 total maximum are if:

i. The Member’s place of residence changes; or

ii. The Member’s condition has changed so significantly that additional modifications are necessary to ensure the health, welfare, and safety of the Member, or are necessary to enable the Member to function with greater independence in the home and avoid institutionalization or hospitalization.

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c) Members at risk for institutionalization in a nursing facility are eligible for environmental accessibility adaptations.

d) Environmental accessibility adaptations may serve as an immediate alternative to a California Medicaid State Plan covered service or setting, or as a replacement over a longer timeframe. Environmental accessibility adaptions may potentially substitute the following California Medicaid State Plan covered services or settings: emergency department services, home health agency services, home health aide services, inpatient services, ICF services, ICF services for the developmentally disabled, ICF services for the developmentally disabled - habilitative, personal care services, SNF stay, and specialized rehabilitative services in SNFs and ICFs.

e) Contractor must document the Encounter for the environmental accessibility adaptations rendered using the standard HCPCS code(s) and associated modifier(s) set by the State, located at https://www.dhcs.ca.gov/Documents/MCQMD/Coding-Options-for-ECM-and-Community-Supports.pdf.

12) Medically tailored meals / medically supportive food

a) Medically tailored meals / medically supportive foods are nutrition interventions to improve the health outcomes of Members. In addition to medically tailored meals, these services may also include medically tailored groceries, food pharmacies, or health food vouchers when paired with nutrition education for Members. Members can receive up to two meals per day and may be authorized for up to 12 weeks and may be reauthorized thereafter if Medically Necessary.

b) To be eligible for medically tailored meals / medically supportive foods, Members must have chronic or other serious health conditions, such as, but not limited to, diabetes, cardiovascular disorders, congestive heart failure, stroke, chronic lung disorders, Human Immunodeficiency Virus (HIV), cancer, gestational diabetes or other high risk perinatal conditions, and chronic or disabling mental or behavioral health disorders.

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c) Medically tailored meals / medically supportive foods may serve as an immediate alternative to a California Medicaid State Plan covered service or setting, or as a replacement over a longer timeframe. Medically tailored meals / medically supportive foods may potentially substitute the following California Medicaid State Plan covered services or settings: emergency department services, emergency transport services, home health agency services, home health aide services, inpatient services, outpatient hospital services, and personal care services.

d) Contractor must document the Encounter for the medically tailored meals / medically supportive food services rendered using the standard HCPCS code(s) and associated modifier(s) set by the State, located at https://www.dhcs.ca.gov/Documents/MCQMD/Coding-Options-for-ECM-and-Community-Supports.pdf.

13) Sobering centers

a) Sobering centers are alternative destinations for Members who are found to be publicly intoxicated (due to alcohol or other drugs) and would otherwise be transported to the emergency department or jail. Sobering centers provide these Members with a safe, supportive environment to become sober and receive support such as rehydration and food service and treatment for nausea. This service is covered for a duration of less than 24 hours.

b) Members must meet all of the following sets of eligibility criteria (i, ii, and iii):

i) Are age 18 or older;

ii) Are intoxicated but conscious, cooperative, able to walk, are nonviolent, and free from any medical distress (including life threatening withdrawal symptoms or apparent underlying symptoms); and

iii) Who would otherwise be transported to the emergency department or a jail, or who presented at an emergency department and are appropriate to be diverted to a sobering center.

c) Sobering centers may serve as an immediate alternative to a California Medicaid State Plan covered service or setting, or as a replacement over a longer timeframe. Sobering centers may potentially substitute the following California Medicaid State Plan covered services or settings: emergency department services, inpatient services, and emergency transport services.

d) Contractor must document the Encounter for the sobering center services rendered using the standard HCPCS code(s) and associated modifier(s) set by the State, located at https://www.dhcs.ca.gov/Documents/MCQMD/Coding-Options-for-ECM-and-Community-Supports.pdf.

14) Asthma remediation

a) Asthma remediation services are physical modifications to a home environment that are necessary to ensure the health, welfare, and safety of Members, or enable Members to function in the home, and without which acute asthma episodes could result in the need for emergency services and hospitalization. These services include minor mold removal and remediation services, ventilation improvements, and allergen impermeable mattresses and pillow dustcovers.

b) Asthma remediation services are payable up to a total lifetime maximum of $7,500. The only exceptions to the $7,500 total maximum is if the Member's condition has changed so significantly that additional modifications:

i) Are necessary to ensure the health, welfare, and safety of the Member; or

ii) Are necessary to enable the Member to function with greater independence in the home and avoid institutionalization or hospitalization.

c) Eligible Members are those with poorly controlled asthma (as determined by an emergency department visit or hospitalization, two sick or urgent care visits in the past 12 months, or a score of 19 or lower on the asthma control test) for whom a licensed health care provider has documented that the service will likely avoid asthma-related

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hospitalizations, emergency department visits, or other high-cost services.

d) Asthma remediation may serve as an immediate alternative to a California Medicaid State Plan covered service or setting, or as a replacement over a longer timeframe. Asthma remediation may potentially substitute the following California Medicaid State Plan covered services or settings: asthma-related Primary Care and specialty visits, emergency department services, home health aide, home health agency, inpatient stay, outpatient hospital services, and personal care services.

e) Contractor must document the Encounter for the asthma remediation services rendered using the standard HCPCS code(s) and associated modifier(s) set by the State, located at https://www.dhcs.ca.gov/Documents/MCQMD/Coding-Options-for-ECM-and-Community-Supports.pdf.

B. Contractor must list all Community Supports it offers in its Community Supports Model of Care (MOC) template and Community Supports MOC amendments.

C. Contractor must ensure Community Supports are provided in accordance with APLs and DHCS' Community Supports Policy Guide.

D. Contractor must ensure Community Supports are provided to Members in a timely manner, and must develop policies and procedures outlining its approach to managing Community Supports Provider shortages or other barriers to ensure timely provision of Community Supports.

E. Contractor may discontinue offering Community Supports annually with notice to DHCS at least 90 calendar days prior to the discontinuation date.

Contractor must ensure Community Supports that were authorized for a Member prior to the discontinuation of those specific Community Supports are not disrupted by a change in Community Supports offerings, either by completing the authorized service or by seamlessly transitioning the Member into other Medically Necessary services or programs that meet the Member's needs.

F. At least 30 calendar days before discontinuing one or more Community Supports, Contractor must notify impacted Members of the following:

1) The change and timing of discontinuation, and

2) The procedures that will be used to ensure completion of the authorized Community Supports or a transition into other comparable Medically Necessary services.

G. Contractor may provide voluntary services that are neither State-approved Community Supports nor Covered Services when medically appropriate for the Member, in accordance with 42 CFR section 438.3(e)(1). Such voluntary services are not subject to the terms of this Section 4.5 and are subject to the limitations of 42 CFR section 438.3(e)(1).

4.5.3 Community Supports Providers

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

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

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

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

1) Obtain and document Member Information including eligibility, Community Supports authorization status, Member authorization for

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data sharing (to the extent required by law), and other relevant demographic and administrative information; and

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

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

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

4.5.4 Community Supports Provider Capacity

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

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

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

4.5.5 Community Supports Model of Care

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

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

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

D. Contractor must submit its Community Supports MOC for DHCS review and approval. Contractor must also submit to DHCS any significant changes to its Community Supports MOC for DHCS review and approval at least 60 calendar days in advance of any such occurrence of changes or updates, in accordance with DHCS policies and guidance, including APLs. Significant changes may include, but are not limited to, changes to Contractor's approach to administer or deliver Community Supports services; approved policies and procedures; and Network Provider Agreement, Subcontractor Agreement, or Downstream Subcontractor Agreement boilerplates, as appropriate.

4.5.6 Identifying Members for Community Supports

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

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

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

2) How Contractor will notify Members; and

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

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

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

4.5.7 Authorizing Members for Community Supports and Communication of Authorization Status

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

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

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

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

C. Contractor's policies and procedures must include detailed documentation that a Network Provider, or Contractor's staff Provider using their professional judgement has determined it to be medically appropriate for the Member to receive Community Supports as it is likely to reduce or prevent the need for acute care or other California Medicaid State Plan services in accordance with APLs and to be defined in forthcoming guidance.

D. Contractor must develop and maintain policies and procedures to ensure Members do not experience undue delays pending the authorization process for Community Supports. If Medically Necessary, Contractor must make available the California Medicaid State Plan services that the

Community Supports replace, pending authorization of the requested Community Supports.

E. Contractor must have policies and procedures for expediting the authorization of certain Community Supports for urgent needs, as appropriate, and that identify the circumstances in which any expedited authorization processes apply, in accordance with APLs.

F. When a Member has requested Community Supports, directly or through a Provider, community-based organization, or other entity, Contractor must notify the requestor and the Member of Contractor's decision regarding Community Supports authorization, in accordance with APLs. If the Member is enrolled in ECM, Contractor must ensure the ECM Provider is informed of the Community Supports authorization decision.

G. Members always retain the right to file Appeals and/or Grievances if they request one or more Community Supports offered by Contractor but were not authorized to receive the requested Community Supports.

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

4.5.8 Referring Members to Community Supports Providers for Community Supports

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

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

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

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

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

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

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

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

1) Ensure the Member agrees to receive Community Supports;

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

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

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

4.5.9 Data System Requirements and Data Sharing to Support Community Supports

A. Contractor must use systems and processes capable of tracking Community Supports referrals, access to Community Supports, and Grievances and Appeals.

Contractor must support Community Supports Provider access to systems and processes allowing them to track and manage referrals for Community Supports and Member information.

B. Consistent with federal, State and, if applicable, local privacy and confidentiality laws, Contractor must ensure Community Supports Providers have access to the below as part of the referral process to Community Supports Providers:

1) Demographic and administrative information confirming the referred Member's eligibility and authorization for the requested service;

2) Appropriate administrative, clinical, and social service information that Community Supports Providers might need to effectively provide the requested service; and

3) Billing information necessary to support the Community Supports Providers' ability to submit claims or invoices to Contractor.

C. Contractor must use defined federal and State standards, specifications, code sets, and terminologies when sharing physical, behavioral, social, and administrative data with Community Supports Providers and with DHCS in compliance with data exchange policies and procedures, as defined by the California Health and Human Services Data Exchange Framework in accordance with H&S section 130290, when sharing physical, behavioral, social, and administrative data with Community Supports Providers and with DHCS.

4.5.10 Contractor's Oversight of Community Supports Providers

A. Contractor must comply with all State and federal reporting requirements.

B. Contractor must perform oversight of Community Supports Providers, holding them accountable for all Community Supports requirements contained in this Contract and all applicable APLs.

C. Contractor must use all applicable APLs to develop its Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements, as appropriate, with Community Supports Providers and must incorporate all of its Community Supports Provider requirements. Contractor must submit its Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements, as appropriate, with Community Supports Providers to DHCS for review and approval in a form and manner specified by DHCS.

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D. To streamline Community Supports implementation:

1) Contractor must hold Community Supports Providers responsible for the same reporting requirements as are required of Contractor by DHCS;

2) Contractor must not impose mandatory reporting requirements that are alternative or additional to those required for Encounter Data and supplemental reporting as described in Subsection 4.5.13 (*Community Supports Reporting Requirements*); and

3) Contractor may collaborate with other Medi-Cal managed care health plans within the same county on reporting requirements and oversight.

E. Contractor must not utilize tools developed or promulgated by NCQA to perform oversight of Community Supports Providers, unless by mutual consent with the Community Supports Provider.

F. Contractor must provide Community Supports training and technical assistance to Community Supports Providers, including in-person sessions, webinars, and calls, as necessary, in addition to Network Provider training requirements, as applicable, as described in Exhibit A, Attachment III, Subsection 3.2.5 (*Network Provider Training*).

G. Contractor must not require Community Supports Providers to use a contractor-specific portal for day-to-day documentation of services. However, this prohibition does not preclude providers and Contractor from mutually agreeing to use of portals to facilitate reporting and other administrative transactions.

4.5.11 Delegation of Community Supports Administration to Network Providers, Subcontractors, or Downstream Subcontractors

A. Contractor may enter into Network Provider Agreements, Subcontractor Agreements, or Downstream Subcontractor Agreements, as appropriate, with other entities to administer Community Supports in accordance with the following:

1) Contractor must maintain and be responsible for oversight of compliance with all Contract provisions and Covered Services, as described in Exhibit A, Attachment III, Section 3.1 (*Network Provider Agreements, Subcontractor Agreements, Downstream Subcontractor Agreements, and Contractor's Oversight Duties*);

2) Contractor must develop and maintain DHCS-approved policies and procedures to ensure Network Providers, Subcontractors, and Downstream Subcontractors meet required responsibilities and functions as described in Exhibit A, Attachment III, Subsection 3.1.4 (*Contractor's Duty to Ensure Subcontractor, Downstream Subcontractor, and Network Provider Compliance*);

3) Contractor must evaluate the prospective Network Provider's, Subcontractor's, or Downstream Subcontractor's ability to perform services as described in Exhibit A, Attachment III, Subsection 3.1.4 (*Contractor's Duty to Ensure Subcontractor, Downstream Subcontractor, and Network Provider Compliance*);

4) Contractor must ensure the Network Provider's, Subcontractor's, or Downstream Subcontractor's Community Supports Provider capacity is sufficient to serve all Populations of Focus;

5) Contractor must, as applicable, report to DHCS the names of all Subcontractors and Downstream Subcontractors by Subcontractor and Downstream Subcontractor type and service(s) provided, and identify the county or counties in which Members are served as described in Exhibit A, Attachment III, Subsection 3.1.3 (*Contractor's Duty to Disclose All Delegated Relationships and to Submit Delegation Reporting and Compliance Plan*); and

6) Contractor must make all Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements available to DHCS upon request. Such agreements must contain minimum required information specified by DHCS, including method and amount of compensation as described in Exhibit A, Attachment III, Subsection 3.1.5. (*Requirements for Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements*).

B. Contractor must ensure all Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements mirror the requirements set forth in this Contract and APLs, as applicable to the Network Provider, Subcontractor, or Downstream Subcontractor.

C. Contractor may collaborate with its Network Providers, Subcontractors, and Downstream Subcontractors on its approach to Community Supports to minimize divergence in how the Community Supports will be implemented between Contractor and its Network Providers, Subcontractors and Downstream Subcontractors, and to ensure a

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streamlined, seamless experience for Community Supports Providers and Members.

4.5.12 Payment of Community Supports Providers

A. Contractor must pay contracted Community Supports Providers for the provision of authorized Community Supports to Members in accordance with established Network Provider Agreements, Subcontractor Agreements, or Downstream Subcontractor Agreements between Contractor and each Community Supports Provider.

B. Contractor must utilize the claims timeline and process as described in Exhibit A, Attachment III, Subsection 3.3.5 (*Claims Processing*) to ensure timely payment of claims, bills, or invoices.

C. Contractor must identify any circumstances under which payment for Community Supports must be expedited to facilitate timely delivery of the Community Supports to the Member, such as recuperative care for a Member who is homeless and being discharged from the hospital.

   For such circumstances, Contractor must develop and maintain policies and procedures to ensure payment to the Community Supports Provider is expedited. Contractor must submit these policies and procedures to DHCS for review and approval prior to implementation.

D. Contractor must ensure Community Supports Providers submit a claim for rendered Community Supports, to the greatest extent possible.

   1) If a Community Supports Provider is unable to submit a claim for Community Supports rendered, Contractor must ensure the Community Supports Provider apply the DHCS approved billing and guidance to submit invoices, located at https://www.dhcs.ca.gov/Documents/MCQMD/ECM-and-Community-Supports-Billing-and-Invoicing-Guidance.pdf.

   2) Upon receipt of such an invoice, Contractor must document the Encounter for the Community Supports rendered using the standard HCPCS code(s) and associated modifier(s) set by the State, located at https://www.dhcs.ca.gov/Documents/MCQMD/Coding-Options-for-ECM-and-Community-Supports.pdf.

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4.5.13 Community Supports Reporting Requirements

A. In the Community Supports MOC, Contractor must include details on the Community Supports Contractor plans to offer, including which counties Community Supports will be offered and its network of Community Supports Providers.

B. After implementation of Community Supports, Contractor must submit the following data and reports to DHCS to support DHCS oversight of Community Supports:

1) Encounter Data

a) Contractor must submit all Community Supports Encounter Data to DHCS using national standard specifications and code sets to be defined by DHCS. Contractor must comply with DHCS guidance on billing and invoicing standards for Contractor to use with Community Supports Providers.

b) Contractor must submit to DHCS all Community Supports Encounter Data, including Encounter Data for Community Supports generated under Network Provider Agreements, Subcontractor Agreements, or Downstream Subcontractor Agreements.

c) In the event the Community Supports Provider is unable to submit Community Supports Encounter Data to Contractor using the national standard specifications and code sets to be defined by DHCS, Contractor must convert Community Supports Providers' invoicing and billing data into the national standard specifications and code sets, for submission to DHCS.

d) Encounter Data, when possible, must include data necessary for DHCS to stratify services by age, sex, race, ethnicity, and language spoken to inform Health Equity initiatives and efforts to mitigate Health Disparities undertaken by DHCS.

2) Supplemental reporting on a schedule and in a form to be defined by DHCS.

C. Contractor must timely submit any related data requested by DHCS, Centers for Medicare & Medicaid Services (CMS), or an independent

entity conducting an evaluation of Community Supports including, but not limited to:

1) Data to evaluate the utilization and effectiveness of Community Supports.

2) Data necessary to monitor health outcomes and quality metrics at the local and aggregate levels through timely and accurate Encounter Data and supplemental reporting on health outcomes and equity of care. When possible, metrics must be stratified by age, sex, race, ethnicity, and language spoken.

3) Data necessary to monitor Member Appeals and Grievances associated with Community Supports.

D. In the event of underperformance by Contractor in relation to its administration of Community Supports, DHCS may impose sanctions in accordance with Exhibit E, Section 1.19 (*Sanctions*).

4.5.14 Community Supports Quality and Performance Incentive Program

A. Contractor must meet all quality management and Quality Improvement requirements described in Exhibit A, Attachment III, Section 2.2 (*Quality Improvement and Health Equity Transformation Program (QIHETP)*), and any additional quality requirements for Community Supports set forth in associated guidance from DHCS.

B. Contractor may participate in a performance incentive program related to adoption of Community Supports, building infrastructure and Provider capacity for Community Supports, related health care quality and outcomes, and other performance milestones and measures, in accordance with APL 23-003 or other technical guidance.

Exhibit A, ATTACHMENT III

4.6 Member Grievance and Appeal System

4.6.1 Grievance and Appeal Program Requirements
4.6.2 Grievance Process
4.6.3 Discrimination Grievances
4.6.4 Notice of Action
4.6.5 Appeal Process
4.6.6 Responsibilities in Expedited Appeals
4.6.7 State Hearings and Independent Medical Reviews
4.6.8 Continuation of Services Until Appeal and State Hearing Rights Are Exhausted
4.6.9 Grievance and Appeal Reporting and Data

4.6 Member Grievance and Appeal System

4.6.1 Grievance and Appeal Program Requirements

Contractor must have in place a Member Grievance and Appeal system that complies with 42 Code of Federal Regulations (CFR) sections 438.228 and 438.400 - 424, 28 California Code of Regulations (CCR) sections 1300.68 and 1300.68.01, and 22 CCR section 53858 for Covered Services including Contractor's selected Community Supports under 42 CFR section 438.3(e)(2). Contractor must follow Grievance and Appeal requirements set forth in, and use all notice templates included in, All Plan Letter (APL) 21-011. Contractor must ensure that its Grievance and Appeal system meets the following requirements:

A. Allows the Member, or a Provider or Authorized Representative (AR) with the Member's written consent, to file a Grievance, or request an Appeal with Contractor either orally or in writing.

B. Ensures timely written acknowledgement of each Grievance or Appeal, and provides a notice of resolution to the Member as quickly as the Member's health condition requires, not to exceed 30 calendar days from the date the Member makes an oral or written request to Contractor for a standard Grievance or Appeal or 72 hours for an expedited Grievance or Appeal. Contractor must notify the Member, Provider, or AR with a written resolution of the Grievance or Appeal in the Member's preferred language as required by 42 CFR sections 438.10 and 438.404, W&I section 14029.91, and 22 CCR section 53876.

C. Ensures that Members are given assistance when completing Grievance and Appeal forms and all other procedural steps. Required assistance includes, but is not limited to, providing Members with all documents Contractor relied on for its decision, and providing Auxiliary Aid and services upon request, such as translation and interpreter services, use of alternative formats for all documents Contractor relied upon for its decision, and a toll-free number with TTY/TDD and interpreter capability.

D. Ensures that the person making the final decision for the proposed resolution of a Grievance or Appeal has neither participated in any prior decisions related to the Grievance or Appeal, nor is a subordinate of someone who has participated in the prior decision. Contractor must ensure that all Grievance or Appeals related to medical Quality of Care issues be immediately submitted to Contractor's medical director for action. Contractor must ensure that the person making the decision on the Grievance or Appeal has clinical expertise in treating a Member's condition or disease when deciding:

1) An Appeal of a denial based on lack of Medical Necessity or that the service is experimental or investigational;

2) A Grievance regarding denial of a request for expedited resolution of an Appeal; and

3) Any Grievance or Appeal involving clinical issues.

E. Considers all comments, documents, records, and other information submitted by the Member, Provider, or AR, regardless of whether Contractor had the Member's additional information during the initial review.

F. Ensures that Members are given a reasonable opportunity to present evidence and testimony, and make legal or factual arguments, in person, by telephone, or in writing, in support of their Grievance or Appeal. Contactor must inform Members that they must submit additional evidence for Contractor to consider within the 30-calendar-day review timeframe for an Appeal and within the 72-hour timeframe for resolving an expedited Appeal.

G. Ensures that Notices of Appeal Resolution (NAR) be in a format and a language that, at a minimum, meets the standards set forth in 42 CFR section 438.10, W&I section 14029.91, 22 CCR section 53876, and Exhibit A, Attachment III, Subsection 5.1.3 (*Member Information*). Contractor must ensure that language assistance taglines and a nondiscrimination notice meeting the minimum requirements in APL 21-004 accompanies each Member notification, and that the nondiscrimination notice is made available, upon request or as otherwise required by law, in all of the Threshold Languages/Threshold or Concentration Standard Languages and Americans with Disabilities Act of 1990 (ADA)-compliant, accessible formats as needed by Members to effectively understand Contractor's notices.

H. Provides oral notice of the resolution of an expedited Appeal to the Member, Provider, or AR within 72 hours.

I. Provides Contractor's Grievance and Appeal policies and procedures to Network Providers, Subcontractors, and Downstream Subcontractors at the time that they enter into a Network Provider Agreement, Subcontractor Agreement, or Downstream Subcontractor Agreement. Contractor must ensure that Network Providers, Subcontractors, and Downstream Subcontractors are trained on and immediately notified of any changes to Contractor's Grievance and Appeal policies and procedures.

J. Maintains policies and procedures for compiling, aggregating, and reviewing Grievance and Appeal data for use in Contractor's Quality Improvement Strategy (QIS). Contractor must regularly analyze Grievance and Appeal data to identify, investigate, report, and act upon systemic patterns of improper service denials and other trends impacting health care access and delivery to Members. Contractor must impose necessary Corrective Action to remedy all identified deficiencies.

K. Maintains records of Grievances and Appeals in a manner accessible to DHCS and to the Centers for Medicare & Medicaid Services (CMS), upon request. Contractor must review Grievance and Appeal data and information as part of its ongoing monitoring procedures as well as for updates and revisions to its QIS. The record of each Grievance or Appeal must contain, at a minimum, all information set forth in 42 CFR section 438.416(b). Contractor must ensure that all documents and records, whether in written or electronic format, generated or obtained by Contractor in the course of responding to Adverse Benefit Determinations (ABD), Grievances, Appeals, and Independent Medical Reviews (IMRs) are retained for at least 10 years pursuant to 42 CFR section 438.3(u).

4.6.2 Grievance Process

Contractor's policies and procedures must include all required information set forth below for Grievances and the expedited review of Grievances as required under 42 CFR sections 438.402, 438.406, and 438.408; 28 CCR sections 1300.68 and 1300.68.01; and 22 CCR section 53858:

A. A policy and procedure for Members to file a Grievance with Contractor at any time to express dissatisfaction about any matter other than a notice of ABD.

B. A policy and procedure to allow Members to file a Grievance to contest Contractor's unilateral decision to extend the timeframe for resolution of an Appeal or expedited Appeal.

C. A policy and procedure to ensure that every Grievance involving clinical issues that is submitted is reported to qualified medical professionals with appropriate clinical expertise and is escalated to Contractor's medical director as needed, to ensure the Grievance is properly handled.

D. A policy and procedure to ensure that Contractor's staff monitor Grievances to identify issues that require Corrective Action. Grievances related to medical Quality of Care issues must be referred to qualified

medical professionals with appropriate clinical expertise and be escalated to Contractor's medical director as needed.

E. A policy and procedure for Contractor to provide written acknowledgement to the Member within five calendar days of receipt of the Grievance. The acknowledgement letter must advise the Member that the Grievance has been received; provide the date of receipt; and provide the name, telephone number, and address of the representative who the Member, their Provider, or their AR may contact about the Grievance.

4.6.3 Discrimination Grievances

Contractor must process Discrimination Grievances as required by federal and State nondiscrimination law and DHCS policy, as stated in 45 CFR section 84.7, 34 CFR section 106.8, 28 CFR section 35.107, W&I section 14029.91(e)(4), and APL 21-004.

A. Contractor must designate a Discrimination Grievance coordinator responsible for ensuring compliance with federal and State nondiscrimination requirements and investigating Discrimination Grievances related to any action that would be prohibited by, or out of compliance with, federal or State nondiscrimination law.

B. Contractor must adopt and implement written policies and procedures to ensure the prompt and equitable resolution of Discrimination Grievances. Contractor must not require a Member or Potential Member to file a Discrimination Grievance with Contractor before filing with the DHCS Office of Civil Rights or the U.S. Department of Health and Human Services Office for Civil Rights.

C. Within ten calendar days of mailing a Discrimination Grievance resolution letter, Contractor must submit information regarding the Discrimination Grievance to the DHCS Office of Civil Rights, as specified in APL 21-004 to DHCS.DiscriminationGrievances@dhcs.ca.gov.

D. Contractor must inform Members on its website that Discrimination Grievances may be filed directly with the DHCS Office of Civil Rights and must include contact information for the DHCS Office of Civil Rights, as required by Exhibit A, Attachment III, Subsection 5.1.3 (*Member Information*).

4.6.4 Notice of Action

When Contractor makes an authorization decision, it must send a Notice of Action (NOA). A NOA is a notice of any action that impacts a Member's ability to obtain Covered Services or other benefits Contractor is required to provide under this Contract. A NOA includes, but is not limited to, a notice of ABD for a requested health care service under 42 CFR sections 438.210(d) and 438.404, including requested Community Supports that Contractor has elected to cover under 42 CFR section 438.3(e)(2).

Contractor's failure to render a decision and send a written NOA to the Member within the required timeframes below is considered a denial of the requested service and therefore constitutes an ABD on the date that Contractor's timeframe for approval expires, in accordance with 42 CFR section 438.404(c)(5). In cases where Contractor fails to meet the required notice timeframes, the Member may immediately request an Appeal with Contractor and Contractor must send the Member written notice of all Appeal rights.

A. Standard Authorization Requests

1) Contractor must ensure a NOA is sent when approving, denying or modifying a Provider's Prior Authorization or concurrent request for health care services (excluding pharmacy services, but including Community Supports) for a Member within the shortest applicable timeframe that is appropriate for the nature of the Member's condition, but no longer than five Working Days from Contractor's receipt of information reasonably necessary and requested by Contractor to make a determination, not to exceed 14 calendar days following Contractor's receipt of the request for service, in accordance with 42 CFR sections 438.210(d)(1) and 438.404(c)(3); and

2) Contractor must notify the requesting Provider of its authorization decision within 24 hours of the decision and send the written NOA to the Member within two Working Days in accordance with H&S section 1367.01(h)(1) and (3).

3) Contractor must send the written NOA approving, denying, or modifying the authorization request. Contractor must approve, deny, or modify the request and send the written NOA within the shortest applicable timeframe that is appropriate for the nature of the Member's condition, but no longer than five Working Days from Contractor's receipt of information reasonably necessary and requested by Contractor to make a determination, not to exceed 14

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calendar days in accordance with 42 CFR sections 438.210(d)(1) and 438.404(c)(3); and

4) Contractor must send the written NOA to the Member with sufficient time to allow for continuation of benefits pursuant to 42 CFR section 438.420.

B. Expedited Authorization Requests

1) In instances where a Provider indicates, or Contractor determines, that the standard request timeframe may seriously jeopardize the Member's life; health; or ability to attain, maintain, or regain maximum function, Contractor must approve, modify, or deny a Prior Authorization or concurrent request for health care services, and send the written NOA, in a timeframe which is appropriate for the nature of the Member's condition, but no longer than 72 hours from receipt of the authorization request in accordance with 42 CFR section 438.210(d)(2) and (d)(2)(i).

2) Contractor must send the written NOA approving, denying, or modifying the authorization request. Contractor must send the written NOA to the Member with sufficient time to allow for continuation of benefits pursuant to 42 CFR section 438.420.

3) Contractor must approve, modify, or deny the request within the shortest applicable timeframe that is appropriate for the nature of the Member's condition, but no longer than 72 hours from Contractor's receipt of additional information requested by Contractor to make a determination. Contractor's written notice to the Member must be sent with sufficient time to allow the Member to request Aid Paid Pending if applicable.

C. Retrospective Review

Contractor must approve, modify, or deny a Provider's request for Retrospective Review authorization for health care services provided to a Member, and send the written NOA to the Member, within 30 calendar days from receipt of information that is reasonably necessary to make a determination.

D. Terminations, Suspensions, or Reductions

1) For terminations, suspensions, or reductions of previously authorized services, Contractor must notify Members at least ten

calendar days before the date of the action pursuant to 42 CFR section 431.211, with the exception of circumstances permitted under 42 CFR sections 431.213 and 431.214.

2) For purposes of auditing, the postmark on Contractor's notice to the Member will be used to confirm compliance with all authorization request timeframes and notice requirements set forth in Exhibit A, Attachment III, Section 4.6 (*Member Grievance and Appeal System*).

E. Required Information in Contractor's NOA Informing Member of Notice of ABDs.

Contractor must ensure all NOAs informing a Member of an ABD are in writing in a format and language that, at a minimum, meets the standards set forth 42 CFR sections 438.10, 438.404, and 438.408; W&I section 14029.91; 22 CCR section 53876; and Exhibit A, Attachment III, Subsection 5.1.3 (*Member Information*), and APL 21-004, Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services. Contractor's NOA informing of an ABD must include all of the following:

1) A clear and concise explanation of the action that Contractor or its Network Provider has taken or intends to take, including a fully translated written notice with a fully translated clinical rationale for Contractor's decision at the point of each determination;

2) The reason for the action, including notification to the Member of the right to be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and any other information Contractor relied on for the decision, including clinical criteria; Medical Necessity criteria; and any processes, strategies, or evidentiary standards relied on for the decision;

3) The Member's right to request an Appeal with Contractor no later than 60 calendar days from the date on the NOA, and information on exhausting Contractor's one-level Appeal system;

4) The Member's right to an expedited Appeal if the Member's health condition requires resolution in less than 72 hours and information on how to request an expedited Appeal;

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5) The Member's rights and information on the process to request a State Hearing after having exhausted Contractor's internal Appeal process and having received notice that Contractor is upholding its action. The NOA must also advise that the Member may request a State Hearing in cases where Contractor fails to send a NAR or notice of extension in response to the Appeal within 30 calendar days of the Member's request for an Appeal. This is known as Deemed Exhaustion pursuant to 42 CFR section 438.402(c)(1)(i)(A);

6) The Member's right to continue receiving Covered Services pending the resolution of the Appeal, and Contractor's obligation to continue benefits as required by 42 CFR section 438.420 and Exhibit A, Attachment III, Subsection 4.6.8 (*Continuation of Services Until Appeal and State Hearing Rights Are Exhausted*) below; and

7) If applicable, the Member's right to request a clinical review of Contractor's action, called an IMR, from DMHC and that the Member must request an IMR before there is a final decision on their State Hearing.

F. For visually impaired Members, Contractor must provide the NOA in the Member's selected alternative format in order to be considered adequate notice. Contractor must not deny, delay, modify, limit, or terminate services or treatments without providing adequate notice within the timeframes stated in this Exhibit A, Attachment III, Subsection 4.6.4 (*Notice of Action*). In accordance with APL 22-002, Contractor must calculate the appropriate timeframe(s) for a visually impaired Member to take action from the date of receiving adequate notice in their selected alternative format, including all deadlines for Appeals.

G. Contractors are not permitted to make any changes to DHCS' NOA templates or the NOA "Your Rights" Attachment without prior review and approval from DHCS, except to insert the specific reasons for Contractor's action to the Member, as required.

4.6.5 Appeal Process

Pursuant to 42 CFR sections 438.228 and 438.400 - 424, Contractor must have an Appeal process as required below to attempt to resolve Member Appeals before the Member requests a State Hearing or an IMR. Contractor must have only one level of Appeal for Members. Upon a Member's request, Contractor must assist any Member in preparing their Appeal, which includes assisting the

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Member with navigating Contractor's website, providing all documents that Contractor relied on for its decision, and providing the Appeal form to the Member.

A. Following the receipt of a NOA, a Member has 60 calendar days from the date on the NOA to file a request for an Appeal either orally or in writing. The Member, or a Provider or AR acting on behalf of the Member and with the Member's written consent, may request an Appeal. Unless the Member is requesting an expedited Appeal, the date of the Member's oral or written request for an Appeal establishes the filing date for the Appeal. Contractor must resolve the Appeal within 30 calendar days of the Member's oral or written request for an Appeal.

B. If Contractor fails to send a written NOA within 30 calendar days or fails to comply with notice and language translation requirements in 42 CFR sections 438.10, 438.404, and 438.408; W&I section 14029.91; 22 CCR section 53876; and Exhibit A, Attachment III, Subsection 5.1.3 (*Member Information*), the Member is deemed to have exhausted Contractor's internal Appeal process and may request a State Hearing pursuant to 42 CFR section 438.402(c)(1)(i)(A).

C. Contractor's NOA informing the Member of its NAR must, at a minimum, indicate whether Contractor upheld its decision on the Appeal and the date of Contractor's decision on the Appeal. For decisions not wholly in the Member's favor, Contractor's NAR must, at a minimum, include:

   1) Member's right to request a State Hearing;

   2) How to request a State Hearing;

   3) That the Member has a right to continuation of benefits during the State Hearing, and that Contractor is obligated to continue benefits as long as the requirements of 42 CFR section 438.420 are met;

   4) If applicable, the right to request an IMR or a review of Contractor's decision by DMHC, and that the IMR must be requested before there is a final State Hearing decision; and

   5) The DHCS-approved "Your Rights" Attachment.

D. If Contractor reverses its decision during the Appeal, it must authorize or provide the disputed services promptly, and as expeditiously as the Member's health condition requires, but no later than 72 hours from the

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date it reverses the action if the disputed services were not provided during the Appeal.

E. Contractor must pay for disputed services if the Member received the disputed services while the Appeal was pending.

F. Contractor must provide the Member or AR the opportunity before and during their Appeal process to examine their case file. Contractor must provide, sufficiently in advance of the resolution timeframe and free of charge, the Member's case file, including Medical Records, clinical criteria, guidelines, and all documents and records Contractor relied on during the Appeal process for its decision. Contractor must assist any Member who requires assistance preparing their Appeal.

G. Contractor may withdraw a Grievance or Appeal upon Member request if performed in compliance with the established Grievance and Appeals processes required in this Contract and federal and State laws and regulations. Where a Grievance or Appeal was filed by a Provider or AR of a Member, written Member consent is required for a Provider or AR to withdraw the Grievance or Appeal.

4.6.6 Responsibilities in Expedited Appeals

Contractor must implement and maintain policies and procedures as described below to resolve expedited Appeals. Contractor must follow the expedited Appeal process when it determines or the requesting Provider indicates that taking the time for a standard resolution could seriously jeopardize the Member's life; physical or mental health; or ability to attain, maintain, or regain maximum function.

A. A Member, or a Provider or an AR with the Member's written consent, may file an expedited Appeal either orally or in writing. No additional follow-up from the Member is required. Contractor must ensure that punitive action is not taken against a Provider who requests an expedited resolution or supports a Member's Appeal.

B. Contractor must inform the Member of the limited time available for the Member to present evidence and allegations of fact or law, in person, by phone, or in writing, sufficiently in advance of the resolution timeframe.

C. Contractor must resolve an expedited Appeal as quickly as the Member's health condition requires, but no later than 72 hours from the day Contractor receives the request for an expedited Appeal.

D. Contractor must make a reasonable effort to provide oral notice of an expedited Appeal decision.

E. If Contractor denies a request for an expedited resolution of an Appeal, it must process the request for an Appeal in accordance with the standard Appeal process timeframes for resolutions and extensions as required in Exhibit A, Attachment III, Subsection 4.6.5 (*Appeal Process*).

4.6.7 State Hearings and Independent Medical Reviews

A. State Hearings

1) The Member, or a Provider or AR with the Member's written consent, may request a State Hearing:

a) After receiving a NAR confirming that Contractor has upheld its ABD, and the request is made within 120 calendar days from the date on the NAR;

b) In cases of Deemed Exhaustion, due to Contractor's failure to comply with Appeal notice and timing requirements as required by 42 CFR sections 438.10, 438.402, 438.404, 438.406, 438.408, and 438.410; W&I sections 10951 and 10951.5; and as stated in this Contract, the Member may immediately request a State Hearing. In cases of Deemed Exhaustion, Contractor must not request a dismissal of the State Hearing based on a failure to exhaust Contractor's internal Appeal process; or

c) If Contractor fails to provide Appeal notices required in 42 CFR section 438.408 to a Member with a visual impairment, in the Member's selected alternative format and within the applicable federal or State timeframes, the Member is deemed to have exhausted Contractor's internal Appeal process and may immediately request a State Hearing. In such cases, Contractor is prohibited from requesting dismissal of a State Hearing on the basis of failure to exhaust Contractor's internal Appeal process.

2) Upon request from the Member, Contractor must assist the Member with preparing for the State Hearing by providing the Member or their AR with the Member's case file, including Medical Records, other documents and records, guidelines, clinical criteria, and any new or additional evidence that Contractor relied on for its

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initial denial and anything Contractor considered during its internal Appeal process. This information must be provided free of charge and sufficiently in advance of the resolution timeframe.

3) Contractor must provide its statement of position for the State Hearing to the Member and to the California Department of Social Services at least two Working Days before the State Hearing.

4) Contractor must ensure that an employee familiar with the facts of the case and Contractor's basis for upholding its ABD is available to actively participate in the State Hearing by ensuring that the employee is available and prepared to present Contractor's position and be subject to cross examination at the State Hearing as required by 42 CFR sections 431.205 and 431.242 and *Goldberg v. Kelly* (1970) 397 US 254. Contractor must ensure that it provides accurate contact information for its State Hearing representative to ensure an appearance at the State Hearing via telephone or in person. Additionally, to ensure Member's right to due process during the State Hearing process, Contractor must ensure that a statement of position is timely filed with the California Department of Social Services and provided to the Member not less than two Working Days before the hearing as required by W&I section 10952.5.

5) In cases where the State Hearing decision overturns Contractor's decision, Contractor must authorize or provide the disputed services promptly, and as expeditiously as the Member's health condition requires, but no later than 72 hours from the date Contractor receives notice that the State Hearing decision reversed Contractor's decision.

6) Contractor must pay for disputed services if the Member received the disputed services while the State Hearing was pending.

7) The parties to a State Hearing must include Contractor as well as the Member, their AR, or the representative of a deceased Member's estate.

8) Contractor must notify Members that the State must make a decision for a State Hearing within 90 calendar days of the date of the State Hearing request. For an expedited State Hearing, DHCS will take final administrative action as expeditiously as the individual's health condition requires, but no later than three Working Days after Contractor provides DHCS with the case file

and information supporting its Appeal of an ABD pursuant to W&I section 10951.5. Contractor must also comply with all other requirements as required by 42 CFR sections 438.410 and 438.404(a), W&I section 14029.91(e), 22 CCR sections 53876 and 53895, and APL 21-011.

B. Contractor's Obligations for Expedited State Hearings

1) Within two Working Days of being notified by DHCS or the California Department of Social Services that a Member has filed a request for State Hearing which meets the criteria for expedited resolution, Contractor must deliver directly to the designated/appropriate California Department of Social Services administrative law judge all information and documents which either support, or which Contractor considered in connection with, the action which is the subject of the expedited State Hearing. This includes, but is not limited to, copies of the relevant Treatment Authorization Request and NOA, plus any pertinent NAR and all documents Contractor relied on for its denial, including clinical criteria and guidelines. If the NOA or NARs are not in English, Contractor must transmit fully translated copies to the California Department of Social Services along with copies of the original NOA and NARs.

2) Contractor must ensure that an employee familiar with the facts of the case and Contractor's basis for upholding its ABD is available to actively participate in the expedited State Hearing by ensuring that the employee is available and prepared to present Contractor's position during cross examination at the State Hearing as required by 42 CFR sections 431.205 and 431.242 and *Goldberg v. Kelly* (1970) 397 US 254. Contractor must ensure that it provides accurate contact information for its State Hearing representative to ensure an appearance at the Hearing via telephone or in person. Additionally, to ensure Member's right to due process during the State Hearing process, Contractor must ensure that its completed case file, including the statement of position, is timely filed with the California Department of Social Services as required by W&I section 10951.5(b)(1).

C. Independent Medical Review

1) If applicable to Contractor's plan model, Contractor must inform Members of the right to request an IMR of an action resulting in a Member request for an Appeal, or the outcome of an Appeal.

2) An IMR must be requested by the Member, or a Provider or AR with written authorization from the Member to act on the Member's behalf. Contractor must not require a Member to request an IMR before, or use one as a deterrent to, requesting a State Hearing.

3) IMRs must be conducted by the California Department of Managed Healthcare (DMHC) independently from either the Member or Contractor, and at no cost to the Member.

4) IMRs do not extend any of the time frames stated in this Contract for Appeals, and do not disrupt the continuation of Covered Services per 42 CFR section 438.420.

4.6.8 Continuation of Services Until Appeal and State Hearing Rights Are Exhausted

A. Contractor must automatically continue providing the disputed services to the Member while the Appeal and State Hearing are pending if all of the following conditions are met:

1) The Member filed their Appeal within the required timeframes set forth in 42 CFR section 438.420;

2) The Appeal involves the termination, suspension, or reduction of previously authorized Covered Services;

3) The disputed services were ordered by the Member's Provider; and

4) The period covered by the original authorization has not expired.

B. If Contractor, at the Member's request, continues or reinstates the provision of disputed services while an Appeal or State Hearing is pending, those services must continue until:

1) The Member withdraws their request for an Appeal or a State Hearing;

2) The Member fails to request a State Hearing and continuation of disputed services within ten calendar days of when the NOA was sent; or

3) The final State Hearing decision is adverse to the Member.

C. Contractor must pay for disputed services if the Member received the disputed services while the Appeal or State Hearing was pending. Contractor must ensure the Member is not billed for the continued services even if the State Hearing or IMR finds the disputed services were not Medically Necessary.

4.6.9 Grievance and Appeal Reporting and Data

A. Contractor must submit a Grievance and Appeal log to DHCS upon request for Medi-Cal Members only in the form that is required by and submitted to Department of Managed Health Care (DMHC), as set forth in 28 CCR section 1300.68(f), with additional information required by DHCS per 42 CFR section 438.416 and 22 CCR section 53858(e).

B. Contractor must submit Grievance and Appeal data to DHCS monthly as specified in Exhibit A, Attachment III, Section 2.1.5 (*Program Data Reporting)* and APL 20-017.

C. Contractor must comply with the requirements set forth in Exhibit A, Attachment III, Section 2.1 (*Management Information System*) of this Contract for the reporting of Grievance and Appeal data.

D. Contractor must maintain records of Grievances and Appeals and must have policies and procedures in place governing the review of the information as part of its ongoing QIS. Contractor must identify systemic patterns of wrongful denials and impose Corrective Action as necessary. The records must be accurately maintained in a manner accessible to the State and available to CMS upon request. Records must include all required information set forth in 42 CFR section 438.416(b). Contractor must ensure that all documents and records, whether in a written or electronic format, generated or obtained by Contractor in the course of responding to ABDs, Grievances, Appeals, and IMRs are retained for at least 10 years pursuant to 42 CFR section 438.3(u).

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Exhibit A, ATTACHMENT III

5.0 Services – Scope and Delivery

DHCS has a longstanding commitment to ensure Members have access to high-quality services. The provisions in this Article lay out DHCS expectations of Contractor for promoting access to medical, behavioral, and social services; increasing integration and collaboration across delivery systems and with local partners; and ultimately improving health outcomes.

Through the provisions in this Article, several key goals of California Advancing and Innovating Medi-Cal (CalAIM) are addressed. For example, Contractor must manage the health care needs of the Member over time through a comprehensive array of person-centered health and social services spanning all levels of intensity of care, from birth to dignified end of life. This Article also includes provisions related to Advance Directives and ensuring that Contractor informs Members of what an Advance Directive is and how to put a valid one in place. This Article contains key provisions related to information Members must receive to help them navigate the health care system including information that must be included in the Member Handbook and Provider Directory.

This Article also address access to evidence-based Behavioral Health care, with a focus on integration with physician health and earlier identification and engagement in treatment for Children, youth, and adults. Provisions included here also implement No Wrong Door policies and outline expectations that Contractor ensure Members receive timely mental health services without delay regardless of the delivery system where they seek care. Contractors are expected to ensure Members maintain treatment relationships with trusted Providers without interruption, to the extent feasible.

This Article lays out expectations for services and access to community-based Providers that provide social support including Dyadic Care Services, Doula services, and Community Health Workers (CHW). The intent for enabling access to these provider types is to improve health outcomes by meeting the Behavioral Health (including emotional health and wellbeing), and physical health needs of culturally diverse populations.

DHCS recognizes the importance of coordination and collaboration with other local partners in order to meet the needs of the whole person. Accordingly, DHCS sets forth requirements for Contractor to engage with local entities to promote Member needs for not only Medically Necessary health care services but also any supportive services as needed to treat the whole person and prevent avoidable negative health and social outcomes for individual Members to treat the whole person. This entails partnerships with Local Health Departments,

Local Educational and Government Agencies, and other local programs and services including county social services departments, Child welfare departments, and justice departments. This Article also establishes oversight of Memorandum of Understanding (MOU) requirements and requires referrals to ensure Member care is coordinated and community-based resources, including Community Supports, are availed. Beyond the MOU requirements, DHCS seeks to embed the whole person care and community-informed care approach within its Population Health Management (PHM) strategy and requires the same of Contractor. As such, this Article includes provisions requiring Contractor engagement with community representatives of diverse cultural and ethnic backgrounds to develop its PHM strategies.

To empower Members to become active participants in their care, DHCS has enhanced existing processes and created new channels for engagement for Members, families, and the community. Historically, Medi-Cal managed care plans are required to maintain a Community Advisory Committee (CAC), which serves to inform Contractor's cultural and linguistic services program. DHCS seeks to elevate the CAC by clarifying its role and member composition and prescribing Contractor's role in providing support for CAC members in order to maximize participation and involvement.

Exhibit A, ATTACHMENT III

5.1 Member Services

5.1.1 Member Rights and Responsibilities
5.1.2 Member Services Staff
5.1.3 Member Information
5.1.4 Primary Care Provider Selection
5.1.5 Notices of Action for Denial, Deferral, or Modification of Prior Authorization Requests

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5.1 Member Services

5.1.1 Member Rights and Responsibilities

A. Member Rights and Responsibilities

Contractor must develop, implement, and maintain written policies and procedures that set forth the Member's rights and responsibilities and must communicate its policies to its Members, Providers, and, upon request, Potential Members.

1) Contractor's written policies and procedures must include the following Member rights:

a) To be treated with respect, giving due consideration to the Member’s right to privacy and the need to maintain confidentiality of the Member’s Protected Health Information (PHI) and private information.

b) To be provided with information about Contractor’s organization and all services available to Members.

c) To be able to choose their Primary Care Provider (PCP) within Contractor's Network unless the PCP is unavailable or is not accepting new patients.

d) To participate in decision-making regarding their health care, including the right to refuse treatment.

e) To submit Grievances, either verbally or in writing, about Contractor, Providers, care received, and any other expression of dissatisfaction not related to an Adverse Benefit Determination (ABD).

f) To request an Appeal of an ABD within 60 calendar days from the date on the Notice of Adverse Benefit Determination (NABD) and request how to continue benefits during the in-plan Appeal process through the State Hearing, when applicable.

g) To request a State Hearing, including information on the circumstances under which an expedited State Hearing is available.

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h) To receive interpretation services and written translation of critical informing materials in their preferred Threshold Language, including oral interpretation and American Sign Language.

i) To have a valid Advance Directive in place, and an explanation to Members of what an Advance Directive is.

j) To have access to family planning services and sexually transmitted disease services, from a Provider of their choice, without referral or Prior Authorization, either in or outside of Contractor's Network. To have Emergency Services provided in or outside of Contractor's Network, as required pursuant to federal law.

k) To have access to Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs) and Indian Health Care Providers (IHCP) outside of Contractor's Network, pursuant to federal law.

l) To have access to, and receive a copy of, their Medical Records, and request that they be amended or corrected, as specified in 45 Code of Regulations (CFR) sections 164.524 and 164.526.

m) To change Medi-Cal managed care plans upon request, if applicable.

n) To access Minor Consent Services.

o) To receive written Member informing materials in alternative formats, including Braille, large size print no smaller than 20 point font, accessible electronic format, and audio format, upon request and in accordance with 42 CFR section 438.10 and 45 CFR sections 84.52(d) and 92.102.

p) To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

q) To receive information on available treatment options and alternatives, presented in a manner appropriate for the Member's condition and ability to understand available treatment options and alternatives.

r) To freely exercise these Member rights without retaliation or any adverse conduct by Contractor, Subcontractors, Downstream Subcontractors, Network Providers, or the State.

2) Contractor must provide its written policies and procedures regarding Member rights and responsibilities to its staff and all Network Providers, Subcontractors, and Downstream Subcontractors. Contractor must ensure that its staff, Network Providers, Subcontractors, and Downstream Subcontractors are trained and knowledgeable on Members' rights as required under Exhibit A, Attachment III, Section 3.2 (*Provider Relations*).

B. Member's Right to Confidentiality

Contractor must have policies and procedures in place to ensure Members' rights to confidentiality of PHI and Personal Information (PI) in accordance with 45 CFR parts 160 and 164, and in accordance with Civil Code section 1798 *et seq*.

1) Contractor must ensure that all Subcontractors, Downstream Subcontractors, and Network Providers have policies and procedures in place to guard against unlawful disclosure of PHI, PI, and any other Confidential Information to any unauthorized persons or entities.

2) Contractor must inform and advise Members on the right to confidentiality of their PHI and PI. Contractor must obtain the Member's prior written authorization to release Confidential Information, unless such prior written authorization is not required by State and federal law.

C. Member's Right to Advance Directives

Contractor must have written policies and procedures to ensure Members are informed of what an Advance Directive is and how to put a valid Advance Directive in place. Contractor must have policies and procedures in place to ensure all involved in the Member's care comply with the terms of a Member's valid Advance Directive in accordance with the requirements of 42 CFR sections 422.128 and 438.3(j).

1) Contractor must ensure that its process for a Member's right to have an Advance Directive in place is included in the Member Handbook. Information in the Member Handbook must include the

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Member's right to be informed by Contractor of State law regarding Advance Directives, and to receive information from Contractor regarding any changes to that law. Contractor must ensure that the following statement, or similar language provided by DHCS is included:

Advance care planning for Members enrolled in Medi-Cal palliative care in accordance with All Plan Letter (APL) 18-020, must include documented discussions between a physician or other qualified healthcare professional and a patient, family member, or legally-recognized decision-maker. Counseling that takes place during these discussions addresses, but is not limited to, Advance Directives, such as Physician Orders for Life-Sustaining Treatment (POLST) forms.

2) Information on Advance Directives must comply with all State and federal law requirements and must be updated to reflect any changes to laws governing Advance Directives.

3) Contractor must ensure its Network Providers, Subcontractors, and Downstream Subcontractors are trained on complying with valid Advance Directives in accordance with 42 CFR sections 422.128 and 438.3(j).

D. Interoperability Requirements for Member Records

Contractor must implement and maintain a Patient Access Application Programming Interface (API) as specified in 42 CFR section 431.60 as if such requirements applied directly to Contractor, and as set forth in APL 22-026. The Patient Access API must also meet the technical standards in 45 CFR section 170.215. Data maintained on or after January 1, 2016, must be made available to facilitate the creation and maintenance of a Member's cumulative health record.

1) At a minimum, Contractor must permit third-party applications to retrieve, with the approval and at the direction of the Member, the following Member records:

a) Adjudicated claims data from Contractor, and from any Subcontractors, Downstream Subcontractors and Network Providers, including claims data and cost data that may be Appealed, or are in the process of Appeal, Provider remittances, and Member cost-sharing pertaining to such claims, within (1) Working Day after a claim is processed;

b) Encounter Data, including Encounter Data from any capitated Subcontractors, Downstream Subcontractors, and Network Providers, within one (1) Working Day after receiving the data from Providers;

c) Clinical data, including diagnoses and related codes, and laboratory test results, within one (1) Working Day after the data is received by Contractor; and

d) Information about coverage for drugs administered in an outpatient setting as part of medical services, and updates to such information, including, if applicable, Member costs and any preferred drug list information, within one (1) Working Day after the effective date of any such information or updates to such information.

2) Contractor may deny or discontinue any third-party application's connection to an API if it reasonably determines, consistent with its security risk analysis under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Security Rule set forth in 45 CFR part 160 and 45 CFR part 164, subparts A and C, that continued access presents an unacceptable level of risk to the security of protected health information on its systems. The determination must be made using objective verifiable criteria that are applied fairly and consistently across all applications and developers, including but not limited to criteria that may rely on automated monitoring and risk mitigation tools.

E. Member Cost-Sharing Protections

1) Pursuant to The Social Security Act section 1932(b)(6) and 42 USC section 1396u-2(b)(6), Contractor and all of its Subcontractors must not hold a Member liable for any of the following:

a) Debts of Contractor in the event of Contractor's insolvency;

b) Payment for Covered Services provided by Contractor if Contractor has not received payment from DHCS, or if a Provider, under an agreement or other arrangement with Contractor, fails to receive payment from either DHCS or Contractor; or

c) When payments to a Provider that furnishes Covered Services under an agreement or other arrangement with

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Contractor are in excess of the amount that normally would be paid by the Member if the service had been received directly from the Contractor.

2) Contractor, including its Network Providers and Subcontractors, must not bill a Member for any Covered Services provided under this Contract. Contractor must assure that all Network Provider Agreements include requirements whereby the Member must be held harmless for charges for any Covered Services.

3) Contractor and its Network Providers are prohibited from imposing on Members cost-sharing requirements. Contractor's Subcontractor Agreements and Network Provider Agreements must specify that a Provider agrees to accept Contractor's reimbursement as payment in full for services rendered to Members.

5.1.2 Member Services Staff

A. Contractor must employ and train a sufficient number of staff knowledgeable about Contractor's policies and procedures and capable of providing information to Members or Potential Members.

B. Contractor must ensure its Member services staff are trained and educated on all contractually required services for Members including policies and procedures on the scope of services required to be offered under this Contract, how to utilize services in the Medi-Cal program, how to access carved out services, and how obtain referrals to appropriate community resources and other agencies.

C. Contractor must ensure its Member services staff are educated on assisting Members with disabilities, chronic conditions, and components of Health Equity in accordance with Exhibit A, Attachment III, Subsection 5.2.11.C. *(Cultural and Linguistic Programs and Committees)*. This includes assisting Members with access barriers, disability access issues, referral to appropriate clinical services, Grievance and Appeal resolution, and State Hearings.

D. Contractor's Member services staff must refer Potential Members to the DHCS Enrollment broker when Potential Members request Enrollment with Contractor.

E. Contractor's Member services staff must refer Potential Members to their local county office for Medi-Cal eligibility determinations or redeterminations.

F. Contractor must ensure its Member services staff assist Members with a warm hand-off to Subcontractors and Downstream Subcontractors when Member services functions are delegated under a Subcontractor Agreement or Downstream Subcontractor Agreement.

5.1.3 Member Information

A. Contractor must provide all new Members, and Potential Members upon request, with information in compliance with 42 CFR section 438.10, Welfare and Institutions Code (W&I) section 14406, 22 CCR section 53895, and as set forth in this provision.

B. Contractor must provide information as required in 42 CFR section 438.10, W&I section 14406, and 22 CCR section 53895 no later than seven calendar days after the effective date of a Member's Enrollment.

C. Contractor must distribute the information required by Exhibit A, Attachment III, Subsection 5.1.3 *(Member Information)*, Paragraphs A-B annually, and upon a Member's request. Contractor must ensure the information is current and has prior approval for distribution from DHCS.

D. All Member Information must be in a format that is easily understood and in a font size no smaller than 12-point, in compliance with all requirements in 42 CFR sections 438.10, 438.404, and 438.408, W&I section 14029.91, and 22 CCR section 53876. Member Information is defined in this Contract and discussed in detail in APL 21-004. Member Information includes, but is not limited to, the Member Handbook (also called the Evidence of Coverage, or EOC), Provider Directory, and all mailings and notices critical to obtaining services, including form letters, Notices of Action (NOAs), NABDs, Grievances or Appeals, welcome packets, Marketing information, preventive health reminders, Member surveys, notices advising of the availability of free language assistance, and newsletters.

E. If a Member or Potential Member requests Member Information in a format other than as printed materials, Contractor must provide the Member Information in the alternate formats, including Braille, large-size print font no smaller than 20-point, accessible electronic format, or audio format.

F. Contractor must ensure that all Member Information is provided to Members at a sixth grade reading level and approved by DHCS before distribution. Member Information must inform Members on Contractor's processes and the Member's right to make informed health decisions.

1) Contractor must submit to DHCS for review and approval their policy and process for collecting requests and disseminating materials in an alternative format when requested by Member.

2) For Members with disabilities, including visual impairment Contractor must provide Member Information in all Threshold Languages, alternative formats as specified by DHCS and in APL 21-004 and APL 22-002 (including Braille, large-size print font no smaller than 20-point, accessible electronic format, audio compact disc (CD) format, or data CD format), and through Auxiliary Aids at no cost and upon request. Contractor must provide Member Information in a timely fashion appropriate for the format being requested and taking into consideration the special needs of Members with disabilities or Limited English Proficiency (LEP) Members.

    a) Contractor must inform Members who exhibit or mention difficulty reading print communications of their right to receive Auxiliary Aids and services, including alternative formats.

    b) For Members who request an electronic alternative format to receive Member information, Contractor must inform the Member that, unless they request a password-protected format, the Member Information will be provided in an electronic format that is not password protected, which may make the information more vulnerable to loss or misuse. Contractor must clearly communicate to Members that they may request an encrypted electronic format with unencrypted instructions on how the Member can access the encrypted information.

    c) Contractor must accommodate the communication needs of qualified individuals with disabilities, which may include communication with the Member's Authorized Representative (AR) or someone with whom it is appropriate for Contractor to communicate, such as a Member's disabled spouse. For these qualified individuals, Contractor must facilitate alternative format requests as identified in this Paragraph, as well as requests for other Auxiliary Aids and services.

3) Contractor must establish policies and procedures to ensure Members receive all Member Information in a Threshold Language

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or alternative format of their choice as required by 42 CFR section 438.10, W&I section 14029.91, and Exhibit A, Attachment III, Subsection 5.2.10.B (*Access Rights*).

4) Contractor must post a DHCS-approved nondiscrimination notice. Contractor must also post a notice with language taglines in a conspicuously visible font size in English, at least the top 15 non-English languages in the State, and any other languages, as determined by DHCS, explaining the availability of free language assistance services, including written translation and oral interpretation, and information on how to request Auxiliary Aids and services, including materials in alternative formats. The nondiscrimination notice and the notice with taglines must include Contractor's toll-free and Telephone Typewriters (TTY)/Telecommunication Devices for the Deaf (TDD) telephone number for obtaining these services, and must be posted as follows:

   a) In a conspicuous place in all physical locations where Contractor interacts with the public;

   b) In a location on Contractor’s website that is accessible on Contractor’s home page, and in a manner that allows Members, Potential Members, and members of the public to easily locate the information; and

   c) In the Member Handbook/EOC, and in all Member Information, informational notices, and materials critical to obtaining services targeted to Members, Potential Members, applicants, and the public at large, in accordance with APL 21-004 and APL 22-002, 42 CFR section 438.10(d)(2)-(3), and W&I section 14029.91(a)(3) and (f).

5) Contractor’s nondiscrimination notice must include all information required by W&I section 14029.91(e), any additional information required by DHCS, and must provide information on how to file a Discrimination Grievance with:

   a) Both Contractor and the DHCS Office of Civil Rights, if there is a concern of discrimination based on sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, health status, marital status, gender, gender identity, or sexual orientation, or identification with

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any other persons or groups defined in Penal Code section 422.56; and

b) The United States Department of Health and Human Services (U.S. DHHS) Office for Civil Rights if there is a concern of discrimination based on race, color, national origin, sex, age, or disability, per W&I section 14029.91(e)(5).

G. Member Information Noticing in Electronic Format

1) Contractor has the option to send Members a notice in Member welcome packets or annual informational mailings to inform Members of how to obtain their Provider Directory and Member Handbook electronically or in a paper version if preferred. The notice can be an insert, flyer, or other form of noticeable communication.

a) Contractor may provide Seniors and Persons with Disabilities (SPDs) a notice in lieu of a paper Member Handbook in Member welcome packets. Contractor must still provide all SPDs with the paper form of the Provider Directory. The paper form of the Provider Directory may be a personalized, shorter version of the full-sized Provider Directory.

b) Contractor may provide their non-SPD, dual eligible Members a notice on how to access the Provider Directory and Member Handbook electronically in lieu of a paper version in Member welcome packets.

c) Contractor may provide all Members, except SPDs, a notice in lieu of a paper Provider Directory and Member Handbook for annual informational mailings.

2) Prior to using a notice, Contractor must submit the following to DHCS for approval:

a) A written proposal on Contractor’s letterhead addressed to “DHCS Contract Manager” requesting to use a notice instead of mailing the informing materials. The proposal must include the following:

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i. An overview of Contractor's process for utilizing the notice and how Contractor will meet all notice requirements.

ii. An explanation of the notice's purpose, including a description of the Member population(s) who will receive the notice.

iii. Time frame for implementation.

iv. A statement that Contractor is complying with all applicable State and federal laws, the requirements of this Contract, and other DHCS guidance, including APLs and Policy Letters (PLs).

v. For Member packages only, a proposal of how Contractor will move toward creating a personalized Provider Directory, with a timeline included that covers the cycle of production to delivery of personalized Provider Directories.

vi. Any other pertinent information necessary for DHCS to review.

b) A written policy and procedure describing in detail the process Contractor will utilize for the notice and how Contractor will continue to meet all language and format requirements set forth in 42 CFR section 438.10(d)(3), Provider Directory and website requirements in accordance with 42 CFR section 438.10(h), and sub-contractual relationship and delegation requirements set forth in 42 CFR section 438.230.

c) A sample of Contractor's proposed notice regarding electronic communications. The notice must be easily identifiable by the Member, state the purpose of each piece of Member material offered, and identify the options Members will have for receiving their Member materials.

3) The notice must be compliant with all the requirements of this Contract and DHCS policy, and federal and State statutes and regulations on Member Information, including 42 CFR sections 438.10 and 438.404, and W&I section 14029.91. DHCS will approve Contractor's notices on a case-by-case basis.

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4) DHCS reserves the right to require Contractor to revert to sending printed copies of the Provider Directory and Member Handbook to its Members, at any time.

H. Provider Directory

1) Contractor must submit its complete Provider Directory to DHCS for review and approval prior to initial operations.

2) Contractor must make its Provider Directory available to all Members and to DHCS for distribution as required.

3) Contractor's Provider Directory must be available in both paper and electronic formats. Provider Directory information must be included with Contractor's written Member Information for new Members, and thereafter available upon request. An electronic Provider Directory must be posted on Contractor's website in a machine readable and accessible file and format.

4) Contractor must update and submit its paper and electronic Provider Directories to DHCS in accordance with 42 CFR section 438.10(h)(3)(i)(A)-(B). Contractor must submit under the following timelines:

a) A paper Provider Directory must be updated at least monthly, if Contractor does not have a mobile-enabled, electronic Provider Directory; or quarterly, if Contractor has a mobile-enabled, electronic Provider Directory; and

b) An electronic Provider Directory must be updated no later than one week after Contractor receives updated provider information.

5) Contractor's Provider Directory submission must include complete, accurate and updated Provider Directory and Network information and data and submit as required by 42 CFR section 438.10(h)(3). Contractor's Provider Directory must also comply with all requirements in PL 11-009. DHCS is authorized to require changes or corrections to Contractor's Provider Directory at any time.

6) Contractor must implement and maintain a publicly accessible standards-based Provider Directory API, as described in 42 CFR section 431.70 and APL 22-026, which must include the information required here in Exhibit A, Attachment III, Subsection 5.1.3.H

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(*Member Information*). The Provider Directory API must meet the technical standards in 45 CFR section 170.215, excluding the security protocols related to user authentication and authorization.

7) Provider Directories must comply with 42 CFR section 438.10(h) and H&S section 1367.27, and must include the following information for in-Network PCP, Specialists, hospitals, Enhanced Care Management (ECM), Community Support Providers, Behavioral Health Providers, and any other Providers (e.g., Community Health Workers (CHW)) contracted for Medi-Cal Covered Services:

   a) The Provider's or site's location name and any group affiliation(s), National Provider Identifier (NPI) number, street address(es), all telephone numbers associated with the practice site, and, if applicable, website URL for each Service Location;

   b) Provider's specialty type and paneling status that allows them to treat specific populations, including but not limited to, whether they are a California Children's Services (CCS paneled provider;

   c) Whether the Provider is accepting new patients;

   d) Information on the Provider's affiliated medical group or Independent Physician/Provider Associations (IPA), NPI number, address, telephone number, and, if applicable, website URL for each Physician Provider of affiliated group or IPA;

   e) The hours and days when each Service Location is open, including the availability of evening or weekend hours;

   f) The services and benefits available, including accessibility symbols approved by DHCS confirming whether the office/facility (exam room(s), equipment, etc.) can accommodate Members with physical disabilities as required by PL 11-009;

   g) The Provider's cultural and linguistic capabilities, including whether non-English languages and American Sign Language are offered either by the Provider or a skilled medical interpreter at the Provider's facility;

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h) The telephone number to call after normal business hours;

i) Identification of Network Providers or sites that are not available to all or new Members

j) The link to the Medi-Cal Rx Pharmacy Locator, which can be found on the dedicated Medi-Cal Rx website described in APL 22-012.

I. Member Handbook

Contractor must comply with the requirements in 22 CCR section 53895(b) by distributing a Member Handbook, also known as an Evidence of Coverage and Disclosure Form (EOC/DF) to each Member and to Potential Members, upon request. The Member Handbook must meet all requirements in 42 CFR section 438.10(g), 22 CCR section 53881, and any other requirements in State and federal law, and this Contract. In addition, the Member Handbook must meet all applicable requirements contained in 42 CFR section 438.10(d), W&I section 14029.91, 22 CCR section 53876 for Limited English Proficiency (LEP) Members and Potential Members and H&S section 1363 as to translation, print size, readability, and understandability of text.

1) Contractor must provide to each Member, or Member's family unit, a Member Handbook that constitutes a full and fair disclosure of the Member's right to obtain and Contractor's provision of all Medi-Cal services that are available and accessible to the Member. Contractor must post its most recent Member Handbook to its website.

2) Contractor must use the DHCS template for its Member Handbook. Contractor must submit its information that is specific to Contractor, where applicable. Contractor must submit its completed Member Handbook, with all Contractor-specific information included in redline, for review and approval by DHCS before distribution to Members.

3) Contractor must make the revised Member Handbook available to Members based on the timeframes required by State and federal law and at any time DHCS, a Member, or a Potential Member requests a copy.

4) Although Contractor is required to use the DHCS Member Handbook template, Contractor remains solely responsible for

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ensuring that Members receive the following information through the Member Handbook:

a) Contractor's name, address, toll-free telephone number(s) for Member services, Medi-Cal Rx telephone number(s) and website information, any other Contractor staff providing services directly to Members, and information on Contractor's Service Area;

b) Information on how to access services in the Medi-Cal managed care system, including a description of the full amount, duration, and scope of Covered Services and how to obtain services under this Contract. The Member Information must also include information on services that require Prior Authorization and how to request it, health education and how to access appropriate community resources and other agencies, interpretive services provided by Contractor's staff and at service sites, and an explanation of "carved- out" services, including Specialty Mental Health Services, and any service limitations and exclusions from coverage or charges for services. The Member Handbook must also include information on services to which Contractor, Subcontractor, Downstream Subcontractor, or a Network Provider may have a moral objection to perform or support and alternative methods for obtaining those services;

c) Procedures for accessing Covered Services, which explain that Covered Services will be obtained through Contractor's Network Providers unless otherwise allowed under this Contract;

d) A description of the Member identification card issued by Contractor, if applicable, and an explanation of its use in authorizing or assisting Members in obtaining services;

e) Procedures for selecting or requesting a change in PCP at any time, any requirements for a Member to change their PCP, reasons for which a request for a specific PCP may be denied, and reasons why a PCP may request a change;

f) The purpose and value of scheduling and completing an Initial Health Appointment (IHA);

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g) The availability and procedures for obtaining after-hours services 24 hours a day, seven days a week, including the appropriate Network Provider locations and telephone numbers to obtain services. This must include an explanation of the Members' right to interpretive services, at no cost, to assist in receiving after-hours services;

h) Definition of what constitutes an Emergency Medical Condition, Emergency Services, and post-stabilization services. The Member Handbook must expressly state that Prior Authorization is not required to receive Emergency Services and include the use of 9-1-1 for obtaining Emergency Services;

i) The right to receive Emergency Services in any hospital or other setting, and procedures for obtaining Emergency Services from specified Network Providers or from out-of-Network Providers, including Emergency Services outside of Contractor's Service Area. This includes the right to the provision of at least a 72-hour supply of Medically Necessary medication in an emergency situation is provided;

j) Process for referral to Specialists, including an explanation of the Prior Authorization process, in sufficient detail so the Member can understand how the process works, including authorization and referral timeframes and alternative access standards as required by W&I section 14197.04, APL 23-001, and APL 21-011;

k) Procedures for obtaining Emergency Medical Transportation (EMT) and Non-Emergency transportation services to service sites that are offered by Contractor or available through the Medi-Cal program, and how to obtain such services. Include a description of medical transportation, including EMT, Non-Medical Transportation (NMT) and Non-Emergency Medical Transportation (NEMT) services, and how Contractor coordinates access to appropriate transportation, when needed;

l) The right to file a Grievance and request an Appeal with Contractor, and procedures for filing either orally, in writing, or over the phone. Contractor must inform Members of all Appeal and State Hearing rights when it makes a decision to deny, delay or modify a Member's request for services as set

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forth in Exhibit A, Attachment III, Section 4.6 (*Member Grievance and Appeal System*);

m) Information on disenrollment from Contractor. Contractor must ensure that the following information is included:

i. The causes for which a Member may lose eligibility to receive services under this Contract as set forth in Exhibit A, Attachment III, Subsection 4.2.2 (*Disenrollment*), and the procedures for disenrollment due to the loss of eligibility.

ii. An explanation of the expedited disenrollment process for Members qualifying under conditions specified under 22 CCR section 53889(j), which includes Children receiving services under the Foster Care or Adoption Assistance Programs, Members who require out-of-Network transplant services if they are unavailable in-Network, and Members already enrolled in another Medi-Cal, Medicare, or commercial managed care plan.

n) An explanation of the Member's right to disenroll at any time, and reenroll in the competing Medi-Cal managed care plan in the county (in counties where another Medi-Cal managed care plan is available), subject to the requirements in 22 CCR 53889, 22 CCR 53891(c) and any restricted disenrollment period;

o) Information on the Member's right to a Medi-Cal State Hearing, the process for obtaining a State Hearing, the timeframe to request a State Hearing, and the rules that govern representation in a State Hearing. Contractor must ensure the following information is included:

i. The circumstances under which an expedited State Hearing is possible;

ii. Information stating that Contractor will assist in completing the State Hearing request when a health care service requested by the Member or Provider has been denied, delayed, or modified, as required by APL 21-011;

iii. The timelines which govern a Member's right to a State Hearing, pursuant to W&I section 10951 and for an expedited State Hearing pursuant to W&I section 10951.5;

iv. The **California** Department of Social Services (DSS) Public Inquiry and Response Unit toll-free telephone number (1-800-952-5253) to request a State Hearing; and

v. Contractor's obligation to continue the disputed service(s) until there is a final decision on the State Hearing as long as if the Member requests a State Hearing in the specified timeframe(s) as required by 42 CFR section 438.420.

p) The availability of, and procedures for obtaining services at FQHCs, RHCs and IHCPs;

q) The Member's right to seek family planning services from any qualified family planning Provider in the Medi-Cal program, including out-of-Network Providers; how to access these services; that a referral is not necessary; and a description of the limitations on the services that Members may seek out-of-Network. The DHCS Office of Family Planning toll-free telephone number (1-800-942-1054) that provides consultation and referral to family planning clinics must also be included. Contractor must ensure that the following statement, or similar language provided by DHCS is included:

Family planning services are provided to Members of childbearing age to enable them to determine the number and spacing of Children. These services include all methods of birth control approved by the Federal Food and Drug Administration. As a Member, you pick a doctor who is located near you and will give you the services you need. Our Primary Care Providers and OB/GYN Specialists are available for family planning services. For family planning services, you may also pick a doctor or clinic not connected with [Plan Name] without having to get permission from [Plan Name]. [Plan Name] will pay that doctor or clinic for the family planning services you get.

r) Procedures for providing female Members with direct access to an in-Network women's health Specialist for women's preventive and routine health care services without requiring Prior Authorization. Access to a women's health Specialist must be provided in addition to the Member's designated PCP if the PCP is not a women's health Specialist;

s) Information on the availability of and procedures for obtaining Certified Nurse Midwife (CNM) and Nurse Practitioner services, pursuant to Exhibit A, Attachment III, Subsection 5.2.8.G. (*Specific Requirements for Access to Programs and Covered Services*);

t) Information on how to access the DHCS Medi-Cal Managed Care Ombudsman Program and toll-free telephone number (1-888-452-8609), and the DMHC HMO Consumer Service toll-free telephone number (1-800-400-0815) for resolution of Member concerns and complaints;

u) Information on the provision and availability of services covered under the California Children's Services (CCS) Program from out-of-Network Providers, and how to access CCS Program;

v) Information on how to obtain Minor Consent Services through Contractor's Network, an explanation of those services, and information on how Minor Consent Services can also be obtained from out-of-Network Providers without requiring Prior Authorization;

w) Information on the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit for Members less than 21 years of age, and that it includes all Medically Necessary health care, diagnostic services, treatments, and other measures listed in 42 United States Code (USC) section 1396d(a) and (r), whether or not covered under the California Medicaid State Plan. All EPSDT services are Covered Services unless expressly excluded under this Contract;

x) An explanation on how to use the Medi-Cal Fee-For-Service (FFS) system when Medi-Cal services are excluded or limited under this Contract, and how to obtain additional information;

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y) An explanation that an American Indian Member's status as a Member is voluntary and that an American Indian Member cannot be required to enroll in a Medi-Cal managed care plan and has the right to access IHCP, choose an IHCP within Contractor's Network as a PCP, and disenroll from Contractor at any time, without cause;

z) Language regarding the positive benefits of organ donations and how a Member can become an organ or tissue donor, pursuant to H&S section 7158.2. This information must be provided in the Member Handbook as well as Contractor's newsletter and any other direct communication with Members, and must be provided the Members annually under H&S section 7158.2;

aa) Confirmation of whether Contractor offers financial bonuses or other incentives to its Network Providers. This information must inform the Member of the right to request additional information about these bonuses or incentives from Contractor, their Network Provider, or the Network Provider's medical group or IPA, pursuant to H&S section 1367.10;

bb) Instructions on how a Member can request a copy of, or the website link to locate, Contractor's non-proprietary clinical and administrative policies and procedures;

cc) That oral interpreter services are available for any language spoken by the Member, and that the Member can inform Contractor of their preferred language to receive written translations of Member materials in the identified Threshold Languages, both free of charge, with instruction on Contractor's obligations to ensure these services are provided;

dd) That Auxiliary Aids and services are available upon request and at no cost for Members with disabilities, and how to access these services;

ee) Information on how to report suspected Fraud, Waste and Abuse; and

ff) Information on how to request Community Supports.

J. Member Identification Card

Contractor must provide an identification card to each Member, which identifies the Member and authorizes them to access Covered Services. The card must inform the Member that they may seek Emergency Services from out-of-Network Providers. The card must inform the Member of the Medi-Cal Rx telephone number. The Member identification card must also inform the Member that Emergency Services are covered by Contractor without Prior Authorization, and at no cost to the Member.

5.1.4 Primary Care Provider Selection

A. Contractor must implement and maintain DHCS-approved procedures to ensure that each new Member who is not enrolled in comprehensive Other Health Coverage (OHC) has an appropriate and available PCP. Comprehensive OHC refers to:

1) Members with the OHC Code indicator C, H, F, K, or P as listed in the 834 file, or,

2) OHC with a scope of coverage of at least Outpatient, Inpatient, and Medical/Allied (OIM) Services found in positions 119 through 126 in the Health Insurance System Database (HISDB) file.

B. Contractor must provide each new Member an opportunity to select a PCP within the first 30 calendar days of Enrollment. Contractor must make best efforts to ensure the Member is assigned to the PCP the Member selected at the time of their Enrollment, unless the PCP is unavailable or is not accepting new patients.

C. If the Member does not select a PCP within 30 calendar days of the effective date of Enrollment, Contractor must assign that Member to a PCP and notify the Member and the assigned PCP no later than 40 calendar days after the Member's Enrollment. Contractor must ensure that adverse selection does not occur when Members are assigned to PCPs.

1) Contractor must allow Members to select a clinic that provides Primary Care in lieu of selecting a specific PCP, where available.

2) If Contractor's Network includes Nurse Practitioners (NP), Certified Nurse Midwives (CNMs), OB-GYN, or Physician Assistants, the Member may select one of these practitioners as their PCP within 30 calendar days of Enrollment to provide Primary Care services in accordance with 22 CCR section 53853(a)(4).

3) SPD Members may select a Specialist or clinic as a PCP if the Specialist or clinic agrees to serve as the Member's PCP and is qualified to treat the health conditions of the SPD Member, in accordance with W&I section 14182(b)(11).

4) Contractor must ensure that Members are allowed to change their PCP, NP, CNM, or Physician Assistant assignment, upon request, by selecting a different PCP from Contractor's Network.

D. Contractor must inform Members through direct outreach to provide an explanation for the reason the Member could not be assigned to their selected PCP.

E. Contractor must ensure that Members who have an established relationship with a Network Provider, and who want to continue their patient-Provider relationship, are assigned to that Provider without disruption in the Member's care if the Member's existing relationship meets the requirements set forth in APL 18-008 (revised).

F. Contractor must ensure that Members can choose Traditional and Safety-Net Providers as their PCP, and that American Indian Members may choose an IHCP within Contractor's Network as their PCP.

G. Contractor is not obligated to require full benefit dual eligible Members to select a Medi-Cal PCP. Nothing in this section must be construed to require Contractor to pay for services that would otherwise be paid for by Medicare.

H. If a Member does not select a PCP within 30 calendar days of the effective date of Enrollment, Contractor must use utilization data or other data sources in its possession or provided by DHCS to select a PCP for the Member. This includes review of electronic data to confirm existing Provider relationships for the purpose of PCP assignment, including a Specialist or clinic for an SPD if they have indicated they have a preference for either to act as their PCP. Contractor must comply with all federal and State privacy laws in the provision and use of this data.

I. Contractor must notify the PCP that a Member has selected or been assigned to the Provider within ten calendar days from the date selection or assignment is complete.

J. Contractor must maintain procedures that proportionately include contracting with Traditional and Safety-Net Providers in the assignment process for Members who do not choose a PCP. Contractors in public

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hospital health system counties must assign PCPs in compliance with W&I section 14199.1.

5.1.5 Notices of Action for Denial, Deferral, or Modification of Prior Authorization Requests

Contractor must notify Members of a decision to deny, defer, or modify requests for Prior Authorization, in accordance with 42 CFR section 438.210(c) and 22 CCR sections 51014.1 and 53894 by providing a NOA to Members and/or their AR, regarding any denial, deferral, or modification of a request for approval to provide a health care service. This notification must be provided in accordance with all requirements set forth in Exhibit A, Attachment III, Subsection 4.6.4 (*Notice of Action*).

Exhibit A, ATTACHMENT III

5.2 Network and Access to Care

5.2.1 Access to Network Providers and Covered Services
5.2.2 Network Capacity
5.2.3 Network Composition
5.2.4 Network Ratios
5.2.5 Network Adequacy Standards
5.2.6 Access to Emergency Service Providers and Emergency Services
5.2.7 Out-of-Network Access
5.2.8 Specific Requirements for Access to Programs and Covered Services
5.2.9 Network and Access Changes to Covered Services
5.2.10 Access Rights
5.2.11 Cultural and Linguistic Programs and Committees
5.2.12 Continuity of Care for Seniors and Persons with Disabilities
5.2.13 Network Reports
5.2.14 Site Review
5.2.15 Street Medicine

5.2 Network and Access to Care

5.2.1 Access to Network Providers and Covered Services

A. Primary Care

1) Contractor must ensure that each Member has an assigned Primary Care Provider (PCP) who is available and physically present at the Service Location for sufficient time to ensure access and appointments for the assigned Member when medically required. This requirement does not preclude an appropriately licensed Provider from being a substitute for the Member's assigned PCP in the event of vacation, illness, or other unforeseen circumstances.

2) Contractor must have processes in place to assist Members in selecting PCPs who are accepting new patients.

3) Contractor must consider the requirements in Welfare and Institutions Code (W&I) section 14182(b)(11) when assigning Members who are Seniors and Persons with Disabilities (SPD) to a PCP. Additionally, Contractor must ensure that Members have the option of selecting an Indian Health Care Provider (IHCP), Federally Qualified Health Center (FQHC), or Rural Health Clinic (RHC), as their PCP, where available.

B. Specialists

1) Contractor must ensure that Members have access to Specialists for Medically Necessary Covered Services in accordance with W&I section 14197, 22 CCR section 53853, and 28 CCR section 1300.67.2.2.

2) Contractor must maintain an adequate Network that includes adult and pediatric Specialists, and at a minimum, the core Specialists required in W&I section 14197(h)(2), within its Network to ensure Medically Necessary specialty care is available in accordance with 22 CCR section 53853(a), and W&I sections 14182(c)(2) and 14197.

C. Contractor must ensure its Network Providers, Subcontractors, and Downstream Subcontractors have adequate Networks and staff within its Service Area, including Physicians, nurses, and administrative and other support staff to ensure that they have sufficient capacity to provide and

coordinate care for Covered Services are provided in accordance with W&I section 14197, 22 CCR section 53853, 28 CCR section 1300.67.2.2, and all requirements in this contract.

D. Contractor must monitor Subcontractors and Downstream Subcontractors to ensure they can adequately deliver culturally and linguistically competent care including offering interpreter services when a Limited English Proficient (LEP) Member accesses a Provider who does not speak the Member's language.

E. Contractor must ensure that Members have access to all Non-**S**~~s~~pecialty Mental Health and Substance Use Disorder (SUD) Covered Services in accordance with 42 Code of Federal Regulations (CFR) section 438.900 *et seq.* Contractor must coordinate care for all Specialty Mental Health Services (SMHS) and SUD services and provide referrals including mechanisms to track completion of follow up visits, to the county mental health plan (MHP) and Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS) services as outlined in Exhibit A, Attachment III, Section 5.5 (*Mental Health and Substance Use Disorder Benefits*)

5.2.2 Network Capacity

A. Contractor must maintain a Network adequate to provide the full scope of benefits to 60 percent of all Potential Members or current Member Enrollment, whichever is higher, within its Service Area. Contractor must increase the capacity of the Network as necessary to accommodate all Enrollment growth beyond the 60 percent.

B. Contractor may request to renegotiate its Network capacity requirement with DHCS if utilization by Contractor's Members does not exceed 75 percent of the required Network capacity, after the first 12 months of operation. Any such change is subject to DHCS review and approval.

5.2.3 Network Composition

A. Contractor must maintain an adequate Network within its Service Area, in compliance with W&I section 14197, and if necessary to ensure contract compliance with Network adequacy. Contractor may offer to contract with Providers in adjoining Service Areas but must make good faith efforts to contract with Providers within Contractor's Service Area. Contractor's Network must include at a minimum adult and pediatric PCPs, obstetrics, and gynecology (OB/GYNs), adult and pediatric Behavioral Health Providers, adult and pediatric Non-**S**~~s~~pecialty outpatient Mental Health Service (NSMHS) Providers, adult and pediatric Specialists, hospitals, and

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Long-Term Care (LTC) Providers to ensure adequate access to all Medically Necessary Covered Services for all Members and to meet all Network adequacy requirements.

B. Contractor must maintain an adequate Network of Allied Health Personnel, supportive paramedical personnel, public hospitals and health care systems, care navigators, caseworkers, and public health nurses, and an adequate number of accessible service sites to ensure adequate access to all Medically Necessary Covered Services for all Members.

C. Contractor must include in its Network, where available, IHCP, FQHC, RHCs, Freestanding Birthing Centers (FBC), Certified Nurse Midwives (CNMs), and Licensed Midwives (LM) in accordance with W&I section 14087.325, Medicaid State Health Official Letter #16-006, All Plan Letter (APL) 18-022, and APL 23-001.

1) If Contractor is a local initiative health plan model, it must offer to contract with all FQHCs and RHCs in its county(ies), in accordance with W&I section 14087.325. Local initiative health plans must maintain and provide supporting documentation of all contracting efforts with each FQHC and RHC in its county(ies) to DHCS upon request, even if Contractor has a minimum of one active contract with an FQHC and RHC in their county(ies).

2) If Contractor is not a local initiative health plan model, it must contract with a sufficient number of and include at least one FQHC, one RHC, and one FBC in the Network, where available in Contractor's Service Area(s), to the extent that the FQHC, RHC, and FBC Providers are licensed and recognized under State law.

D. Contractor must offer to contract with all IHCP available in each county(ies) in which Contractor operates in accordance with 22 CCR section 55120. If Contractor is unable to contract with an IHCP, Contractor must allow eligible Members to obtain services from out-of-Network IHCP in accordance with 42 CFR section 438.14.

E. Contractor must make good faith efforts to contract with at least one cancer center within their Networks and subcontracted Networks, if applicable, within each county in which Contractor operates for the provision of Covered Services to any eligible Member diagnosed with complex cancer diagnosis in accordance with W&I section 14197.45.

F. Contractor must continually ensure that the composition of its Network meets the ethnic, cultural, and linguistic needs of Contractor's Members.

G. Contractor must have an adequate number of NSMHS Providers to provide Medically Necessary, NSMHS based on current and anticipated utilization trends for its Members.

H. Contractor must include in its Network any traditional and Safety-Net Provider that is willing to contract under the same terms and conditions that Contractor offers to any other similar Provider in accordance with 22 CCR section 53800(b)(2)(C)(1).

I. Contractor must ensure that every LTC Provider in its Service Area that is licensed by the California Department of Public Health (CDPH) as a qualified LTC Provider is included in Contractor's Network, to the extent that the LTC Provider remains licensed, certified, operating, and is willing to enter into a Network Provider Agreement with Contractor on mutually agreeable terms and meets Contractor's Credentialing and quality standards. If Contractor determines that additional LTC Providers are necessary to meet the needs of its Members, Contractor must offer to contract or enter into a letter of agreement with any additional CDPH licensed LTC Providers in its Service Area or in adjoining Service Areas.

J. Contractor must receive a preapproval or assessment of suitability from CDPH prior to the execution of a Network Provider Agreement for LTC Providers undergoing a change of ownership. Network Provider Agreements must have a clause that LTC Providers must notify Contractor if it is undergoing a change of ownership so Contractor can obtain preapproval or assessment of suitability from CDPH.

K. Contractor must ensure that every CBAS Provider within Contractor's Service Area, that has been approved by the California Department of Aging (CDA) as a CBAS Provider, is included in Contractor's Network to the extent that the CBAS Provider remains licensed as an Adult Day Health Care (ADHC) Center, is certified and enrolled as a Medi-Cal Provider, is willing to enter into a Network Provider Agreement with Contractor on mutually agreeable terms, and meets Contractor's credentialing and quality standards. Contractor must contract with a sufficient number of Community-Based Adult Service (CBAS) Providers to timely meet the needs of Members who are CBAS-eligible. Contractor must have an adequate number of CBAS Providers that are geographically located within one hour's transportation time of its CBAS-eligible Members and that are appropriate for and proficient in addressing CBAS-eligible Members' specialized health needs and acuity, communication, cultural, and language needs and preferences. Contractor must also meet expected CBAS-utilization without a waitlist.

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5.2.4 Network Ratios

A. Contractor must continually comply with 22 CCR sections 53853(a)(1) - (2) and ensure that its Network meets the following full-time equivalent (FTE) Physician to Member ratios:

1) FTE Primary Care Providers that are Physicians: Member 1:2,000

2) FTE Total Physicians: Member 1:1,200

B. Contractor must ensure that FTE non-physician medical practitioner's Member caseload does not exceed 1,000 patients in accordance with 22 CCR section 53853(a)(3).

C. Contractor must ensure compliance with 22 CCR sections 51240 and 51241, and Business and Professions Code sections 3516 and 2836.1. Contractor must ensure full-time equivalent Physician supervisor to non-physician medical practitioner ratios do not exceed the following:

1) Physician Supervisor: Nurse Practitioners 1:4

2) Physician Supervisor: Physician Assistants 1:4

3) A Physician supervisor may not supervise more than four non-physician medical practitioners in any combination.

5.2.5 Network Adequacy Standards

A. Timely Access

1) Contractor must continuously monitor and enforce Network Providers', Subcontractors', and Downstream Subcontractors' compliance with the requirements in W&I section 14197(d)(1)(A), 28 CCR section 1300.67.2.2, and the requirements in this Contract.

2) Contractor must develop, implement, and maintain procedures to monitor and ensure that Contractor, Network Providers, Subcontractors, and Downstream Subcontractors:

a) Comply with requirements for Members to obtain appointments for routine care, Urgent Care, routine specialty referral appointments, prenatal care, Children's preventive periodic health assessments, and adult Initial Health Appointments (IHAs) in accordance with W&I section 14197, and 28 CCR section 1300.67.2.2:

i. Urgent Care appointment for services that do not require Prior Authorization within 48 hours of a request;

ii. Urgent Care appointment for services that do require Prior Authorization within 96 hours of a request;

iii. Non-urgent appointments for Primary Care within ten (10) business days of request;

iv. Non-urgent appointments with Specialists within 15 business days of request;

v. Non-urgent appointment with a non-physician mental health Provider with ten (10) business days of request;

vi. Non-urgent appointment for ancillary services for the diagnosis or treatment of injury, or illness within 15 business days of request;

vii. Availability of LTC Providers for the following counties: Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara within five (5) business days of request;

viii. Availability of LTC Providers for the following counties: Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura within seven (7) business days of request; and

ix. Availability of LTC Providers for the following counties: Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Fresno, Glenn, Humboldt, Imperial, Inyo, Kern, Kings, Lake, Lassen, Madera,

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Mariposa, Mendocino, Merced, Modoc, Mono, Monterey, Napa, Nevada, Plumas, San Benito, San Bernardino, San Luis Obispo, Santa Barbara, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tulare, Tuolumne, Yolo, and Yuba within 14 business days of request.

b) Offer Members appointments for Covered Services within a time frame appropriate for their health condition but no longer than the appointment timeframes set forth in 28 CCR section 1300.67.2.2, unless the Member's preference is to wait for a later appointment from a specific Network Provider. The applicable waiting time for a particular appointment may be extended if the following conditions are met:

i. The Member's Medical Record notes that waiting will not have a detrimental impact on the Member's health, as determined by the referring or treating licensed health care Provider, or by the health professional providing triage or screening services, who is acting within the scope of their practice consistent with professionally recognized standards of practice;

ii. The Provider's decision to extend the applicable waiting time is noted in the Member's Medical Record and made available to DHCS upon request; and

iii. Contractor ensures that the Member receives notice of the Provider's decision to extend the applicable waiting time with an explanation of the Member's right to file a Grievance disputing the extension.

c) Contractor must provide the appointment time standards to Network Providers, Subcontractors, and Downstream Subcontractors, and monitor appointment waiting times in Network Providers' offices pursuant to 42 CFR section 438.206, W&I section 14197, and 28 CCR section 1300.67.2.2. Contractor must also ensure that Network Providers comply with requirements for follow up on missed appointments;

d) Offer hours of operation to Members that are no less than the hours of operation offered to non-Medi Cal patients, or to Medi-Cal Fee-For-Service (FFS) beneficiaries if the Network Provider serves only Medi-Cal beneficiaries; and

e) Maintain procedures for triaging Members' telephone calls, providing telephone medical advice, and accessing telephone interpreters 24 hours a day, seven days a week.

3) During normal business hours, the waiting time for a Member to speak by telephone with Contractor's customer service representative must not exceed ten minutes.

4) Contractor must ensure its customer service representatives have knowledge and competency to assist in resolving Members' questions and concerns.

5) Contractor must have a medical director or licensed Physician acting on behalf of Contractor's medical director, who is available 24 hours a day, seven days a week to assist with access issues.

6) Contractor must ensure that its Network Providers, Subcontractors, and Downstream Subcontractors participate in all timely access survey(s) and Network adequacy activities conducted by DHCS or its contractors. Contractor entering into new or amended Network Provider or Subcontractor agreements with Network Providers, Subcontractors, and/or Downstream Subcontractors must include language requiring Provider participation.

B. Time or Distance

1) Contractor must ensure that its Network Providers, Subcontractors, and Downstream Subcontractors meet the time or distance standards for adult and pediatric PCPs, adult and pediatric core Specialists, OB/GYN primary and specialty care, adult and pediatric mental outpatient health Providers, and hospitals, as required by W&I section 14197(b) and (c).

2) Contractor must either exhaust all other reasonable options for contracting with Providers, including offering to contract with Providers in adjoining Service Areas, or provide evidence to DHCS demonstrating that its delivery structure is capable of delivering the appropriate level of care and access as required by W&I section

14197 prior to submitting an Alternate Access Standard (AAS) request to DHCS.

3) If Contractor is unable to comply with the time or distance standards set forth in W&I section 14197, Contractor must submit an AAS request to DHCS for review and approval in accordance with APL 23-001, detailing how it intends to arrange for Covered Services in accordance with W&I section 14197(e)(3).

4) Contractor must publish on its website its approved AAS requests in accordance with W&I section 14197.04.

5) If Contractor has received an AAS approval from DHCS for a core Specialist, upon a Member's request, Contractor must assist the Member in obtaining an appointment with the appropriate core Specialist in accordance with W&I section 14197.04. Contractor must either make its best effort to establish a Member-specific case agreement with an out-of-Network Provider or arrange for an appointment with a Network Provider in an adjoining Service Area within the time or distance standards in accordance with W&I section 14197.04. If needed, Contractor must assist in arranging transportation for the Member. Contractor must not be held liable for fulfilling these requirements if either there is no core Specialist within the time or distance standards of this Contract, or the core Specialist has refused to contract in the previous 12 months.

6) Contractors that do not meet time or distance standards without the use of an AAS request must provide documentation demonstrating efforts to recruit new Providers to these areas. Contractor must submit this documentation as part of the Network certification report detailed in 5.2.13.

5.2.6 Access to Emergency Service Providers and Emergency Services

A. Contractor must have within its Network, at a minimum, a designated Emergency Services facility, providing care 24 hours a day, seven days a week. This designated Emergency Services facility must have one or more Physicians and one nurse on duty in the facility at all times.

B. Contractor must ensure that Members with Emergency Medical Conditions are seen on an emergency basis and that Emergency Services are available and accessible within Contractor's Service Area seven days a week, 24 hours a day, in accordance with 42 USC sections 1395dd and

1396u-2(b)(2), 42 CFR sections 438.114 and 438.206(c)(1)(iii), and 28 CCR 1300.67(g)(1).

C. Contractor must reimburse the costs of Emergency Services without Prior Authorization pursuant to 42 USC section 1395dd, 42 CFR section 438.114, 28 CCR section 1300.67(g), and 22 CCR section 53216 and 53855.

D. Contractor must have a medical director or licensed physician acting on behalf of Contractor's medical director, who is available 24 hours a day, seven days a week to authorize Medically Necessary Post-Stabilization Care Services, to respond to hospital inquiries within 30 minutes, and to coordinate the transfer of a Member whose Emergency Medical Condition is stabilized.

E. Contractor must ensure that Members have timely access to Medically Necessary follow-up care including but not limited to appropriate referrals to Primary Care, Behavioral Health Services, and social services for Members who have been screened in the emergency room and do not require Emergency Services.

F. Contractor must coordinate access to Emergency Services in accordance with Contractor's DHCS-approved emergency department protocol, as required in Exhibit A, Attachment III, Section 3.2 (*Provider Relations*).

G. If Contractor delegates its Emergency Services and Post-Stabilization Care Services oversight obligations to Network Providers, Subcontractors, or Downstream Subcontractors, it must ensure a licensed physician is available seven days a week, 24 hours a day, to authorize Medically Necessary Post-Stabilization Care Services and coordinate the transfer of stabilized Members in an emergency department to an appropriate Network Provider, if necessary, as required under Health & Safety Code (H&S) section 1371.4.

5.2.7 Out-of-Network Access

A. Contractor must authorize and arrange for out-of-Network access in the following circumstances:

1) Contractor does not meet Network adequacy requirements set forth in W&I section 14197;

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2) Contractor does not have an AAS approved by DHCS and fails to meet the Network adequacy standards set forth in W&I section 14197;

3) Contractor fails to comply with the requirements for timely access to appointments; or

4) Contractor must arrange for access to out-of-Network LTC when Medically Necessary for a Member in cases where Contractor does not have in-Network LTC capacity.

B. Contractor must authorize and arrange for services from out-of-Network Providers when the Provider type is unavailable within the Network but available in an adjoining county(ies). If there is no Network Provider in the adjoining county(ies), Contractor must authorize out-of-Network services to the most appropriate Provider as close to time or distance requirements as possible.

C. Contractor must provide Non-Emergency Medical Transportation (NEMT) or Non-Medical Transportation (NMT) to the out-of-Network Provider, at no cost to the Member. Contractor must inform Members of their right to obtain NEMT or NMT services to access out-of-Network services in accordance with W&I section 14197.04.

D. Contractor must adequately and timely cover and reimburse Providers for out-of-Network services rendered to its Members for as long as Contractor is unable to provide these services in its Network. Contractor must ensure that the Member is not charged for services furnished out-of-Network. Contractor must also ensure that Members are not balance-billed for any service provided out-of-Network.

5.2.8 Specific Requirements for Access to Programs and Covered Services

A. Family Planning Services

1) Contractor must ensure Members have access to family planning services through any available family planning Provider regardless of whether they are in or out of the Network, without requiring Prior Authorization. Contractor must provide family planning services in a manner that ensures Members have the freedom to choose their preferred method of family planning consistent with 42 CFR section 441.20.

2) Contractor must not restrict a Member's Provider choice for family planning services covered pursuant to 42 CFR section 431.51(a)(3) and W&I section 14132.07.

3) Contractor's Member Handbook must inform Members of their right to access any qualified family planning Provider regardless of whether the Provider is in the Network and without Prior Authorization, in addition to requirements included in Exhibit A, Attachment III, Section 5.1 (*Member Services*).

4) Contractor must ensure that Members are advised of their options for all contraceptive methods to allow them to provide informed consent for their choice of contraceptive method, including sterilization, as required by 22 CCR sections 51305.1 and 51305.3. Members of childbearing age may access the following services from an out-of-Network family planning Provider to temporarily or permanently prevent or delay pregnancy:

   a) Health education and counseling necessary to make informed choices and understand contraceptive methods;

   b) Limited history and physical examination;

   c) Laboratory tests if medically indicated as part of the decision-making process in choice of contraceptive methods, except pap smears if Contractor provides pap smears to meet the United States Preventive Services Taskforce (USPSTF) guidelines, http://www.uspreventiveservicestaskforce.org;

   d) Follow-up care for complications associated with contraceptive methods provided or prescribed by the family planning Provider;

   e) Provision of contraceptive pills, devices, and supplies;

   f) Tubal ligation;

   g) Vasectomies; and

   h) Pregnancy testing and counseling.

B. Sexually Transmitted Diseases

Contractor must ensure Members have access to Sexually Transmitted Disease (STD) services from any Network Provider or out-of-Network Provider without requiring Prior Authorization or referral. Contractor must allow Members to access out-of-Network STD services through Local Health Department (LHD) clinics, family planning clinics, or through other community STD service Providers.

C. HIV Testing and Counseling

Contractor must ensure that Members have access to confidential Human Immunodeficiency Virus (HIV) counseling and testing services from any Network Provider or out-of-Network Provider without requiring Prior Authorization.

D. Minor Consent Services

Contractor must ensure access to Minor Consent Services for **minor** Members ~~over the age of 12~~ **under the age of 18** from any Network Provider or out-of-Network Provider without requiring Prior Authorization. Contractor must ensure Members are informed of the availability of these services without Prior Authorization. Minors over the age of 12 do not need parent, legal guardian, or Authorized Representative (AR) consent to access these services, **if the minor, in the opinion of the attending professional person, is mature enough to participate intelligently in the outpatient services,** and Contractor, Network Providers, Subcontractors, or Downstream Subcontractors are prohibited from disclosing any information relating to Minor Consent Services without the express consent of the minor Member. Minor Consent Services include treatment for the following:

1) Under Age 12

   a) Pregnancy and pregnancy related services

   b) Family planning services

   c) Sexual assault services

2) Age 12 and Older

   a) Pregnancy and pregnancy related services

   b) Family planning services

c) Sexual assault services

d) Infectious, contagious, or communicable disease diagnosis and treatment

e) Sexually transmitted diseases prevention (or infections), diagnosis, and treatment

f) Drug and alcohol abuse treatment and counseling

g) Outpatient mental health treatment and counseling. Minors may obtain outpatient mental health services, if in the opinion of the attending professional person determines that the minor is mature enough to participate intelligently in their health care pursuant to Family Code section 6924.

h) Intimate partner violence **services**

E. Immunizations

Members may access LHD clinics for immunizations regardless of whether the LHD is in the Network or out-of-Network, without Prior Authorization. Upon request, Contractor must provide updated information on the status of the Member's immunizations to the LHD clinic. Contractor must reimburse LHD clinics that provide immunizations to its Members after receipt of claims and supporting immunization records.

F. Indian Health Care Providers

Contractor must ensure qualified Members have timely access to IHCPs within its Network, where available, as required by 42 USC section 1396j. IHCPs, whether in the Network or out-of-Network, can provide referrals directly to Network Providers without requiring a referral from a Network PCP or Prior Authorization in accordance with 42 CFR section 438.14(b). Contractor must also allow for access to an out-of-Network IHCPs without requiring a referral from a Network PCP or Prior Authorization in accordance with 42 CFR section 438.14(b).

G. Certified Nurse Midwife and Nurse Practitioner Services

1) Contractor must ensure that its Members have access to CNM services as required by 42 United States Code (USC) section 1396d(a)(17) and 22 CCR section 51345.

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2) Contractor must ensure its Members have access to Nurse Practitioner (NP) services as required in 22 CCR section 51345.1.

3) Contractor must inform its Members that they have a right to obtain out-of-Network CNM services if CNM services are not available in-Network.

H. Services to Which Network Provider, Subcontractor, or Downstream Subcontractor Has a Moral Objection

1) If a Network Provider, Subcontractor, or Downstream Subcontractor has religious or ethical objections to perform or otherwise support the provision of Covered Services, Contractor must timely arrange for, coordinate, and ensure the Member receives the Covered Services through referrals to a Provider that has no religious or ethical objection to performing the requested service or procedure, at no additional expense to DHCS or the Member.

2) Contractor's Member Handbook must identify services to which a Network Provider, Subcontractor, or Downstream Subcontractor may have a moral objection and explain that the Member has a right to obtain such services from another Provider. Contractor must also inform the Member that it will assist the Member in locating a Network Provider who will perform the service or procedure.

I. Federally Qualified Health Center, Rural Health Clinic, and Freestanding Birthing Center Services

Contractor must meet federal requirements for access to a FQHC, RHC, and FBC services consistent with 42 USC section 1396b(m) and Medicaid State Health Official Letter #16-006.

J. Community Based Adult Services

Contractor must provide Members with access to CBAS as set forth in the California Advancing and Innovating Medi-Cal (CalAIM) Special Terms and Conditions, or as set forth in any subsequent demonstration amendment or renewal, or successor demonstration, waiver, or other Medicaid authority. Without limitation, Contractor must do the following:

1) Provide and coordinate the provision of unbundled CBAS services for affected CBAS recipients as needed for continuity of care if there is a 5 percent reduction in CBAS Provider capacity in a

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county within the Service Area relative to the capacity that existed on April 1, 2012; and

2) Arrange Medically Necessary Covered Services for Members with similar clinical conditions as CBAS recipients if there is insufficient CBAS Provider capacity in a county in which ADHC was available prior to April 1, 2012, and coordinate their access to community resources to assist them to remain in the community.

5.2.9 Network and Access Changes to Covered Services

A. DHCS Notification Requirements

1) Contractor must provide notification to DHCS immediately upon discovery of a Network Provider initiated termination or at least 60 calendar days before any change occurs in the availability or location of services Contractor's Covered Services. Contractor must provide this notice if the change impacts more than 2,000 Members or impacts Contractor's ability to meet Network adequacy standards in accordance with APL 21-003. In the event of an emergency or other unforeseeable circumstance, Contractor must notify DHCS of the change in the availability or location of services as expeditiously as possible.

2) Contractor must provide notification to DHCS immediately, or within 10 calendar days of learning of a Provider's exclusionary status from any database or list included in APL 21-003.

3) Contractor must notify DHCS when it is unable to contract with a certified CBAS Provider or upon termination of a CBAS Network Provider Agreement. If Contractor and the CBAS Provider cannot come to an agreement on terms, Contractor must notify DHCS within five Working Days of Contractor's decision to exclude the CBAS Provider from its Network. DHCS may attempt to resolve the contracting issue when appropriate.

4) In accordance with APL 21-003, Contractor must notify DHCS within 60 calendar days of termination of a LTC Network Provider or immediately if the termination is a result of the LTC Network Provider having been decertified by the California Department of Public Health (CDPH). DHCS will attempt to resolve the contracting issue when appropriate. If termination of a LTC Network Provider Agreement is for a cause related to Quality of Care or patient safety concerns, Contactor may expedite termination of the LTC Network

Provider Agreement and transfer Members to an appropriate, contracted LTC Provider in an expeditious manner. DHCS must be notified of the termination within 72 hours of said termination. Contractor must not continue to assign or refer Members to a LTC Network Provider during the 60 calendar days between notifying DHCS and the termination effective date.

B. Member Notification Requirements

1) Contractor must ensure Members are notified in writing of any changes in the availability or location of Covered Services, of any termination of a Network Provider, Subcontractor, or Downstream Subcontractor either 30 calendar days prior to the effective date of the contract termination or at least 15 calendar days after receipt of issuance of the termination notice, whichever is longer, unless directed by DHCS. The notification must be provided to each Member who received Primary Care from, or was seen on a regular basis by, the terminated Provider. This notification must also be submitted to DHCS in writing for approval before its release.

2) Contractor must obtain DHCS approval before sending a notice of termination to its Members no later than 60 calendar days prior to the effective date of the termination. Contractor may use a member notice template previously approved by DHCS. Any changes from the approved template must be submitted to DHCS 60 calendar days prior to the effective date of the termination for review and approval before mailing the notice. In the event of an emergency or other unforeseeable circumstance, Contractor must provide notice of the emergency or other unforeseeable circumstance to DHCS as soon as possible.

5.2.10 Access Rights

A. Equal Access for Linguistic Services

Contractor must ensure equal access to the provision of high quality interpreter and linguistic services for LEP Members and Potential Members, and for Members and Potential Members with disabilities, in compliance with federal and State law, and APL 21-004.

B. Linguistic Services

1) Contractor must comply with W&I section 14029.91 and ensure that all monolingual, non-English-speaking, or LEP Members and

Potential Members receive 24-hour interpreter services at all key points of contact, as defined in Paragraph B.4) of this provision, either through interpreters, telephone language services, or other legally compliant electronic options.

2) Contractor must ensure that any lack of interpreter services does not impede or delay a Member's timely access to care.

3) Contractor must comply with Title VI of the Civil Rights Act of 1964 and 42 CFR section 438.10(d) and have the capacity to provide, at minimum, the following linguistic services at no cost to Members or Potential Members:

   a) Oral interpreters, sign language Providers, or bilingual Network Providers, Network Provider staff, Subcontractors, and Downstream Subcontractors at all key points of contact. These services must be provided in all languages spoken by Medi-Cal Members and Potential Members and not limited to those that speak the threshold or concentration standards languages.

   b) Full and immediate translation of written materials pursuant to 42 CFR sections 438.10(d)(3), 438.404(a), and 438.408(d); W&I section 14029.91; and 22 CCR section 53876 for LEP Members and Potential Members who speak Threshold or Concentration Standard Languages, fully translated Member Information, including: the Member Handbook, Provider Directory, welcome packets, Marketing information, Member rights information, form letters and individual notices, including Notice of Action (NOA) letters, all notices related to Grievances and Appeals including Grievance and Appeal acknowledgement and resolution letters, and any other materials as required by Title VI of the Civil Rights Act of 1964 and APL 21-004;

   c) Referrals to culturally and linguistically appropriate community service programs; and

   d) Auxiliary Aids such as Telephone Typewriters (TTY)/ Telecommunication Devices for the Deaf (TDD), qualified interpreters including American Sign Language interpreters, and information in alternative formats including Braille, large print text (20 point font or larger), audio, and electronic formats, in accordance with written informing materials in

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alternative formats, selected by the Member, as specified in APL 21-004 and APL 22-002.

4) Key points of contact include:

a) Medical care settings, such as telephone, advice and Urgent Care transactions, and outpatient Encounters with Providers; and

b) Non-medical care settings, such as Member services, orientations, and appointment scheduling.

C. Access for Persons with Disabilities

Contractor must comply with the requirements of Titles II and III of the Americans with Disabilities Act of 1990 (42 USC sections 12131 et seq. and 12181 et seq.), section 1557 of the Affordable Care Act of 2010 (42 USC section 18116), sections 504 and 508 of the Rehabilitation Act of 1973 (29 USC sections 794 and 794d), Government Code (GC) sections 7405 and 11135, and all applicable implementing regulations, and must ensure access for people with disabilities including, without limitation, accessible web and electronic content, ramps, elevators, accessible restrooms, designated parking spaces, and accessible drinking water.

5.2.11 Cultural and Linguistic Programs and Committees

A. Cultural and Linguistic Program

1) Contractor must develop and implement policies and procedures for assessing the performance of its employees, contracted staff, and other individuals who provide linguistic services, addressing any identified gaps in the provision of cultural and linguistic services by Contractor's staff, and for overall monitoring and evaluation of its cultural and linguistic services programs.

2) Contractor must have in place and continually monitor, improve, and evaluate cultural and linguistic services that support the delivery of Covered Services to Members. Contractor must ensure it has proper policies and procedures in place to provide appropriate cultural and linguistic services for all of its Members.

3) Contractor must take immediate action to improve the delivery of culturally and linguistically appropriate services when deficiencies are noted.

4) Contractor must be active in recruiting and retaining culturally and linguistically competent Providers that reflect the needs of the Medi-Cal population in Contractor's Service Area.

5) Contractor must have a cultural and linguistic services program, as required by 22 CCR section 53876, that incorporates all requirements of applicable federal and State law, including without limitation those requirements cited in Exhibit A, Attachment III, Subsection 5.2.10 (*Access Rights*), 42 CFR section 438.206(c)(2), 22 CCR sections 51202.5 and 51309.5(a), and 28 CCR sections 1300.67.04(c)(2)(A) - (B) and 1300.67.04(c)(2)(G)(v) - (c)(4). Contractor must ensure immediate translation of all critical Member Information as required by 42 CFR sections 438.10, 438.404(a), and 438.408(d), and W&I section 14029.91.

6) Contractor must review and update its cultural and linguistic services programs to align with the Population Needs Assessment (PNA) implementation and subsequent findings. Contractor must ensure its Network Providers, Subcontractors, Downstream Subcontractors cultural and Health Equity linguistic services programs also align with the PNA.

7) Contractor must implement and maintain a written description of its cultural and linguistic services program which must include, at a minimum, the following:

    a) Its organizational commitment to deliver culturally and linguistically appropriate health care services;

    b) Services that comply with Title VI of the Civil Rights Act of 1964 (42 USC section 2000e et seq.), section 1557 of the Affordable Care Act of 2010 (42 USC section 18116), 42 CFR section 438.10, APL 21-004, and Exhibit A, Attachment III, Subsection 5.2.10 (*Access Rights*).

    c) Use of national standards for Culturally and Linguistically Appropriate Services (CLAS) for reference;

    d) An organizational chart showing the key staff with overall responsibility for cultural and linguistic services programs;

    e) A narrative explaining the organizational chart and describing the oversight and direction to the Community Advisory Committee (CAC), requirements for Contractor's

support staff, and reporting relationships. Qualifications of Contractor's staff, including appropriate education, experience, and training must also be included;

f) The role of the PNA to inform Contractor's cultural and linguistic services program priorities in compliance with Exhibit A, Attachment III, Subsection 4.3.2 (*Population Needs Assessment*);

g) The implementation and maintenance of annual sensitivity, diversity, communication skills, Health Equity, and cultural competency/humility training and related trainings (e.g., providing gender affirming care) for employees and contracted staff (clinical and non-clinical), as determined by Section C of this provision, Diversity, Equity, and Inclusion Training; and

h) Contractor's administrative oversight and compliance monitoring of the cultural and linguistic services program and requirements for the delivery of culturally and linguistically appropriate health care services.

B. Linguistic Capability of Employees and Contracted Staff

Contractor must assess and track the linguistic capability of its interpreters or bilingual staff and contracted staff (clinical and non-clinical). Contractor must implement a system to provide adequate training regarding its language assistance programs to all employees and contracted staff who have routine contact with LEP Members or Potential Members and systematically address any identified gaps in Contractor's ability to address Members' cultural and linguistic needs. The training must include instruction on:

1) Contractor's policies and procedures for language assistance;

2) How to work effectively with LEP Members and Potential Members;

3) How to work effectively with interpreters in person and through video, telephone, and other media; and,

4) Understanding the cultural diversity of Members and Potential Members, and sensitivity to cultural differences relevant to delivery of health care interpretation services, in accordance with Exhibit A,

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Attachment III, Subsection 5.2.11 *(Cultural and Linguistic Programs and Committees).*

C. Diversity, Equity, and Inclusion Training

Contractor must provide annual sensitivity, diversity, cultural competency/humility and Health Equity training for its employees and contracted staff as detailed in APL 23-025. Training must consider structural and institutional racism and Health Inequities and their impact on Members, staff, Network Providers, Subcontractors, and Downstream Subcontractors. Contractor must ensure Network Providers and Allied Health Personnel receive pertinent information regarding the PNA findings and the identified targeted strategies. Contractor must use the most appropriate communication method(s) to assure the information can be accessed and understood. The training must include the following requirements:

1) Promote access and delivery of services in a culturally competent manner to all Members and Potential Members, regardless of sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, health status, marital status, gender, gender identity, sexual orientation, or identification with any other persons or groups defined in Penal Code section 422.56; and

2) Information about the Health Inequities and identified cultural groups in Contractor's Service Area which includes but is not limited to: the groups' beliefs about illness and health; need for gender affirming care; methods of interacting with Providers and the health care structure; traditional home remedies that may impact what the Provider recommends to treat the patient; and language and literacy needs.

D. Community Engagement

Contractor must develop a policy and procedure for a Member and family engagement strategy that involves Members and their families as partners in the delivery of Covered Services. This includes, but is not limited to the following:

1) Maintaining an organizational leadership commitment to engaging with Members and their families in the delivery of care;

2) Routinely engaging with Members and families through focus groups, listening sessions, surveys and/or interviews and incorporating results into policies and decision-making, as described in Exhibit A, Attachment III, Subsection 2.2.7.A (*Quality Improvement and Health Equity Annual Plan*);

3) Developing processes and accountability for incorporating Member and family input into policies and decision-making;

4) Developing processes to measures and/or monitor the impact of Member and family input into policies and decision-making;

5) Developing processes to share with Members and families how their input impacts policies and decision-making;

6) Conducting consumer surveys and incorporating results in Quality Improvement (QI) and Health Equity activities as described in Exhibit A, Attachment III, Subsection 2.2.9.C (*Consumer Satisfaction Survey*);

7) Partnering with community based organizations to cultivate Member and family engagement;

8) Maintaining a CAC whose composition reflects Contractor's Member population and whose input is actively utilized in policies and decision-making by Contractor, as outlined below in Exhibit A, Attachment III, Subsection 5.2.11.E. (*Cultural and Linguistic Programs and Committees*).

E. Community Advisory Committee (CAC)

1) Contractor must have a diverse CAC pursuant to 22 CCR section 53876(c), comprised primarily of Contractor's Members, as part of Contractor's implementation and maintenance of Member and community engagement with stakeholders, community advocates, traditional and Safety-Net Providers, and Members.

2) CAC Membership

a) Contractor must convene a CAC selection committee tasked with selecting the members of the CAC. Contractor must demonstrate a good faith effort to ensure that the CAC selection committee is comprised of a representative sample

of each of the persons below to bring different perspectives, ideas, and views to the CAC:

i. Persons who sit on Contractor's Governing Board, which should include representation in the following areas: Safety Net Providers including FQHCs, Behavioral Health Providers, Regional Centers (RC), Local Education Agencies (LEAs), dental Providers, IHCPs, and Home and Community-Based Service (HCBS) program Providers; and

ii. Persons and community-based organizations who are representatives of each county within Contractor's Service Area adjusting for changes in membership diversity.

b) The CAC selection committee must ensure the CAC membership reflects the general Medi-Cal Member population in Contractor's Service Area, including representatives from IHCPs, and adolescents and/or parents and/or caregivers of Children, including foster youth, as appropriate and be modified as the population changes to ensure that Contractor's community is represented and engaged. The CAC selection committee must make good faith efforts to include representatives from diverse and hard-to-reach populations on the CAC, with a specific emphasis on persons who are representative of or serving populations that experience Health Disparities such as individuals with diverse racial and ethnic backgrounds, genders, gender identity, and sexual orientation and physical disabilities.

c) Contractor's CAC selection committee must select all of its CAC members promptly no later than 180 calendar days from the effective date of this contract.

d) Should a CAC member resign, is asked to resign, or is otherwise unable to serve on the CAC, Contractor must make its best effort to promptly replace the vacant seat within 60 calendar days of the CAC vacancy.

e) Contractor must designate a CAC coordinator and maintain a written job description detailing the CAC coordinator's responsibilities, which must include having responsibility for managing the operations of the CAC in compliance with all

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statutory, rule, and contract requirements, including, but not limited to:

i. Ensuring CAC meetings are scheduled and committee agendas are developed with the input of CAC members;

ii. Maintaining CAC membership, including outreach, recruitment, and onboarding of new members, that is adequate to carry out the duties of the CAC;

iii. Actively facilitating communications and connections between the CAC and Contractor leadership, including ensuring CAC members are informed of Contractor decisions relevant to the work of the CAC;

iv. Ensuring that CAC meetings, including necessary facilities, materials, and other components, are accessible to all participants and that appropriate accommodations are provided to allow all attending the meeting, including, but not limited to, accessibility for individuals with a disability or LEP Members to effectively communicate and participate in CAC meetings;

v. Ensuring compliance with all CAC reporting and public posting requirements; and

vi. The CAC coordinator may be an employee of Contractor, Subcontractor, or Downstream Subcontractor. Contractor's CAC coordinator must not be a member of the CAC or a Member enrolled with Contractor.

3) CAC Meetings

a) Contractor must hold its first regular CAC meeting promptly after all initial CAC members have been selected by the CAC selection committee and at least quarterly thereafter.

b) Contractor must make the regularly scheduled CAC meetings open to the public, posting meeting information publicly on Contractor's website in a centralized location 30

calendar days prior to the meeting, and in no event later than 72 hours prior to the meeting.

c) Contractor must provide a location for CAC meetings and all necessary tools and materials to run meetings, including, but not limited to, making the meeting accessible to all participants and providing accommodations to allow all individuals to attend and participate in the meetings.

d) CAC must draft written minutes of each of its meetings and the associated discussions. All minutes must be posted on Contractor's website and submitted to DHCS no later than 45 calendar days after each meeting. Contractor must retain the minutes for no less than ten years and provided to DHCS, upon request.

e) Contractor must ensure that CAC members are supported in their roles on the CAC, including but not limited to providing resources to educate CAC members to ensure they are able to effectively participate in CAC meetings, providing transportation to CAC meetings, arranging childcare as necessary, and scheduling meetings at times and in formats to ensure the highest CAC member participation possible.

f) Contractor must demonstrate that CAC input is considered in annual reviews and updates to relevant policies and procedures, including CAC input pursuant to Exhibit A, Attachment III, Subsection 5.2.11.E. (*Cultural and Linguistic Programs and Committees)* that is relevant to policies and procedures affecting quality and Health Equity. Contractor must provide a feedback loop to inform CAC members how their input has been incorporated.

4) Duties of the CAC

The CAC must carry out the duties as set forth in this Contract. Such duties include, but are not limited to:

a) Identifying and advocating for Preventive Care practices to be utilized by Contractor;

b) Contractor must ensure that the CAC is included and involved in developing and updating cultural and linguistic policy and procedure decisions including those related to QI,

education, and operational and cultural competency issues affecting groups who speak a primary language other than English. The CAC may also advise on necessary Member or Provider targeted services, programs, and trainings;

c) The CAC must provide and make recommendations to Contractor regarding the cultural appropriateness of communications, partnerships, and services;

d) Contractor must engage their CAC as a part of their participation in LHJs' CHA/CHIP process, as defined further in the PHM Policy Guide;

e) Contractor must provide sufficient resources for the CAC to support the required CAC activities outlined above, including supporting the CAC in engagement strategies such as consumer listening sessions, focus groups, and/or surveys; and

f) The CAC must provide input and advice, including, but not limited to, the following:

i. Culturally appropriate service or program design;

ii. Priorities for health education and outreach program;

iii. Member satisfaction survey results;

iv. Findings of the PNA;

v. Plan Marketing Materials and campaigns.

vi. Communication of needs for Network development and assessment;

vii. Community resources and information;

viii. Population Health Management;

ix. Quality;

x. Health Delivery Systems Reforms to improve health outcomes;

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xi. Carved Out Services;

xii. Coordination of Care; and

xiii. Health Equity;

xiv. Accessibility of Services

5) Contractor's Annual CAC Demographic Report

To ensure Contractor's CAC membership is representative of the Communities in Contractor's Service Area, Contractor must complete and submit to DHCS annually an Annual CAC Member Demographic Report by April 1 of each year. The Annual CAC Member Demographic Report must include descriptions of all of the following:

a) The demographic composition of CAC membership;

b) How Contractor defines the demographics and diversity of its Members and Potential Members within Contractor's Service Area;

c) The data sources relied upon by Contractor to validate that its CAC membership aligns with Contractor's Member demographics;

d) Barriers to and challenges in meeting or increasing alignment between CAC's membership with the demographics of the Members within Contractor's Service Area;

e) Ongoing, updated and new efforts and strategies undertaken in CAC membership recruitment to address the barriers and challenges to achieving alignment between CAC membership with the demographics of the Members within Contractor's Service Area; and

f) A description of the CAC's ongoing role and impact in decision-making about Health Equity, health-related initiatives, cultural and linguistic services, resource allocation, and other community-based initiatives, including examples of how CAC input impacted and shaped Contractor initiatives and/or policies.

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5.2.12 Continuity of Care for Seniors and Persons with Disabilities

A. For newly enrolled Seniors and Persons with Disabilities (SPD) who request continuity of care, Contractor must provide continued access for up to 12 months to an out-of-Network Provider with whom the SPD Member has an ongoing relationship, as long as Contractor has no Quality of Care issues with the Provider and the Provider will accept either Contractor's or the Medi-Cal FFS Rates, whichever is higher, pursuant to W&I section 14182(b)(13) - (14). Contractor must use Medi-Cal FFS utilization data from DHCS to confirm that the SPD Member has an ongoing relationship with the Provider.

B. Contractor must allow all Members to request continuity of care in accordance with 42 CFR section 438.62 and APL 23-022.

C. Contractor must provide for the completion of Covered Services at the request of a Member in accordance with H&S section 1373.96. All Members with pre-existing Provider relationships who make a continuity of care request must be given the option to continue treatment for up to 12 months with an out-of-Network Provider, if the following criteria are met:

1) The Member has seen the out-of-Network Provider at least once within the 12 months before Enrollment with Contractor;

2) The out-of-Network Provider accepts Contractor's rate offered in accordance with H&S section 1373.96(d)(2) or (e)(2); and

3) The out-of-Network Provider meets Contractor's applicable professional standards and has no disqualifying Quality of Care issues.

D. Contractor must conduct Person-Centered Planning for SPD Members as follows:

1) Upon the Enrollment of a SPD Member, Contractor must provide, or ensure the provision of, Person-Centered Planning and treatment approaches that are collaborative and responsive to the SPD Member's continuing health care needs.

2) Contractor must include identifying each SPD Member's preferences and choices regarding treatments and services, and abilities.

3) Contractor must allow or ensure the participation of the SPD Member, and any family, friends, and professionals of their choosing, to participate fully in any discussion or decisions regarding treatments and services.

4) Contractor must ensure that SPD Members receive all necessary information regarding treatment and services so that they may make an informed choice.

5) Complex Case Management services for SPD Members must include the concepts of Person-Centered Planning.

E. Contractor must ensure the provision of Discharge Planning when a SPD Member is admitted to a hospital or institution and continuation into the post-discharge period. Discharge Planning must include ensuring that necessary care, services, and supports are in place in the community for the SPD Member once they are discharged from a hospital or institution, including scheduling an outpatient appointment and/or conducting follow-up with the SPD Member and/or caregiver. The minimum criteria for a Discharge Planning checklist must include:

1) Documentation of pre-admission status, including living arrangements, physical and mental function, social support, Durable Medical Equipment (DME), and other services received.

2) Documentation of pre-discharge factors, including an understanding of the medical condition by the SPD Member or an AR of the SPD Member as applicable, physical and mental function, financial resources, and social supports.

3) Services needed after discharge, the type of placement preferred by the SPD Member or their AR and hospital/institution, type of placement agreed to by the SPD Member or their AR, the specific agency or home recommended by the hospital, the specific agency or home agreed to by the SPD Member or their AR, and the pre-discharge counseling that is recommended.

4) Summary of the nature and outcome of the SPD Member's, or their AR's, involvement in the Discharge Planning process, anticipated problems in implementing post-discharge plans, and further action contemplated by the hospital or institution.

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5.2.13 Network Reports

A. Network Certification Report

1) Contractor must submit its Network certification report to DHCS. The report must demonstrate Contractor's capacity to serve the current and expected membership for its Service Area in accordance with 42 CFR section 438.207(b), W&I section 14197(f)(1), and APL 23-001.

2) Contractor must demonstrate good faith compliance with contracting and referral requirements with certain cancer centers in accordance with W&I section 14197.45.

3) Contractor must demonstrate how it will arrange for Covered Services to Members through the use of NEMT, NMT, and Telehealth if Contractor does not meet time or distance standards for adult and pediatric PCPs, core Specialist and outpatient mental health Providers in accordance with W&I section 14197(f)(2).

4) Contractor must submit Network certification in accordance with the requirements placed upon DHCS pursuant to 42 CFR section 438.66(e). Contractor must submit its Network certification report as outlined in APL 23-001. As part of the Network certification report, Contractor must provide documentation demonstrating efforts to recruit new Providers to areas that do not meet time or distance standards without the use of an AAS request.

B. Periodic Reporting Requirements

1) Contractor must report to DHCS any time there is a Significant Change to Contractor's Network that affects Network capacity and Contractor's ability to provide health care services, such as the following:

a) Change in Covered Services or benefits;

b) Change in geographic Service Area;

c) Change in the composition of, or the payments to, its Network Providers, Subcontractors, or Downstream Subcontractors; or

d) Enrollment of a new population.

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2) Contractor must provide supporting documentation detailing any Significant Change to DHCS. DHCS will determine what information Contractor must provide after Contractor reports a Significant Change to its Network pursuant to 42 CFR section 438.207.

C. Network Change Report

1) Contractor must submit to DHCS, in a format specified by DHCS, a report summarizing changes in the Network.

2) Contractor must submit the report 30 calendar days following the end of the reporting quarter.

D. Subcontractor and Downstream Subcontractor Network Certification Report

1) Contractor must develop, implement, and maintain a process to annually certify the Network(s) of its Subcontractor(s) and Downstream Subcontractor(s) that provide Medi-Cal Covered Services for compliance with Network Ratios set forth in Exhibit A, Attachment III, Subsection 5.2.4 (*Network Ratios*), Network Adequacy Standards set forth in Subsection 5.2.5 (*Network Adequacy Standards*), and Network Composition requirements set forth in Exhibit A, Attachment III, Subsection 5.2.3 (*Network Composition*) of this Contract in accordance with APL 23-006.

2) Contractor must submit complete and accurate Network Provider Subcontractor and Downstream Subcontractor Network Provider Data to confirm its Subcontractor Network(s) is compliant with all applicable network adequacy requirements, as set forth in Exhibit A, Attachment III, Subsection 2.1.4 (*Network Provider Data Reporting*).

3) Contactor must have a process in place to impose Corrective Action and sanctions and report to DHCS when Subcontractor and Downstream Subcontractors that provide Covered Services fail to meet Network adequacy standards as set forth in APL 23-006. Contractor must ensure all Members assigned to a Subcontractor or Downstream Subcontractor Network that is under a Corrective Action continue access to Medically Necessary Covered Services within timely access standards and applicable time or distance standards as set forth in Exhibit A, Attachment III, Subsection 5.2.5 (*Network Adequacy Standards*) by supplementing the

Subcontractor or Downstream Subcontractor Network until the Corrective Action is resolved.

4) Contractor must submit Network certification in accordance with the requirements placed upon DHCS pursuant to 42 CFR section 438.66(e). Contractor must submit the results of its Subcontractor and Downstream Subcontractor Network Certification to DHCS in a format specified by DHCS and post its submitted certification on its website.

5.2.14 Site Review

A. General Requirement

1) Contractor must conduct Facility Site Reviews (FSR) and Medical Record reviews, initially and every three years, on all PCP sites in accordance with APL 22-017. Contractor must ensure that Network Providers, Subcontractors, and Downstream Subcontractors have the capacity to provide Primary Care services, appropriate Preventive Care services, coordination and continuity of care in accordance with 42 CFR section 438.207.

2) Contractor must ensure that Network Providers provide physical access, reasonable accommodations, and accessible equipment for Members with physical or mental disabilities. Contractor must also conduct facility site physical accessibility reviews on PCP sites, Provider sites which serve a high volume of SPD Members, and all Provider sites including CBAS and ancillary service Providers, in accordance with Policy Letter (PL) 12-006 and W&I section 14182(b)(9).

B. Pre-Operational Site Reviews

The number of Site Reviews to be completed prior to initiating Contractor operation in a Service Area must be based upon the total number of new Primary Care sites in the Network. For more than 30 sites in the Network, a five (5) percent sample size or a minimum of 30 sites, whichever is greater in number, must be reviewed six (6) weeks prior to Contractor operation. Site Reviews must be completed on all remaining sites within six (6) months of Contractor operation. For 30 or fewer sites, reviews must be completed on all sites six (6) weeks prior to Contractor operation.

C. Credentialing Site Review

A Site Review is required as part of the Credentialing process when both the facility and the Provider are added to Contractor's Network. If a Provider is added to Contractor's Network, and the Provider site has a current passing Site Review survey score, a site survey need not be repeated for Provider Credentialing or recredentialing purposes.

D. Corrective Action

Contractor must ensure that a Corrective Action plan is developed to correct cited deficiencies and that corrections are completed and verified within the established guidelines as specified in APL 22-017. PCP sites that do not correct cited deficiencies must be terminated from Contractor's Network; Contractor must assign Members to other Network Providers in accordance with APL 21-003.

E. Data Submission

Contractor must submit the Site Review data to DHCS up to quarterly, or in a manner or timeframe specified by DHCS. All data elements defined by DHCS must be included in the data submission report.

F. Continuing Oversight

Contractor must retain accountability for all Site Review activities even if this function is delegated.

G. Medical Record Documentation

1) General Requirement

Contractor must ensure the documentation of appropriate Medical Records for Members and that Medical Records are available to Providers at each Encounter in accordance with 42 USC section 1396a(w), 28 CCR section 1300.67.1(c), and APL 20-006.

2) Medical Records

Contractor must have policies and procedures for developing, implementing and maintaining written procedures for all forms of Medical Record retention including but not limited to:

a) For storage and filing of Medical Records including: collection, processing, maintenance, storage, retrieval, identification, and distribution;

b) To ensure that Medical Records are protected and confidential in accordance with all federal and State law;

c) For the release of information and obtaining consent for treatment; and

d) To ensure maintenance of Medical Records in a legible, current, detailed, organized and comprehensive manner (records may be electronic or paper copy).

3) On-Site Medical Records

Contractor must have policies and procedures to ensure that an individual is delegated the responsibility for securing and maintaining the security of Medical Records at each site.

4) Member Medical Record

Contractor must ensure that a complete, legible Medical Record is maintained for each Member in accordance with 22 CCR section 53861, which reflects all aspects of patient care, including, but not limited to, ancillary services, and at a minimum includes:

a) Member identification on each page; personal/biographical data in the record;

b) Member's preferred language (if other than English) prominently noted in the record, as well as the request or refusal of language/interpretation services in accordance with Title VI of the Civil Rights Act of 1964;

c) All entries dated with the author identified. For Member visits, all entries must include at a minimum, the documentation of subjective complaints, the objective findings, the plan for diagnosis and treatment, and follow-up care;

d) A problem list, a complete record of immunizations and health maintenance or preventive services rendered, and documentation of any outreach efforts surrounding any missed appointments;

e) Allergies and adverse reactions prominently noted;

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f) All appropriate informed consent documentation, including the human sterilization consent procedures required by 22 CCR sections 51305.1 - 51305.6, if applicable;

g) Reports of Emergency Services provided (directly by the Network Provider or through an emergency room) and the hospital discharge summaries for all hospital admissions, including any follow-up after the provision of Emergency Services or hospitalizations;

h) Consultations and referrals, including for Complex Care Management (CCM), Enhanced Care Management, and Specialists, as well as evidence of review of specialty referrals, pathology, and laboratory reports. Any abnormal results must have an explicit notation in the Medical Record, including follow-up or outreach;

i) For Medical Records of adults, documentation of whether the individual has been informed and has executed an Advance Directive, such as a durable power of attorney, for health care for Members ages 18 and over;

j) Health education behavioral assessment and referrals to health education services where appropriate; and

k) Documentation of blood lead screening, immunizations, and other preventive services provided in accordance with the American Academy of Pediatrics Bright Futures Periodicity Schedule, the United States Preventive Services Task Force Grade A and B recommendations, the American College of Obstetrics and Gynecologists, and the Advisory Committee on Immunization Practice recommendations. Member refusal to receive blood lead screening, immunizations, or other preventive services must also be documented in the Member's Medical Record as described in Exhibit A, Attachment III, Section 5.3 (*Scope of Services*).

5.2.15 Street Medicine

Contractor may provide medical and other Covered Services as described in APL 24-001 via a Street Medicine program for Members experiencing unsheltered homelessness through contracted Street Medicine Providers. Street Medicine Providers are Providers or entities that Contractor has determined can provide Street Medicine services to eligible Members in an effective manner consistent

with Street Medicine industry protocols and practices. Street Medicine Providers may act in the role of the Member's assigned PCP, through a direct contract with Contractor, as an Enhanced Care Management (ECM) Provider, a Community Supports Provider, a referring or treating contracted Provider, or Community Health Worker as set forth in APL 24-001. This subsection refers only to Street Medicine programs and Street Medicine Providers that Contractor may choose to offer.

A. Contracted Street Medicine Providers acting in the role of a Member's assigned PCP are licensed physician and non-physician medical practitioners (e.g., Doctor of Medicine (MD)/Doctor of Osteopathic Medicine (DO), Physician Assistant (PA), NP, and CNM. For a non-physician medical practitioner (PA, NP, and CNM), Contractors must ensure compliance with State law and Contract requirements regarding physician supervision of non-physician medical practitioners. Additionally, given the unique and specialized nature of Street Medicine, a supervising Physician must be a practicing Street Medicine provider, with knowledge of, and experience in, Street Medicine clinical guidelines and protocols. Street Medicine Providers who choose to act as a Member's assigned PCP must agree to provide the essential components of the Medical Home in order to provide comprehensive and continuous medical care, such as Basic Population Health Management; Care Coordination and health promotion; support for Members, their families, and their ARs; referrals to Specialists, including Behavioral Health, community, and social support services, when needed; use of Health Information Technology to link services, as feasible and appropriate; and provision of primary and preventative services to assigned Members. If the Street Medicine Provider does not have the capability to provide Primary Care services on the street, the Street Medicine Provider must be affiliated with a facility that has a physical location.

B. Contractor must ensure Street Medicine Providers have the capability to, and comply with, referral and Care Coordination, administrative, billing and claim, data sharing, and reporting requirements.

C. Contractor must ensure Street Medicine Providers acting in the capacity of an ECM and/or Community Supports Providers comply with requirements as set forth in APL 21-012 and/or APL 21-017. Contractor is to ensure Street Medicine Providers receive appropriate Provider training and manuals and have adequate systems in place to adhere to such requirements.

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D. Contractor must submit contractually required policies and procedures exhibiting compliance with program policy and requirements, and receive approval from DHCS, before operating a Street Medicine program.

Exhibit A, ATTACHMENT III

5.3 Scope of Services

5.3.1 Covered Services
5.3.2 Medically Necessary Services
5.3.3 Initial Health Appointment
5.3.4 Services for Members Less Than 21 Years of Age
5.3.5 Services for Adults
5.3.6 Pregnant and Postpartum Members
5.3.7 Services for All Members
5.3.8 Investigational Services

5.3 Scope of Services

5.3.1 Covered Services

A. Contractor must provide or arrange for all Covered Services for Members, in accordance with the definition of Covered Services set forth in Exhibit A, Attachment I, Article 1.0 (*Definitions*). Contractor must ensure that Covered Services and other services required in this Contract are provided to a Member in an amount no less than what is offered to Medi-Cal beneficiaries in Medi-Cal Fee-For-Service (FFS), as defined in the most current Medi-Cal Provider Manual and consistent with current, evidence-based medical standards. Contractor has the primary responsibility to provide all Covered Services, including services that exceed the services provided by Local Education Agencies (LEAs), Regional Centers (RCs), or local governmental health programs.

B. Contractor must ensure that services provided are sufficient in amount, duration, and scope to reasonably achieve the purpose for which the Covered Services are furnished. Contractor must not arbitrarily deny or reduce the amount, duration, or scope of a required Covered Service solely because of the diagnosis, type of illness, or condition. Contractor may place appropriate limits on a Covered Service on the basis of Medical Necessity or utilization control for services that are not medical services (such as Community Support services), provided the services furnished are reasonably expected to achieve their purpose and are provided in a manner that reflects the Member's ongoing needs, including but not limited to services for chronic conditions.

C. Except as set forth in Attachment 3.1.B.1 of the California Medicaid State Plan or as otherwise authorized by Welfare and Institutions Code (W&I) section 14133.23, drug benefits for Members who are eligible for drug benefits under 42 United States Code (USC) section 1395w-101 *et seq*.) are not a Covered Service under this Contract. Contractor must comply with all applicable provisions of the Medicare Prescription Drug Improvement and Modernization Act of 2003, Policy Letter (PL) 108–173, December 8, 2003, 117 Stat 2066.

D. Unless expressly excluded under this Contract, Contractor must cover any services necessary for compliance with the requirements for parity in mental health and Substance Use Disorder (SUD) benefits, and ensure that Members are given access to all mental health and SUD services in accordance with 42 Code of Federal Regulations (CFR) section 438.900. The types, amount, duration, and scope of these services must be

consistent with the parity compliance analysis conducted by either DHCS or Contractor.

1) If Contractor provides Members with mental health or SUD services in any classification of benefits as described in 42 CFR section 438.910(b)(2), then Contractor must provide to Members those services in every classification that is listed therein and is covered by Contractor. In determining the classification in which a particular benefit belongs, Contractor must apply the same reasonable standards for medical/surgical benefits to mental health or SUD benefits.

2) Contractor must provide referrals and Care Coordination for all non-covered mental health and SUD services, as required in Exhibit A, Attachment III, Subsections 4.3.12 (*Mental Health Services*) and 4.3.13 (*Alcohol and Substance Use Disorder Treatment Services*).

E. Covered Services may be provided to Members through Telehealth, as defined in W&I section 14132.72, and as follows:

1) Contractor is responsible for ensuring that Covered Services provided via a Telehealth modality meet DHCS guidelines in outlined in the Provider Manual.

2) Contractor must oversee that Providers only provide Covered Services that can be appropriately delivered via Telehealth, and that they not provide Covered Services that would otherwise require the in-person presence of the Member for any reason, such as those that are performed in an operating room or while the Member is under anesthesia, where direct visualization or instrumentation of bodily structures is required, or procedures that involve sampling of tissue or insertion/removal of medical devices.

3) Contractor must ensure all Providers furnishing applicable Covered Services via audio-only synchronous interactions also offer those same services via video synchronous interactions.

4) Contractor must ensure all Providers furnishing services through video synchronous interactions or audio-only synchronous interactions must do one of the following:

a) Offer those same services via in-person, face-to-face contact.

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b) Arrange for a referral to, and a facilitation of, in-person care that does not require a Member to independently contact a different Provider to arrange for that care.

5) Contractor is responsible for ensuring Members are informed prior to the initial delivery of Covered Services via Telehealth about the use of Telehealth. Contractor must also ensure Providers obtain and document verbal or written consent from Members for the use of Telehealth as an acceptable mode of delivering services prior to the initial delivery of Covered Services. Consent must be documented in the Member's Medical Record and made available to DHCS upon request.

6) Contractor must communicate to Providers any periodical updates to Covered Services and Provider types and requirements that may be appropriately delivered through Telehealth.

5.3.2 Medically Necessary Services

Contractor must apply the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard of Medical Necessity for Members less than 21 years of age, as set forth in 42 USC section 1396d(r)(5) and All Plan Letter (APL) 23-005. The terms Medically Necessary, or Medical Necessity, are defined in Exhibit A, Attachment I, Article 1.0 (*Definitions*), based upon whether a Member is less than 21 years of age, or ages 21 and over.

5.3.3 Initial Health Appointment

Contractor must ensure provision of an Initial Health Appointment (IHA) in accordance with 22 California Code of Regulations (CCR) sections 53851(b)(1), 53910.5(a)(1) and APL 22-030. An IHA at a minimum must include: a history of the Member's physical and mental health, an identification of risks, an assessment of need for preventive screens or services and health education, a physical examination, and the diagnosis and plan for treatment of any diseases, unless the Member's Primary Care Provider (PCP) determines that the Member's Medical Record contains complete information, updated within the previous 12 months, consistent with the assessment requirements. Contractor must continue to hold Network Providers accountable for providing all preventive screenings for adults and Children as recommended by the United States Preventive Services Taskforce (USPSTF) but will no longer require all of these elements to be completed during the IHA, so long as Members receive all required screenings in a timely manner consistent with USPSTF guidelines.

A. Contractor must cover and ensure the provision of an IHA for each new Member within timelines stipulated in Exhibit A, Attachment III, Subsections 5.3.4 (*Services for Members Less Than 21 Years of Age*) and 5.3.5 (*Services for Adults*) below.

B. Contractor must ensure that a Member's completed IHA is documented in their Medical Record and that appropriate assessments from the IHA are available during subsequent health visits.

C. Contractor must make reasonable attempts to contact a Member to schedule an IHA. Contractor must document all attempts to contact a Member. Documented attempts that demonstrate Contractor's efforts to unsuccessfully contact a Member and schedule an IHA will be considered evidence in meeting this requirement. Contractor may delegate these activities, but Contractor remains ultimately responsible for all delegated functions, as outlined in Exhibit A, Attachment III, Subsection 3.1.1 (*Overview of Contractor's Duties and Obligations*).

5.3.4 Services for Members Less Than 21 Years of Age

Contractor must cover and ensure the provision of all screening, preventive and Medically Necessary diagnostic and treatment services for Members less than 21 years of age required under the EPSDT benefit described in 42 USC section 1396d(r), W&I section 14132(v), and APL 23-005. The EPSDT benefit includes all Medically Necessary health care, diagnostic services, treatments, and other services listed in 42 USC section 1396d(a), whether or not covered under the California Medicaid State Plan. All EPSDT services are Covered Services unless expressly excluded under this Contract.

A. Provision of IHA for Members Less Than 21 Years of Age

1) For Members less than 18 months of age, Contractor must ensure the provision of an IHA within 120 calendar days following the date of Enrollment or within periodicity timelines established by the American Academy of Pediatrics (AAP) Bright Futures for ages two and younger, whichever is sooner.

2) For Members ages 18 months and older, Contractor must ensure an IHA is performed within 120 calendar days of Enrollment.

3) The IHA must provide, or arrange for provision of, all immunizations necessary to ensure that the Member is up to date for their age, Adverse Childhood Experiences (ACEs) screening, and any

required age-specific screenings including developmental screenings.

4) If the provisions of the IHA are not met, then Contractor must ensure case management and Care Coordination are working directly with the Member to receive appropriate services to include but not limited to health screenings, immunizations, and risk assessments.

B. Children's Preventive Services

1) Contractor must provide preventive health visits for all Members less than 21 years of age at times specified by the most recent AAP Bright Futures Periodicity Schedule and anticipatory guidance as outlined in the AAP Bright Futures Periodicity Schedule. Contractor must provide, as part of the periodic preventive visit, all age-specific assessments and services required by AAP Bright Futures.

2) Where a request is made for Children's preventive services by the Member, the Member's parent, legal guardian, or Authorized Representatives (ARs), or through a referral, an appointment must be made for the Member to have a visit within ten Working Days of the request, unless Member declines a visit within ten Working Days of the request and another appointment date is chosen by the Member.

3) At each Non-emergency Primary Care visit with a Member less than 21 years of age, the Member (if an emancipated minor), or the parent, legal guardian, or AR of the Member, must be advised of the Children's preventive services due and available from Contractor. Documentation must be entered in the Member's Medical Record which indicates the receipt of Children's preventive services in accordance with the AAP Bright Futures standards. If the services are refused, documentation must be entered in the Member's Medical Record which indicates the services were advised, and the Member's (if an emancipated minor), or the parent, legal guardian, or AR of the Member's voluntary refusal of these services.

4) All children's preventive services, including all confidential screening and billing reports for EPSDT screening, treatment, and Care Coordination, must be reported as part of the Encounter Data submittal required in Exhibit A, Attachment III, Subsection 2.1.2

(*Encounter Data Reporting*). Contractor must ensure appropriate acquisition for missed reporting of Children's preventive services.

C. Immunizations

1) Contractor must cover vaccinations, except for vaccinations expressly excluded in DHCS guidance to Medi-Cal Managed Care Health Plans, at the time of any health care visit and ensure the timely provision of vaccines in accordance with the most recent childhood immunization schedule and recommendations published by Advisory Committee on Immunization Practices (ACIP). Documented attempts that demonstrate Contractor's unsuccessful efforts to provide the vaccination will be considered sufficient in meeting this requirement. When practical, reasons for failed attempts should be medically coded.

2) At each Non-Emergency Primary Care visit with Members less than 21 years of age, the Member (if an emancipated minor), or the parent, legal guardian, or AR of the Member, must be advised of the vaccinations due and available from Contractor immediately, if the Member has not received vaccinations in accordance with ACIP standards. Documentation must be entered in the Member's Medical Record which indicates the receipt of vaccinations or proof of prior vaccination in accordance with ACIP standards. If vaccinations that could be given at the time of the visit are refused, documentation must be entered in the Member's Medical Record which indicates the vaccinations were advised, and the Member's (if an emancipated minor), or the parent, legal guardian, or AR of the Member's voluntary refusal of these vaccinations. If vaccinations cannot be given at the time of the visit, then it is required that the Medical Record must demonstrate that the Member was informed how to obtain necessary vaccinations or scheduled for a future appointment for vaccinations.

3) Contractor must ensure that Member-specific vaccination information is reported to immunization registries established in Contractor's Service Area(s) as part of the Statewide Immunization Information System. Reports must be made following the Member's IHA and all other health care visits that result in an administered vaccine within 14 calendar days. Reporting must be in accordance with all applicable State and federal laws.

4) Within 30 calendar days of Federal Food and Drug Administration (FDA) approval of any vaccine for childhood immunization

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purposes, Contractor must develop policies and procedures for the provision and administration of the vaccine. Contractor must cover and ensure the provision of the vaccine from the date of its approval regardless of whether or not the vaccine has been incorporated into the Vaccines for Children (VFC) Program. Policies and procedures must be in accordance with Medi-Cal guidelines issued prior to final ACIP recommendations.

5) Contractor must provide information to all Network Providers regarding the VFC Program and is encouraged to promote and support Enrollment of applicable Network Providers in the VFC program as see appropriate.

D. Screening for Childhood Lead Poisoning

1) Contractor must cover and ensure the provision of blood lead screening tests to Members at the ages and intervals specified in 17 CCR sections 37000 - 37100, and in accordance with APL 20-016. Contractor must ensure its Network Providers follow the Childhood Lead Poisoning Prevention Branch (CLPPB) guidelines when interpreting blood lead levels and determining appropriate follow-up activities, including, without limitation, appropriate referrals to the local public health department.

a) While requirements for appropriate follow-up activities, including referral, case management, and reporting, are set forth in the CLPPB guidelines, a Network Provider may determine that additional services that fall within the EPSDT benefit are Medically Necessary.

b) Contractor must ensure that Members less than 21 years of age receive all Medically Necessary care as required under EPSDT.

2) Contractor must identify, at least quarterly, all Members less than six years of age with no record of receiving a required blood lead screening test. Contractor must identify the age(s) at which a required blood lead screening test was missed, including Members under the age of six, without any record of a completed blood lead screening test at each age. On a quarterly basis, Contractor must notify the Network Provider responsible for the care of an identified Member of the requirement to test the Member and provide the written or oral anticipatory guidance as required pursuant to 17 CCR section 37100. For a period of no less than ten years,

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Contractor must maintain records of all Members identified quarterly as having no documentation of receiving a required blood lead screening test, and provide those records to DHCS at least annually, as well as upon request.

3) If the Member, or the Member's parent, legal guardian, or AR, refuses the blood lead screening test, Contractor must ensure a signed statement of voluntary refusal by the Member (if an emancipated minor), or the parent, legal guardian, or AR of the Member, is documented in the Member's Medical Record.

4) If Contractor is unable to ensure a signed statement of voluntary refusal is documented in the Member's Medical Record because the Member, or the Member's parent, legal guardian, or AR refuses or declines to sign, or is unable to sign, such as when services are provided through a Telehealth modality, Contractor must ensure that the reason for not obtaining a signed statement of voluntary refusal is documented in the Member's Medical Record.

5) DHCS will consider unsuccessful attempts to provide the required blood lead screening tests that are documented in the Member's Medical Record in accordance with the requirements in Exhibit A, Attachment III, Subsection 5.3.4.D. (*Services for Members Less Than 21 Years of Age*) as evidence of Contractor's compliance with blood lead screening test requirements.

E. EPSDT Services

1) For Members less than 21 years of age, Contractor must comply with all requirements identified in APL 23-005. Contractor must provide, or arrange and pay for, all Medically Necessary EPSDT services, including all Medicaid services listed in 42 USC section 1396d(a), whether or not included in the California Medicaid State Plan, unless expressly excluded in this Contract. Covered Services will include, without limitation, in-home nursing provided by home health agencies or individual nurse Providers, as required by APL 20-012, Care Coordination, case management, and Targeted Case Management (TCM) services. If Members less than 21 years of age are not eligible or accepted for Medically Necessary TCM services by a RC or local government health program, per requirements in Exhibit A, Attachment III, Section 5.6 (*MOUs with Local Government Agencies, County Programs, and Third Parties*), Contractor must arrange for comparable services for the Member under the EPSDT benefit in accordance with APL 23-005.

2) Contractor must arrange for any Medically Necessary diagnostic and treatment services identified at a preventive screening or other visit indicating the need for diagnosis or treatment, either directly or through referral to appropriate agencies, organizations, or individuals, as required by 42 USC section 1396a(a)(43)(C), APL 23-005, and APL 20-012. Contractor must ensure that all Medically Necessary EPSDT services, including all Covered Services set forth in Exhibit A, Attachment III, Subsection 5.3.4.E.1) (*Services for Members Less Than 21 Years of Age*), above, as well as EPSDT services carved out of this Contract, are provided in a timely manner, as soon as possible but no later than 60 calendar days following the preventive screening or other visit identifying a need for diagnosis or treatment. Without limitation, Contractor must identify available Providers, including if necessary out-of-Network Providers and individuals eligible to enroll as Medi-Cal Providers, to ensure the timely provision of Medically Necessary EPSDT services. Contractor must provide appointment scheduling assistance and necessary transportation, including Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT), to and from medical appointments for Covered Services and pharmacy services. NMT must also be provided for services not covered under this Contract.

3) Covered Services do not include California Children's Services (CCS), pursuant to Exhibit A, Attachment III, Subsection 4.3.14 (*California Children's Services*), or Specialty Mental Health Services (SMHS), pursuant to Exhibit A, Attachment III, Subsection 4.3.12 (*Mental Health Services*). Contractor must ensure that the case management for Medically Necessary services authorized by CCS, county mental health plans, Drug Medi-Cal or Drug Medi-Cal Organized Delivery System (DMC-ODS)Plans under this Subsection is equivalent to that provided by Contractor for Covered Services for Members less than 21 years of age under this Contract and must, if indicated or upon the Member's request, provide additional Care Coordination and case management services as necessary to meet the Member's medical and Behavioral Health needs.

F. Behavioral Health Treatment Services

For Members less than 21 years of age, Contractor must cover Medically Necessary Behavioral Health Treatment (BHT) services regardless of diagnosis in compliance with APL 22-006 and APL 23-010.

1) Contractor must provide Medically Necessary BHT services in accordance with a recommendation from a licensed physician, surgeon, or a licensed psychologist and must provide continuation of BHT services under continuity of care.

2) The Member's treatment plan must be reviewed, revised, and/or modified no less than every six months by a BHT service Provider. The Member's behavioral treatment plan may be modified or discontinued only if it is determined that the services are no longer Medically Necessary under the EPSDT Medical Necessity standard.

3) Contractor has primary responsibility for the provision of Medically Necessary BHT services and must coordinate with LEAs, RCs, and other entities that provide BHT services to ensure that Members timely receive all Medically Necessary BHT services, consistent with the EPSDT benefit. Contractor must provide Medically Necessary BHT services across settings, including home, school, and in the community, that are not duplicative of BHT services actively provided by another entity. Contractor must coordinate with, and make good faith attempts to enter into Memorandum of Understandings (MOUs) with RCs and LEAs, and Contractor must enter into MOUs with County Mental Health Plans (MHPs) in accordance with Exhibit A, Attachment III, Subsection 5.6.1 (*MOU Purpose*), to facilitate the coordination of services for Members with Developmental Disabilities, including Autism Spectrum Disorder (ASD), as permitted by federal and State law, and specified by DHCS in APL 22-005 and APL 22-006. If Contractor is unable to enter into an MOU or a one-time case agreement with a RC, Contractor must inform DHCS why it could not reach an agreement with the RC and must demonstrate, by providing all evidence of contracting efforts, a good faith effort to enter into an agreement with the RC.

G. Local Education Agency Services

Contractor must reimburse LEAs, as appropriate, for the provision of school-linked EPSDT services including but not limited to BHT as specified in Exhibit A, Attachment III, Subsection 4.3.16 (*School-Based Services).*

H. Rapid Whole Genome Sequencing

Rapid whole genome sequencing, including individual sequencing, trio sequencing for a parent or parents and their baby, and ultra-rapid sequencing, is a Covered Service for any Medi-Cal Member who is one year of age or younger and is receiving inpatient hospital services in an intensive care unit as required in W&I section 14132(a)(e).

5.3.5 Services for Adults

A. Initial Health Appointment for Adults Ages 21 and over

1) Contractor must cover and ensure that IHAs for adult Members are performed within 120 calendar days of Enrollment.

2) Contractor must ensure that the IHA for adults includes, but is not limited to, an evaluation of applicable preventive services provided in accordance with the United States Preventive Services Taskforce (USPSTF) grade A and B recommendations.

B. Adult Preventive Services

Contractor must cover and ensure the provision of all preventive services and Medically Necessary diagnostic and treatment services for adult Members as follows:

1) Contractor must ensure provision of all applicable preventive services identified as USPSTF grade A and B recommendations for adult Members in accordance with the Guide to Clinical Preventive Services published by the USPSTF.

2) Contractor must cover and ensure the provision of all Medically Necessary diagnostic, treatment, and follow-up services which are necessary given the findings or risk factors identified in the IHA, or during visits for routine, urgent, or emergent health care situations. Contractor must ensure that these services are initiated as soon as possible but no later than 60 calendar days following discovery of a problem requiring follow up.

3) Contractor must comply with APL 22-025 and ensure the provision of an annual cognitive health assessment for Members who are 65 years of age or older and are otherwise ineligible to receive a similar assessment as part of a Medicare annual wellness visit.

C. Immunizations

1) Contractor must cover vaccinations, except for vaccinations expressly excluded by DHCS in guidance to Medi-Cal Managed Care Health Plans, at the time of any health care visit and ensure the timely provision of vaccines in accordance with the most recent adult immunization schedule and recommendations published by the ACIP. Documented attempts that demonstrate Contractor's unsuccessful efforts to provide the vaccination will be considered sufficient in meeting this requirement.

2) In addition, Contractor must cover and ensure the provision of age and risk appropriate vaccinations in accordance with the findings of the IHA, or other preventive screenings.

3) At each non-emergency Primary Care Encounter the Member must be advised of the vaccinations due and available from Contractor, if the Member has not received vaccinations in accordance with ACIP standards. Documentation must be entered in the Member's Medical Record which indicates the receipt of vaccinations or proof of prior vaccination in accordance with ACIP standards. If vaccinations that could be given at the time of the visit are refused, documentation must be entered in the Member's Medical Record which indicates the vaccinations were advised, and the Member's voluntary refusal of these vaccinations. If vaccinations cannot be given at the time of the visit, then it is required that the Medical Record must demonstrate that the Member was informed how to obtain necessary vaccinations or scheduled for a future appointment for vaccinations.

4) Contractor must ensure that Member-specific vaccination information is reported to immunization registries established in Contractor's Service Area(s) as part of the Statewide Immunization Information System. Reports will be made following the Member's IHA and all other health care visits that result in an administered vaccine within 14 calendar days. Reporting will be in accordance with all applicable State and federal laws.

5.3.6 Pregnant and Postpartum Members

A. Prenatal and Postpartum Care

Contractor must cover and ensure the provision of all Medically Necessary services for Members who are pregnant and postpartum. Contractor must utilize the most current standards or guidelines of American College of Obstetricians and Gynecologists (ACOG) and Comprehensive Perinatal

Services Program (CPSP) to ensure Members receive quality perinatal and postpartum services.

B. Risk Assessment

Contractor must implement a comprehensive risk assessment tool for all pregnant Members that is comparable to the ACOG standard and CPSP standards per 22 CCR section 51348. Contractor must maintain the results of this assessment as part of the Member's obstetrical record, which must include medical/obstetrical, nutritional, psychosocial, and health education needs risk assessment components. The risk assessment tool must be administered at the initial prenatal visit, once each trimester thereafter, and at the postpartum visit. If administration of the risk assessment tool is missed at the appropriate timeframes, then Contractor must ensure case management and Care Coordination are working directly with the Member to accomplish the assessment. Contractor must follow up on all identified risks with appropriate interventions consistent with ACOG standards and CPSP standards and document those interventions in the Member's Medical Record. The risk assessment may be completed virtually through a Telehealth visit with the Member's consent.

C. Referral to Specialists

Contractor must ensure that pregnant Members are referred to medically appropriate Specialists, including, as appropriate, perinatologists, Freestanding Birthing Centers, Certified Nurse Midwives (CNMs), Licensed Midwives, and, are informed about Doula coverage. Pregnant Members may request and receive a recommendation for Doula services from a physician or other licensed practitioner of the healing arts acting within their scope of practice under State law and receive services. Contractor must ensure that pregnant and postpartum Members receive a recommendation for Doula services within one year after pregnancy, if requested by the Member, and must ensure access to genetic screening with appropriate referrals. Members may receive one initial visit; eight visits at any time during the perinatal period; services during labor and delivery, miscarriage, or abortion; and two extended postpartum visits with the standing recommendation issued by DHCS. An additional nine visits during the postpartum period is available with a second recommendation from a licensed provider. Contractor must comply with section 440.130(c) of Title 42 of the Code of Federal Regulations when making a recommendation for Doula services. Doula services are a preventive benefit for Medi-Cal Members, and services include but are not limited to

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personal support to pregnant individuals and families throughout pregnancy, labor, and the postpartum period. Contractor must also ensure that appropriate hospitals are available within the Network to provide necessary high-risk pregnancy services.

5.3.7 Services for All Members

A. Health Education

1) Contractor must implement and maintain a health education system that includes programs, services, functions, and resources necessary to provide health education, health promotion, and patient education for all Members.

2) Contractor must ensure administrative oversight of the health education system by a qualified full-time health educator.

3) Contractor must provide evidence-based health education programs and services to Members, directly, or through Subcontractors, Downstream Subcontractors, or Network Providers.

4) Contractor must ensure organized delivery of health education programs using educational strategies and methods that are appropriate for Members and effective in achieving behavioral change for improved health. Contractor may offer Members non-monetary incentives for participating in incentive programs, focus groups, and Member surveys authorized by W&I section 14407.1 pursuant to APL 16-005.

5) Contractor must ensure that health education materials are written at the sixth-grade reading level and are culturally and linguistically appropriate for the intended audience in accordance with APL 18-016. Contractor must review health education materials to ensure documents are up-to-date.

6) Contractor must ensure availability of Community Health Workers (CHWs) to all Members. CHWs should provide services to include but are not limited to assisting Members with health care system navigation, communicating cultural and language preferences to providers, accessing health care services, educating health needs, and connecting individuals and families with community-based resources.

7) Contractor must maintain a health education system, or use a DHCS-sponsored system if available, that provides educational interventions addressing health categories and topics that align with the Population Health Management (PHM) Strategy, in accordance with Exhibit A, Attachment III, Section 4.3 (*Population Health Management and Coordination of Care*), including education regarding the appropriate use of health care services, risk-reduction and healthy lifestyles, and self-care and management of health conditions.

8) Contractor must ensure that Members receive point of service education as part of preventive and primary health care visits. Contractor must provide education, training, and program resources to Network Providers for the delivery of health education services.

9) Contractor must maintain health education policies, procedures, standards, and guidelines. Contractor must maintain documentation that demonstrates effective implementation of the health education requirements.

10) Contractor must monitor the health education system including accessibility for Limited English Proficient (LEP) Members and the performance of Providers that are contracted to deliver health education services. Contractor must ensure appropriate allocation of health education resources and conduct appropriate levels of program evaluation.

B. Hospice Care

1) Contractor must cover and ensure the provision of hospice care services as defined in 42 USC section 1396d(o)(1) and as required by APL 13-014. Contractor must ensure that Members and their families are fully informed of the availability of hospice care as a Covered Service and the methods by which they may elect to receive these services. In accordance with APL 13-014, a hospice must obtain written certification of terminal illness for each hospice benefit period. “Terminally ill,” as defined in 42 CFR section 418.3, means that an individual has a medical prognosis that their life expectancy is six months or less if the illness runs its normal course. Services are limited to Members who directly or through their AR voluntarily elect to receive hospice care in lieu of other care as specified. However, for Members less than 21 years of age, a voluntary election of hospice care does not constitute a waiver of

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any rights of that Member to be provided with, or to have payment made for, Covered Services that are related to the treatment of that Member's condition for which a diagnosis of terminal illness has been made.

2) For Members who have elected hospice care, Contractor must arrange for continuity of care, including maintaining established patient-Provider relationships, to the greatest extent possible. Contractor must cover the cost of all hospice care provided. Contractor must also cover all Medically Necessary care not related to the terminal condition.

C. Palliative Care

Contractor must cover and ensure the provision of palliative care, as required by W&I section 14132.75 and as set forth in APL 18-020, and as required for Members less than 21 years of age under the EPSDT benefit and standard of Medical Necessity. Contractor must continue to cover all Medically Necessary Covered Services for Members receiving palliative care. For Members less than 21 years of age, Contractor must cover palliative care concurrently with hospice care and other Medically Necessary Covered Services if hospice care is elected by the Member.

D. Vision Care – Lenses

Contractor must cover and ensure the provision of eye examinations to include screening examinations and prescriptions for corrective lenses as appropriate for all Members. Contractor must arrange for the fabrication of optical lenses for Members through Prison Industry Authority (PIA) optical laboratories except when the Member requires lenses not available through PIA. Contractor must cover the cost of the eye examination and dispensing of the lenses fabricated by PIA. DHCS will reimburse PIA for the fabrication of the optical lenses in accordance with the contract between DHCS and PIA. Contractor must cover the cost of fabrication and dispensing of lenses not available through PIA.

E. Mental Health and SUD Services

Contractor must cover all Medically Necessary mental health and SUD services specified in Exhibit A, Attachment III, Subsection 5.5.2 (*Non-**S**~~s~~pecialty Mental Health Services and Substance Use Disorder Services*) in compliance with mental health parity requirements in 42 CFR section 438.900 *et seq*., and Exhibit A, Attachment III, Section 5.5 (*Mental Health and Substance Use Disorder Benefits*).

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F. Organ and Bone Marrow Transplant Surgeries

Contractor must cover all Medically Necessary organ and bone marrow transplant surgeries as set forth in the Medi-Cal Provider Manual, including all updates and amendments to the Manual.

1) Contractor must refer and authorize organ and bone marrow transplant surgeries to be performed in transplant programs that meet criteria set forth by DHCS in the Medi-Cal Provider Manual.

2) Contractor must authorize and cover costs for organ or bone marrow transplants for Members. Contractor must cover all pre and post-operative transplant-related costs such as, but not limited to, evaluation, hospitalization, and all Medically Necessary services such as transportation and prescriptions not covered by and billable to Medi-Cal Rx.

3) Contractor must refer Members identified as potential organ or bone marrow transplant candidates to a transplant program evaluation that meets criteria set forth by DHCS within 72 hours of receiving the referral. If the transplant program considers the Member to be a suitable transplant candidate, Contractor must authorize the request for transplant services on an expedited 72-hour basis or less if the Member's condition requires it, or if the organ or bone marrow the Member will receive is at risk of being unusable due to any delay in obtaining Prior Authorization or any delay in obtaining the organ or bone marrow.

4) Contractor must refer Members less than 21 years of age identified as a potential organ or bone marrow transplant candidate to the local CCS Program for eligibility determination, if necessary, unless Contractor is responsible for the CCS benefit (Whole Child Model contracts only). Major Organ Transplants (MOT) for Members less than 21 years of age must be performed only in a CCS-approved Special Care Center (SCC) or DHCS-approved Transplant Centers of Excellence. If the CCS Program determines that the Member is not eligible for the CCS Program or the MOT is not related to the Member's CCS eligible medical condition, but the MOT is Medically Necessary, Contractor must refer the Member to a transplant program within 72 hours of receipt of the eligibility determination and is responsible for authorizing the MOT, as appropriate.

5) Contractor must refer CCS-eligible Members less than 21 years of age to the appropriate CCS-approved Special Care Center that

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meets criteria set forth by DHCS within 72 hours of receiving the referral from the Member's PCP or Specialist identifying the Member as a transplant candidate. If the CCS-approved Special Care Center considers the Member to be a suitable transplant candidate, Contractor is required to approve the Prior Authorization request.

6) For Members less than 21 years of age, Contractor must provide Prior Authorization for requests for transplant services on an expedited, 72-hour basis, or less if the Member's condition requires it or if the organ or bone marrow the Member will receive is at risk of being unusable due to any delay in obtaining Prior Authorization or any delay in obtaining the organ or bone marrow.

7) Contractor must authorize and cover costs for organ or bone marrow donors, including cadavers and living donors regardless of a living donor's Medi-Cal eligibility. Contractor must cover transplant-related costs such as evaluation, hospitalization for the living donor, organ or bone marrow removal, and all Medically Necessary services related to organ or bone marrow removal including complications, transportation, and prescriptions not covered by and billable to Medi-Cal Rx.

8) Contractor must ensure coordination of care between all Providers, organ or bone marrow donation entities, and transplant centers to ensure the transplant is completed as expeditiously as possible. This coordination of care must include care for all living donors.

9) Contractor must ensure the provision of Discharge Planning as defined in this Contract for Members and living donors.

10) Contractor must cover all readmissions and other health care costs related to any complications the Member or the living donor experiences from the organ or bone marrow transplant.

11) Contractor must cover all Medically Necessary physician administered drugs provided to a Member or the living donor administered by a health care professional in a clinic, physician's office, or outpatient setting and is needed for the Member receiving an organ or bone marrow transplant, such as anti-rejection medication, and any other Medically Necessary Prescription Drug not covered by Medi-Cal Rx.

G. Long-Term Care Services

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Contractor must authorize and cover Long-Term Care (LTC) services as set forth in APL 23-004, APL 23-023, and APL 23-027. Contractor must ensure that Members in need of LTC services are placed in a health care facility that provides the level of care most appropriate to the Member's medical needs, unless the Member has elected hospice care.

1) Contractor must ensure that Members, other than Members requesting hospice services, in need of LTC services are placed in a LTC facility that provides the level of care most appropriate to the Member's medical needs. Contractor must make Member placement decisions based on the appropriate level of care, as set forth in the definitions in 22 CCR sections 51118, 51120, 51120.5, 51121, 51123, 51124, 51124.5, and 51124.6, W&I section 14132.25 and the criteria for admission set forth in 22 CCR sections 51335, 51335.5, 51335.6, and 51334 and related sections of the Manual of Criteria for Medi-Cal Authorization referenced in 22 CCR section 51003(e).

2) Contractor must place Members in LTC facilities that are licensed and certified by the California Department of Public Health (CDPH). Contractor must ensure that contracted LTC facilities have not been decertified by CDPH or otherwise excluded from participation in the Medi-Cal Program.

3) Contractor must provide continuity of care to Members through continued access to the LTC facility in which the Member is residing at time of Enrollment for up to 12 months. During this time, Contractor may attempt to place Members at LTC facilities within its Network only with approval from the Member or individual authorized to make health care decisions on their behalf.

4) Contractor must cover a Member stay in a facility with availability regardless of Medical Necessity if placement in a Medically Necessary appropriate lower level of care is not available, unless otherwise provided by contract. Contractor must continue to attempt to place the Member in a facility with the appropriate level of care, including offering to contract with facilities within and outside of the Service Area.

5) Contractor must provide Transitional Care Services as specified in Exhibit A, Attachment III, Subsection 4.3.11 (*Targeted Case Management Services*).

6) Hospice Services as defined in 22 CCR section 51180 rendered in a Skilled Nursing Facility (SNF) or Intermediate Care Facility for the Developmentally Disabled (ICF/DD), ICF/DD-Habilitative (ICF/DD-H), and ICF/DD-Nursing (ICF/DD-N) homes are not LTC services consistent with 22 CCR section 51544(h).

7) Contractor must ensure that Members in need of ICF/DD, ICF/DD-H, and ICF/DD-N services are placed in the ICF/DD Home deemed most appropriate to the Member's medical needs as specified in the Individualized Program Plan (IPP) issued by the Member's Regional Center.

H. Pharmaceutical Services

1) Drug Use Review (DUR)

Contractor must develop and implement effective DUR and treatment outcome process, as directed in APL 17-008, APL 23-026, and APL 22-012 (excluding prospective DUR activities), to ensure that drug utilization is appropriate, Medically Necessary, and not likely to result in adverse events.

a) Contractor's DUR must meet or exceed the requirements described in 42 USC section 1396r-8(g) and 42 CFR section 438.3(s), to the extent that Contractor provides covered outpatient drugs, and Section 1004 requirements of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patient and Communities Act.

b) Contractor's DUR must implement:

i. A retrospective claims review automated process that monitors when a Member is concurrently prescribed opioids and benzodiazepines or opioids and antipsychotics;

ii. A program to monitor and manage the appropriate use of antipsychotic medications by all Children 18 years of age and under including foster Children enrolled under the California Medicaid State Plan, as required in 42 USC section 1396a(oo)(1)(B), APL 23-026, and APL 22-012; and

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iii. Fraud and abuse identification processes for potential Fraud or abuse of controlled substances by Members, Providers, and pharmacies.

c) Contractor must annually submit to DHCS a detailed report in a format specified by DHCS on their DUR Program activities.

2) Contractor must not impose Quantitative Treatment Limitation (QTL) or Non-Quantitative Treatment Limitation (NQTL) more stringently for mental health and SUD drugs prescriptions than for medical/surgical drugs, in accordance with 42 CFR section 438.900 *et seq*.

I. Transportation

Contractor must cover transportation services as required in this Contract and directed in APL 22-008 to ensure Members have access to all Medically Necessary services.

1) Contractor must cover Emergency Medical Transportation (EMT) services necessary to provide access to all emergency Covered Services.

2) Contractor must cover NEMT services necessary for Members to access Covered Services, subject to a prescription and Prior Authorization when required, in accordance with 22 CCR section 51323.

a) Contractor must require Members to have an approved Physician Certification Statement (PCS) form prescribing NEMT by their provider, as described in APL 22-008, before Prior Authorization can be granted for NEMT services, except as provided in 22 CCR section 51323 (b)(2)(A),(C). For Covered Services requiring recurring appointments, Contractor must provide authorization for NEMT for the duration of the recurring appointments, not to exceed 12 months, and ensure the Member has a standing order guaranteeing assigned rides for the duration of the recurring appointments. Contractor cannot modify the form once the provider prescribes the mode of NEMT.

b) Contractor must refer and coordinate NEMT services for Medi-Cal services that are not covered under the Contract.

However, Contractor must provide NEMT services for their Members for all pharmacy prescriptions prescribed by the Member's Medi-Cal provider(s) and those authorized under Medi-Cal Rx.

c) Contractor must have a process in place to ensure transportation brokers and providers are meeting these requirements and to impose corrective action if non-compliance is identified through oversight and monitoring activities.

3) As provided for in W&I section 14132(ad), Contractor must authorize all NMT for Members to obtain Covered Services in accordance with the requirements and guidelines set forth in APL 22-008. Nothing in this provision will be construed to prohibit Contractor from developing policies and procedures that may include reasonable Utilization Management procedures for NMT. Contractor must also provide NMT for all Medi-Cal services not covered under this Contract. These services include, but are not limited to, Specialty Mental Health Service (SMHS), SUD services, dental, pharmacy, pharmaceutical services, and any other benefits delivered through Medi-Cal FFS.

4) Contractor must provide NEMT or NMT for a parent, legal guardian, or AR when the Member is a minor. With the written consent of a parent, legal guardian, or AR, Contractor may arrange NEMT or NMT services for a minor who is unaccompanied by a parent, legal guardian, or AR. Contractor must provide transportation services for unaccompanied minors when applicable State or federal law does not require parental consent for the minor's service. Contractor must ensure all necessary written consent forms are collected prior to arranging transportation for an unaccompanied minor and cannot arrange NEMT or NMT services for an unaccompanied minor without the necessary consent forms unless State or federal law does not require parental consent for minor's service.

5) Consistent with 42 CFR sections 440.170(a) and 431.53, W&I section 14132(a) and (d), and APL 22-008, Contractor must also cover transportation-related travel expenses for Members obtaining Medically Necessary services. Transportation-related travel expenses are subject to retroactive reimbursement.

J. Care Management and Care Coordination

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1) Contractor must provide all Members with Care Coordination services as specified in Exhibit A, Attachment III, Subsection 4.3.8 (*Basic Population Health Management*).

2) Contractor must provide care management services to all Members as specified in Exhibit A, Attachment III, Subsection 4.3.8 (*Basic Population Health Management*) and Exhibit A, Attachment III, Subsection 4.3.7 (*Care Management Programs*). Care management services include, Basic Population Health Management (Basic PHM), Complex Care Management (CCM), and Enhanced Care Management (ECM).

K. Dyadic Services

Contractor must provide Dyadic Services and the Family Therapy benefit for Members less than 21 years of age and/or their caregivers in an outpatient setting as Medically Necessary as set forth in APL 22-029 and detailed below.

1) Dyadic Services may be provided by Licensed Clinical Social Workers, Licensed Professional Clinical Counselors, Licensed Marriage and Family Therapists, Licensed Psychologists, Psychiatric Physician Assistants, Psychiatric Nurse Practitioners, and Psychiatrists. Associate Marriage and Family Therapists, Associate Professional Clinical Counselors, Associate Clinical Social Workers, and Psychology Assistants may render services under a supervising clinician. Appropriately trained nonclinical staff, including CHWs, are not precluded from screening Members for issues related to SDOH or performing other nonclinical support tasks as a component of the Dyadic Behavioral Health (DBH) visit, as long as the screening is not separately billed.

   a) Under the supervision of a supervising Provider from one of the provider types listed above, CHWs can assist a dyad to gain access to needed services to support their health through the CHW benefit for health navigation services.

   b) Contractor is responsible for ensuring appropriate supervision of Dyadic Services Providers and educating all Network Providers on the Dyadic Services benefit.

2) Member Eligibility for Dyadic Services

a) Children and their parent(s)/ caregiver(s) are eligible for DBH well-Child visits when delivered according to the Bright Futures/American Academy of Pediatrics periodicity schedule for behavioral/social/emotional screening assessment, and when medically necessary, in accordance with Medi-Cal's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standards in 42 USC section 1396d(r).

i. Under EPSDT standards, a diagnosis is not required to qualify for services.

ii. The DBH well-Child visits do not need a particular recommendation or referral and must be offered as an appropriate service option even if the Member does not request them.

b) The family is eligible to receive Dyadic Services so long as the Child is enrolled in Medi-Cal. The parent(s) or caregiver(s) does not need to be enrolled in Medi-Cal or have other coverage so long as the care is for the direct benefit of the Child.

3) Covered Services

a) Contractor may offer the Dyadic Services benefit through Telehealth or in-person with locations in any setting including, but not limited to, pediatric Primary Care settings, doctor's offices or clinics, inpatient or outpatient settings in hospitals, the Member's home, school-based sites, or community settings. There are no Service Location limitations.

b) Covered Dyadic Services are Behavioral Health Services for Children and/or their parent(s) or caregiver(s), and include:

i. DBH Well-Child Visits

a. The DBH well-Child visit must be limited to those services not already covered in the medical well-Child visit.

b. When possible and operationally feasible, the DBH well-Child visit should occur on the same

day as the medical well-Child visit. When this is not possible, Contractors must ensure the DBH well-Child visit is scheduled as close as possible to the medical well-Child visit, consistent with timely access requirements.

c. Contractor may deliver DBH well-Child visits as part of the HealthySteps program, a different DBH program, or in a clinical setting without a certified DBH program as long as all of the following components are included:

   aa. Behavioral Health history for Child and parent(s) or caregiver(s), including parent(s) or caregiver(s) interview addressing Child's temperament, relationship with others, interests, abilities, and parent or caregiver concerns.

   bb. Developmental history of the Child.

   cc. Observation of behavior of Child and parent(s) or caregiver(s) and interaction between Child and parent(s) or caregiver(s).

   dd. Mental status assessment of parent(s) or caregiver(s).

   ee. Screening for family needs, which may include tobacco use, substance use, utility needs, transportation needs, and interpersonal safety, including guns in the home.

   ff. Screening for SDOH such as poverty, food insecurity, housing instability, access to safe drinking water, and community level violence.

   gg. Age-appropriate anticipatory guidance focused on Behavioral Health

promotion/risk factor reduction.

hh. Making essential referrals and connections to community resources through Care Coordination and helping caregiver(s) prioritize needs.

ii. Dyadic Comprehensive Community Supports Services, separate and distinct from the California Advancing and Innovating Medi-Cal (CalAIM) Community Supports, help the Child and their parent(s) or caregiver(s) gain access to needed medical, social, educational, and other health-related services, and may include any of the following:

a. Assistance in maintaining, monitoring, and modifying covered services, as outlined in the dyad's service plan, to address an identified clinical need.

b. Brief telephone or face-to-face interactions with a person, family, or other involved member of the clinical team, for the purpose of offering assistance in accessing an identified clinical service.

c. Assistance in finding and connecting to necessary resources other than covered services to meet basic needs.

d. Communication and coordination of care with the Child's family, medical and dental health care Providers, community resources, and other involved supports including educational, social, judicial, community and other State agencies.

e. Outreach and follow-up of crisis contacts and missed appointments.

f. Other activities as needed to address the dyad's identified treatment and/or support needs.

c) Dyadic Psychoeducational Services for psychoeducational services provided to the Child less than 21 years of age and/or parent(s) or caregiver(s). These services must be planned, structured interventions that involve presenting or demonstrating information with the goal of preventing the development or worsening of Behavioral Health conditions and achieving optimal mental health and long-term resilience.

d) Dyadic Family Training and Counseling for Child Development for family training and counseling provided to both the Child less than 21 years of age and parent(s) or caregiver(s). These services include brief training and counseling related to a Child's behavioral issues, developmentally appropriate parenting strategies, parent/Child interactions, and other related issues.

e) Dyadic Parent or Caregiver Services

Dyadic parent or caregiver services are services delivered to a parent or caregiver during a Child's visit that is attended by the Child and parent or caregiver, including the following assessment, screening, counseling, and brief intervention services provided to the parent or caregiver for the benefit of the Child as appropriate:

i. Brief Emotional/Behavioral Assessment

ii. ACEs Screening

iii. Alcohol and Drug Screening, Assessment, Brief Interventions, and Referral to Treatment

iv. Depression Screening of Health Behavior Assessments and Interventions

v. Psychiatric Diagnostic Evaluation

vi. Tobacco Cessation Counseling

4) Family Therapy as a Behavioral Health Benefit

a) Family therapy is type of psychotherapy covered under Medi-Cal's NSMHS benefit, including for Members less than

21 years of age who are at risk for Behavioral Health concerns and for whom clinical literature would support that the risk is significant such that Family Therapy is indicated, but may not have a mental health diagnosis. The primary purpose of Family Therapy is to address family dynamics as they relate to the Member's mental status and behavior(s).

b) Family Therapy is composed of at least two family members receiving therapy together provided by a mental health Provider to improve parent/Child or caregiver/Child relationships and encourage bonding, resolving conflicts, and creating a positive home environment.

c) All family members do not need to be present for each service. For example, parents or caregivers can qualify for Family Therapy without their infant present, if necessary.

d) Both Children and adult Members can receive Family Therapy mental health services that are medically necessary. Contractor is required to provide Family Therapy to the following Medi-Cal Members to improve parent/Child or caregiver/Child relationships and bonding, resolve conflicts, and create a positive home environment:

i. Members less than 21 years of age with a diagnosis of a mental health disorder;

ii. Members less than 21 years of age with persistent mental health symptoms in the absence of a mental health disorder;

iii. Members less than 21 years of age with a history of at least one of the following risk factors:

a. Neonatal or pediatric intensive care unit hospitalization;

b. Separation from a parent or caregiver (for example, due to incarceration, immigration, or military deployment);

c. Death of a parent or caregiver of Foster home placement;

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d. Food insecurity, housing instability;

e. Maltreatment;

f. Severe and persistent bullying; and

g. Experience of discrimination, including but not limited to discrimination on the basis of race, ethnicity, gender identity, sexual orientation, religion, learning differences, or disability;

iv. Members less than 21 years of age who have a parent(s) or caregiver(s) with one or more of the following risk factors:

a. A serious illness or disability;

b. A history of incarceration;

c. Depression or other mood disorder;

d. Post-Traumatic Stress Disorder or other anxiety disorder;

e. Psychotic disorder under treatment;

f. SUD;

g. Job loss;

h. A history of intimate partner violence or interpersonal violence; and

i. Is a teen parent.

e) Contractor must provide Family Therapy services if needed to correct or ameliorate a Child's mental health condition. Services that sustain, support, improve, or make more tolerable a mental health condition are considered to ameliorate the condition and are thus covered as EPSDT services.

f) Members less than 21 years of age may receive up to five Family Therapy sessions before a mental health diagnosis is

required. Contractor must provide Family Therapy without regard to the five-visit limitation for Members less than 21 years of age with risk factors for mental health disorders or parents/caregivers with related risk factors, including separation from a parent/caregiver due to incarceration, immigration, or death; foster care placement; food insecurity; housing instability; exposure to domestic violence or trauma; maltreatment; severe/ persistent bullying; and discrimination.

5) Billing and Claims

a) Dyadic Services Providers must be reimbursed in accordance with their Network Provider contract.

b) Contractor must not require Prior Authorization for Dyadic Services.

c) Contractor must not establish unreasonable or arbitrary barriers for accessing coverage.

d) Encounters for Dyadic Services must be submitted with allowable current procedural terminology codes as outlined in the Medi-Cal Provider Manual.

e) Multiple Dyadic Services are allowed on the same day and may be reimbursed at the FFS rate.

f) The DBH well-Child visit must be limited to those services that are not already covered in the medical well-Child visit, and any other service codes cannot be duplicative of services that have already provided in a medical well-Child visit or a DBH well-Child visit.

g) Dyadic caregiver service codes (screening, assessment, and brief intervention services provided to the parent or caregiver for the benefit of the Child) may be billed by either the medical well-Child Provider or the DBH well-Child visit Provider, but not by both Providers, when the dyad is seen on the same day by both Providers.

h) Tribal Health Programs, Rural Health Clinics (RHCs), and Federal Qualified Health Centers (FQHCs) are eligible to receive their All-Inclusive Rate from Contractor if Dyadic Services are provided by a billable Provider per APL 17-002

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and APL 21-008.

i. Dyadic Services may be reimbursed at the FFS rate established for services, if the service provided does not meet the definition of a THP, RHC, or FQHC visit, or exceeds frequency limitations.

ii. THP, RHC, and FQHC Providers can bill FFS for Dyadic Services delivered in a clinical setting by Provider types named in the Non-**S**~~s~~pecialty Mental Health Services: Psychiatric and Psychological Services section of the Medi-Cal Provider Manual.

iii. THP, RHC, and FQHC Providers cannot double bill for Dyadic Services that are duplicative of other services provided through Medi-Cal.

iv. All Dyadic Services must be billed under the Medi-Cal identity of the Member less than 21 years of age.

L. Practice Guidelines

Contractor must adopt practice guidelines in accordance with 42 CFR section 438.236, and this Contract. Contractor's decisions for Utilization Management, Member education, provision of Covered Services, and other areas covered by practice guidelines must be consistent with these guidelines. Contractor must also provide their practice guidelines, upon request, to Members and Potential Members.

M. Asthma Preventive Services

Contractor must ensure availability of Asthma Preventive Services (APSs), including clinic-based and home-based asthma self-education, and in-home environmental trigger assessments for all Members with a diagnosis of asthma. APSs may be provided by a Physician or a Non-Physician Medical Practitioner, or a licensed practitioner of the healing arts within their scope of practice. APSs may also be provided by unlicensed Providers, which may include CHW, who have met the qualifications of an APS Provider and are providing these services under a supervising Physician or Non-Physician Medical Practitioner, clinic, hospital, local health jurisdiction, or community-based organization.

N. Community Health Workers Services

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1) Contractor must ensure availability of CHW Services to all Members that meet the eligibility criteria in accordance with 42 CFR section 440.130(c).

2) Contractor must adhere to DHCS guidance on service definitions, eligible populations, and CHW Provider parameters as stated in APL 22-016.

    a) CHW services are defined as preventive health services delivered by a CHW to prevent disease, disability, and other health conditions or their progression; to prolong life; and to promote physical and mental health. CHWs may include individuals known by a variety of job titles, such as promotores, community health representatives, navigators, and other non-licensed public health workers, including violence prevention professionals, with the qualifications specified below.

    b) CHW services are considered Medically Necessary for Members with one or more chronic health conditions (including Behavioral Health) or exposure to violence and trauma, who are at risk for a chronic health condition or environmental health exposure, who face barriers in meeting their health or health-related social needs, and/or who would benefit from preventive services.

3) CHW Provider and Supervising Provider Requirements

    a) Contractor must determine, verify, and validate CHW Providers can provide CHW Services in an effective manner consistent with culturally and linguistically appropriate care.

    b) CHW Providers must have lived experience that aligns with and provides a connection between CHW and the Member population being served in.

    c) CHWs must have lived experience that aligns with and provides a connection between the CHW and the Member or population being served. This may include, but is not limited to, experience related to incarceration, military service, pregnancy and birth, disability, foster system placement, homelessness, mental health conditions or substance use, or being a survivor of domestic or intimate partner violence or abuse and exploitation. Lived experience may also

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include shared race, ethnicity, sexual orientation, gender identity, language, or cultural background with one or more linguistic, cultural, or other groups in the community for which the CHW is providing services.

d) Contractor must contract with a Supervising Provider to oversee CHW providers and the services delivered to Members. CHW providers can be supervised by a community-based organization (CBO) or a local health jurisdiction (LHJ) that does not have a licensed Provider on staff in alignment with the Provider Manual and APL 22-016.

e) Contractor must ensure that Network Providers and Subcontractors contracting with or employing CHWs to provide Covered Services have adequate supervision and training.

f) Contractor must ensure CHW Providers demonstrate, and Supervisor Providers maintain evidence of, minimum qualifications through the CHW certificate pathway, Violence Prevention certificate pathway, or Work experience pathway.

g) Certificate Pathway: CHWs demonstrating qualifications through the Certificate Pathway must provide proof of completion of at least one of the following certificates: ~~e~~ CHW Certificate: A valid certificate of completion of a curriculum that attests to demonstrated skills and/or practical training in the following areas: communication, interpersonal and relationship building, service coordination and navigation, capacity building, advocacy, education and facilitation, individual and community assessment, professional skills and conduct, outreach, evaluation and research, and basic knowledge in public health principles and Social Drivers of Health (SDOH), as determined by the Supervising Provider. ~~6~~ Certificate programs must also include field experience as a requirement. A CHW Certificate allows a CHW to provide all covered CHW services described in ~~this~~ APL **22-016**, including violence prevention services.

h) Violence Prevention Professional Certificate: For individuals providing CHW violence prevention services only, a Violence Prevention Professional (VPP) Certificate issued by Health

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Alliance for Violence Intervention or a certificate of completion in gang intervention training ~~form~~**from** the Urban Peace Institute. ~~7,8~~ A VPP Certificate allows a CHW to provide CHW violence prevention services only. A CHW providing services other than violence prevention services must demonstrate qualification through either the Work Experience Pathway or by completion of a General Certificate.

i) Work Experience Pathway: An individual who has at least 2,000 hours working as a CHW in paid or volunteer positions within the previous three years and has demonstrated skills and practical training in the areas described above, as determined and validated by the Supervising Provider, may provide CHW services without a certificate of completion for a maximum period of 18 months. A CHW who does not have a certificate of completion must earn a certificate of completion, as described above, within 18 months of the first CHW visit provided to a Member.

j) Contractor must have a process for verifying qualifications and experience of Supervising Providers, which must extend to individuals employed by, or delivering CHW Services on behalf of, the Supervising Provider.

k) Contractor must ensure Supervising Providers and CHW Providers comply with all applicable State and federal laws and regulations, Contract requirements, and other DHCS guidance, including APLs and PLs.

O. Community Health Workers Provider Capacity

1) Contractor must ensure and monitor appropriate, adequate Networks within its Service Area, including for CHW Services as stated in APL 21-006.

2) Contractor must use data-driven approaches to determine and understand priority populations eligible for CHW Services, including but not limited to, using past and current Member utilization/encounters, frequent hospital admissions or emergency department visits, demographic and Social Drivers of Health data, referrals from the community, and needs assessments.

P. Identifying Members for Community Health Workers

1) Contractor must require a referral for CHW Services submitted by a Physician or other licensed practitioner of the healing arts within their scope of practice under State law.

2) Contractor must accept recommendations for CHW Services from other licensed practitioners, whether they are in the Network or out-of-Network Providers, within their scope of practice, including physician assistants, nurse practitioners, clinical nurse Specialists, podiatrists, nurse midwives, Licensed Midwives, registered nurses, public health nurses, psychologists, licensed marriage and family therapists, licensed clinical social workers, licensed professional clinical counselors, dentists, registered dental hygienists, licensed educational psychologists, licensed vocational nurses, and pharmacists.

Q. Cancer Biomarker Testing

Contractor must comply with APL 22-010 and cover Medically Necessary biomarker testing for Members with advanced or metastatic stage 3 or 4 cancer and cancer progression or recurrence in the Member with advanced or metastatic stage 3 or 4 cancer. Contract is prohibited from imposing Prior Authorization requirements on biomarker testing that is associated with a federal Food and Drug Administration (FDA)-approved therapy for advanced or metastatic stage 3 or 4 cancer.

R. COVID-19 Coverage

Contractor must cover COVID-19 related services to include prevention, testing, and treatment as detailed in APL 22-009.

5.3.8 Investigational Services

A. Contractor must cover investigational services as defined in 22 CCR section 51056.1(b) when a service is determined to be investigational pursuant to 22 CCR section 51056.1(c), and all requirements in 22 CCR section 51303(h) are met and documented in the Member's Medical Record.

B. Routine Patient Care Costs for Clinical Trials

1) Contractor must cover routine patient care costs for Members participating in a qualifying clinical trial including items and services furnished in connection with participation by Members in a qualifying clinical trial pursuant to 42 USC section 1396d(a)(30),

and W&I section 14132.98. A qualifying clinical trial is a clinical trial in any clinical phase of development that is conducted in relation to the prevention, detection, or treatment of any serious or life-threatening disease or condition.

2) Routine patient care costs are costs associated with the provision of health care services, including drugs, items, devices, and services that would otherwise be covered under the Medi-Cal program if those drugs, items, devices, and services were not provided in connection with an approved clinical trial program.

3) Coverage of routine patient care costs must be provided regardless of geographic location or if the treating Provider or principal investigator of the qualifying clinical trial is a Network Provider.

4) Coverage of routine patient care costs must be based on Provider's and principal investigator's approval regarding the Member's appropriateness for the qualifying clinical trial.

5) The coverage determination must be expedited and completed within 72 hours.

6) Contractor must require the submission of the "Medicaid Attestation Form on the Appropriateness of the Qualifying Clinical Trial" for approval of the clinical trial. The attestation form must include the following information:

   a) The Member's name and client identification number;

   b) The national clinical trial number;

   c) A statement signed by the principal investigator attesting to the appropriateness of the qualified clinical trial; and

   d) A statement signed by the Provider attesting to the appropriateness of the qualified clinical trial.

Exhibit A, ATTACHMENT III

5.4 Community Based Adult Services

5.4.1 Covered Services
5.4.2 Coordination of Care
5.4.3 Required Reports for the Community Based Adult Services Program
5.4.4 Community Participation
5.4.5 Community Based Adult Services Program Integrity

5.4 Community Based Adult Services

5.4.1 Covered Services

In addition to Exhibit A, Attachment III, Section 5.3 (*Scope of Services*), Contractor must cover Community Based Adult Services (CBAS) in accordance with the California Advancing and Innovating Medi-Cal (CalAIM) 1115(a) Demonstration, Number 11-W-00193/9 Special Terms and Conditions (STCs), including Sections V.A.19 through 30 and Attachments H and S, or in accordance with any subsequent demonstration amendment or renewal or successive demonstration, waiver, or other Medicaid authority governing the provision of CBAS. Contractor must cover CBAS and ensure provision of the following services:

A. Arrange for the provision of CBAS to Members determined eligible to receive CBAS core services, and additional services as needed, in accordance with the CalAIM STCs Section V.A.20.a and b, Attachment H, and Exhibit A, Attachment III, Subsection 5.4.2.C. (*Coordination of Care*);

B. Consider a Member's relationship with a previous Provider of services similar to CBAS when referring a Member to a CBAS Provider;

C. Cover CBAS as a bundled service through a CBAS Provider or arrange for the provision of unbundled CBAS based on the assessed needs of Members eligible for CBAS if a certified CBAS Provider is not available or not contracted, or there is insufficient CBAS Provider capacity in the area, as required by Exhibit A, Attachment III, Subsection 5.2.8.J. (*Specific Requirements for Access to Programs and Covered Services*). Arranging for unbundled CBAS services includes authorizing Covered Services and coordinating with community resources to assist Members whose CBAS Providers have closed, and Members who have similar clinical conditions as CBAS Members, to remain in the community, in accordance with the following requirements listed below.

1) Unbundled CBAS Covered Services are limited to the following:

a) Professional Nursing Services;

b) Nutrition;

c) Physical Therapy;

d) Occupational Therapy;

e) Speech and Language Pathology Services;

f) Nonmedical Emergency Transportation (NEMT) and Non-Medical Transportation (NMT), only between the Member's home and the CBAS unbundled service Provider; and

g) Non-**S**~~s~~pecialty Mental Health Services (NSMHS) and Substance Use Disorder (SUD) services that are Covered Services;

2) Contractor must coordinate care for unbundled CBAS services that are not Covered Services based on the assessed needs of the Member eligible for CBAS, including:

a) Personal Care Services;

b) Social Services;

c) Physical and Occupational Maintenance Therapy;

d) Meals;

e) Specialty Mental Health Services (SMHS); and

f) SUD Services

D. Ensure that Member access to Medicare Providers or services is not impeded or delayed through Contractor's provision of CBAS; and

E. Ensure continuity of care, in accordance with Exhibit A, Attachment III, Section 4.3 (*Population Health Management and Coordination of Care*), when Members switch Medi-Cal managed care plans and/or transfer from one CBAS Provider to another.

F. Arrange for the provision of CBAS Emergency Remote Services (ERS), in response to a Member's needs, and in accordance with CalAIM STCs Section V.A.21 and All Plan Letter (APL) 22-020. CBAS ERS must be provided in alternative Service Locations and/or via Telehealth, including telephone or virtual video conferencing, as clinically appropriate.

1) The circumstances for ERS are time-limited and vary based on the unique and identified needs documented in the Member's Individualized Health and Support Plan (IHSP). Contractor must assess Members at least every three months for ERS as part of the

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reauthorization of the Member's Individual Plan of Care (IPC) and review for continued need for ERS.

2) Telehealth delivery of ERS must meet the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirements, and the methodology must be approved by Contractor. Contractor must demonstrate compliance with the Electronic Visit Verification (EVV) System requirements for personal care services and home health services in accordance with section 12006 of the 21st Century CURES Act and APL 22-014.

3) Contractor must provide ERS under the following circumstances:

   a) State or local emergencies as determined by DHCS or Contractor, such as wildfires and power outages, to allow for the provision of ERS prior or subsequent to an official public health emergency declaration as determined by DHCS or Contractor; and

   b) Personal emergencies, such as time-limited illness or injury, crises, or care transitions that temporarily prevent or restrict Members enrolled in CBAS from receiving CBAS in-person at the CBAS Provider location, subject to approval by Contractor.

5.4.2 Coordination of Care

A. Contractor must provide continuity of care to Members through continued access to a CBAS Provider with whom there is an existing relationship for up to 12 months after Member Enrollment. This requirement includes out-of-Network Providers if there are no Quality of Care issues and the Provider will accept Contractor's rate or the Medi-Cal Fee-For-Service (FFS) rate, whichever is higher, as set forth in Exhibit A, Attachment III, Subsection 5.2.12 (*Continuity of Care for Seniors and Persons with Disabilities*).

B. Contractor must ensure that CBAS IPCs are consistent with the Members' overall care plans and goals, based on Person-Centered Planning and completed in accordance with the CalAIM STCs Section V.A.20., "Individual Plan of Care".

C. Contractor must conduct the initial assessment and subsequent reassessments for Members requesting CBAS in accordance with the CalAIM STCs, Sections VIII.A.19.e and 23.b. In addition, Contractor must:

1) Within 30 calendar days from the initial eligibility inquiry request, Contractor must conduct the CBAS eligibility determination using a DHCS-approved assessment tool. CBAS eligibility determinations must include a face-to-face review with the Member by a Registered Nurse with level of care determination experience for Members who have not previously received CBAS through Contractor's Medi-Cal Managed Care Health Plan. Contractor may forgo a face-to-face review if Contractor determined that the Member is clinically eligible for CBAS and needs an expedited start date;

2) Develop and implement an expedited assessment process to determine CBAS eligibility within 72 hours of receipt of a CBAS authorization request for a Member in a hospital or Skilled Nursing Facility (SNF) whose discharge plan includes CBAS, or who is at high risk of admission to a hospital or SNF or faces an imminent and serious threat to their health;

3) Conduct a reassessment, with family involvement, when appropriate, and redetermination of the Member's eligibility for CBAS at least every six months after the initial assessment or up to every 12 months when determined by Contractor to be clinically appropriate. When a Member requests that services remain at the same level or requests an increase in services due to a change in their level of need, contractor may conduct the reassessment using only the Member's CBAS IPC, including any supporting documentation supplied by the CBAS Provider;

4) Notify Members in writing of their CBAS assessment determination in accordance with the timeframes identified in the CalAIM STCs, Section VIII.A.23.b.i. Contractor's written notice must be approved by DHCS and include procedures for Grievances and Appeals in accordance with current requirements identified in Exhibit A, Attachment III, Section 4.6 (*Member Grievance and Appeal System*);

5) Require that CBAS Providers update a Member's CBAS Discharge Plan of Care and provide a copy to the Member and to Contractor whenever a Member's CBAS services are terminated. The CBAS Discharge Plan of Care must include:

   a) The Member's name and ID number;

   b) The name(s) of the Member's Physician(s);

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c) If applicable, the date the Notice of Action denying authorization for CBAS was issued;

d) If applicable, the date the CBAS benefit will be terminated;

e) Specific information about the Member's current medical condition, treatments, and medications;

f) Potential referrals for Medically Necessary services and other services or community resources that the Member may need upon discharge;

g) Contact information for the Member's Case Manager; and

h) A space for the Member or the Member's representative to sign and date the Discharge Plan of Care.

D. Contractor must coordinate with the CBAS Provider to ensure the following:

1) CBAS IPCs are consistent with Members' overall care plans and goals developed by Contractor;

2) Timely exchange of the following coordination of care information: Member Discharge Plan of Care, reports of incidents that threaten the welfare, health and safety of the Member, and Significant Changes in the Member's condition;

3) Clear communication pathways between the appropriate CBAS Provider staff and Contractor staff responsible for CBAS eligibility determinations, service authorizations, and care planning, including identification of the lead care coordinator for Members who have a care team and Utilization Management; and

4) The CBAS Provider receives advance written notification and training prior to any substantive changes in Contractor's policies and procedures related to CBAS.

E. In addition to the requirements for unbundled CBAS contained in Exhibit A, Attachment III, Subsection 5.4.1 (*Covered Services*), and in accordance with Exhibit A, Attachment III, Subsection 5.4.2 (*Coordination of Care*), Contractor must coordinate care for unbundled CBAS that are not Covered Services, based on the assessed needs of the Member eligible for CBAS, including:

1) Personal Care Services

2) Social Services

3) Physical and Occupational Maintenance Therapy

4) Meals

5) SMHS

6) SUD services that are not Covered Services.

5.4.3 Required Reports for the Community Based Adult Services Program

Contractor must submit to DHCS the following reports 30 calendar days following the end of each reporting period and in a format specified by DHCS:

A. How many Members have been assessed for CBAS and the total number of Members currently receiving CBAS, either as a bundled or unbundled service, on a quarterly basis;

B. Identification of CBAS Providers added to or deleted from Contractor's Network, and when there is a 5% drop in capacity, in the quarterly Network changes submission required in Exhibit A, Attachment III, Subsection 5.2.13.C. (*Network Reports*);

C. A summary of any complaints surrounding the provision of CBAS; and

D. Reports on the following areas:

1) Appeals related to requesting CBAS and the inability to receive those services or receiving more limited services than requested;

2) Appeals related to requesting a particular CBAS Provider and the inability to access that Provider;

3) Excessive travel times to access CBAS;

4) Grievances regarding CBAS Providers;

5) Grievances regarding Contractor assessment and/or reassessment; and

6) Any reports pertaining to the health and welfare of Members utilizing CBAS.

E. On an annual basis, Contractor must provide a list of its contracted CBAS Providers and its CBAS accessibility standards.

5.4.4 Community Participation

Contractor must ensure that engagement and community participation for Members receiving CBAS is supported to the fullest extent desired by each Member.

5.4.5 Community Based Adult Services Program Integrity

Following a determination that a credible allegation of Fraud exists involving a CBAS Provider, DHCS must notify Contractor of the finding promptly. In addition to the actions required in APL 15-026, Contractor must report to DHCS, in a timeframe and manner specified by DHCS but no less frequently than quarterly, all payments made to the CBAS Provider involved in a credible allegation of Fraud for CBAS benefits provided after the date of notification. DHCS may recoup payments from Contractor in accordance with CalAIM Terms and Conditions, GPR Section V.A.30.b.

Exhibit A, ATTACHMENT III

5.5 Mental Health and Substance Use Disorder Benefits

5.5.1 Mental Health Parity Requirements
5.5.2 Non-**S**~~s~~pecialty Mental Health Services and Substance Use Disorder Services
5.5.3 Non-**S**~~s~~pecialty Mental Health Services Providers
5.5.4 Emergency Mental Health and Substance Use Disorder Services
5.5.5 Mental Health and Substance Use Disorder Services Disputes
5.5.6 No Wrong Door for Mental Health Services

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5.5 Mental Health and Substance Use Disorder Benefits

5.5.1 Mental Health Parity Requirements

Contractor must comply with all mental health parity requirements in 42 Code of Federal Regulations (CFR) section 438.900 *et seq*. Contractor must ensure it is not applying any financial or treatment limitation to mental health or Substance Use Disorder (SUD) benefits in any classification that is more restrictive than the predominant financial or treatment limitation applied to medical and surgical benefits in the same classification.

5.5.2 Non-~~S~~specialty Mental Health Services and Substance Use Disorder Services

A. Non-~~S~~specialty Mental Health Services (NSMHS) set forth in Welfare and Institutions Code (W&I) section 14189 are Covered Services in accordance with W&I section 14184.402, unless otherwise specifically excluded under the terms of this Contract. Contractor must consider equity in the provision of such services.

B. Contractor must cover NSMHS including: individual and group mental health evaluation and treatment, including psychotherapy, Family Therapy, and Dyadic Services; psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition; outpatient services for the purposes of monitoring drug therapy; psychiatric consultation; and outpatient laboratory, drugs, supplies, and supplements. Contractor must cover hypnotherapy, health behavior assessments and interventions, psychiatric collaborative care, and other NSMHS services described in the Medi-Cal Provider Manual as mental health evaluation and treatment NSMHS. Contractor must cover mental health screening services described in the Medi-Cal Provider Manual as NSMHS, including but not limited to adverse childhood experiences (ACE) screening, brief emotional/behavioral assessments, depression screening, general developmental screening, autism spectrum disorder screening, and other screening services in accordance with Exhibit A, Attachment III, Subsection 5.5.2.F. (*Non-~~S~~specialty Mental Health Services and Substance Use Disorder Services*). Contractor must cover SUD services including: drug and alcohol Screening, **Assessment,** Brief Intervention and Referral to Treatment (S**A**BIRT) services; tobacco cessation counseling; medications for addiction treatment (also known as medication-assisted treatment or MAT) when delivered in Primary Care offices, emergency departments, inpatient hospitals, and other contracted medical settings; and Medically Necessary Behavioral Health Services. Covered NSMHS and SUD Services can be delivered in person and via

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Telehealth/telephone as specified in Exhibit A, Attachment III, Subsection 5.3.1 (*Covered Services*).

C. If a Member is receiving NSMHS and is determined to meet the criteria for Specialty Mental Health Services (SMHS) as defined by W&I section 14184.402, Contractor must use DHCS-approved standardized transition tools in accordance with Exhibit A, Attachment III, Subsection 5.5.2.K. (*Non-~~S~~specialty Mental Health Services and Substance Use Disorder Services*) as required when Members who have established relationships with contracted mental health Providers experience a change in condition requiring SMHS. Likewise, if a Member is receiving SMHS and is determined to meet the criteria for NSMHS as defined by W&I section 14184.402, Contractor must use DHCS-approved standardized transition tools in accordance with Exhibit A, Attachment III, Subsection 5.5.2.K. (*Non-~~S~~specialty Mental Health Services and Substance Use Disorder Services*) as required when Members who have established relationships with SMHS Providers experience a change in condition requiring NSMHS. Contractor must continue to cover the provision of NSMHS provided to a Member concurrently receiving SMHS when those services are not duplicative and provide coordination of care with the County Mental Health Plan (MHP) in accordance with Exhibit A, Attachment III, Subsection 5.5.2.K. (*Non-~~S~~specialty Mental Health Services and Substance Use Disorder Services*). This provision does not preclude coverage of Behavioral Health Services that are within the scope of practice of licensed mental health care Primary Care Providers (PCPs) and mental health care Providers in accordance with All Plan Letter (APL) 22-006 and APL15-008.

D. For Members ages 21 and over who meet the criteria for NSMHS set forth in the W&I section 14184.402(b)(2), Contractor must cover NSMHS that are Medically Necessary Covered Services in accordance with W&I section 14059.5. For Members ages 21 and over, Contractor must cover SUD services that are Medically Necessary Covered Services in accordance with W&I section 14059.5. Contractor's coverage of NSMHS and SUD services must comply with W&I section 14184.402(f).

E. For Members less than 21 years of age, Contractor must cover NSMHS that are Medically Necessary Covered Services in accordance with W&I section 14184.402(b)(2). For Members less than 21 years of age, Contractor must cover SUD services that are Medically Necessary Covered Services. Medical Necessity determinations for NSMHS and SUD services must be made pursuant to W&I section 14059.5, and as required pursuant to 42 United States Code (USC) section 1396dI. For Members less than 21 years of age, NSMHS and Covered SUD services

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are Medically Necessary if they are necessary to correct or ameliorate a mental health or substance use condition discovered by an Early Periodic Screening, Diagnosis and Testing (EPSDT) screening. NSMHS and SUD services need not be curative or restorative to ameliorate a mental health or substance use condition. NSMHS and SUD services that sustain, support, improve, or make more tolerable a mental health or substance use condition are considered to ameliorate the mental health or substance use condition, and Contractor must cover them. Contractor's coverage of NSMHS and SUD services must comply with W&I section 14184.402(f).

F. Contractor must cover mental health and SUD screening, including, but not limited to, tobacco, alcohol and illicit drug screening, in accordance with American Academy of Pediatrics (AAP) Bright Futures Periodicity Schedule and United States Preventive Services Taskforce (USPSTF) grade A and B recommendations for adults; ACE screening; brief emotional/behavioral assessments; depression screening; general developmental screening; autism spectrum disorder screening; and S**A**BIRT Services. Contractor must develop and implement policies and procedures for mental health and substance use screenings and services provided by a PCP, including, but not limited to, provision of S**A**BIRT Services, and referrals for additional assessments and treatments as indicated by the discovery of condition or potential conditions from screening services, as required by Exhibit A, Attachment III, Subsections 4.3.12 (*Mental Health Services*) and 4.3.13 (*Alcohol and Substance Use Disorder Treatment Services*).

G. Contractor must cover a mental health assessment without requiring Prior Authorization. Contractor must follow the authorization criteria requirements outlined in Exhibit A, Attachment III, Section 2.3 (*Utilization Management Program*) of this Contract for authorizing additional mental health and SUD services. Consistent with the No Wrong Door policies set forth in W&I section 14184.402, Contractor must cover the assessment and any NSMHS provided during the assessment period for any Member seeking care, even prior to the determination of a diagnosis, even prior to the determination of whether NSMHS criteria set forth in W&I section 14184.402(b)(2) are met, and even if the Member is later determined to need SMHS and/or SUD services and is referred to the MHP or to the County Department responsible for SUD treatment. Contractor must cover NSMHS even if the service was not included in the individual treatment plan, and even if the Member has a co-occurring mental health condition and SUD.

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H. Contractor must develop and implement policies and procedures for tracking mental and Behavioral Health screenings, assessments, and treatment services provided by licensed mental health care Providers.

I. Contractor must cover and pay for all mental health and SUD services that are Medically Necessary Covered Services for the Member, including the following:

1) Emergency room professional services as described in 22 CCR section 53855 including all professional physical, mental, and substance use treatment services, including screening examinations necessary to determine the presence or absence of an Emergency Medical Condition and, if an Emergency Medical Condition exists, for all services Medically Necessary to stabilize the Member;

2) Facility charges claimed by emergency departments per APL 22-005 and Behavioral Health Information Notice (BHIN) 22-011;

3) All laboratory and radiology services necessary for the diagnosis, monitoring, or treatment of a Member's mental health condition;

4) Non-Medical Transportation (NMT) services required by Members to access Medi-Cal covered mental health services and SUD services, in compliance with APL 22-008 and this Contract. These services include, but are not limited to, SMHS, Drug Medi-Cal (DMC) services, and Drug Medi-Cal Organized Delivery System (DMC-ODS) services;

5) NMT services and, for Members less than 21 years of age, Non-Emergency Medical Transportation (NEMT) services, to and from DMC services, DMC-ODS services, and SMHS, in compliance with APL 22-008 and this Contract;

6) Medically Necessary Covered Services after Contractor has been notified by a DMC, DMC-ODS, County Mental Health Plan (MHP), or mental health Provider that a Member has been admitted to an inpatient psychiatric facility, including an Institution for Mental Diseases (IMD) as defined by 9 CCR section 1810.222.1, regardless of the age of the Member. These services include, but are not limited to:

a) The initial health history and physical examination required upon admission, consultations, and any Medically Necessary

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Covered Services; Skilled Nursing Facility (SNF) room and board when psychiatric nursing facility services are provided to Members age 65 and over.

b) Contractor must not cover other inpatient psychiatric facility room and board charges or other services that are reimbursed as part of the inpatient psychiatric facility per diem rate.

7) All Medically Necessary Medi-Cal covered psychotherapeutic drugs, when administered in the outpatient setting as part of medical services for Members not otherwise excluded under this Contract. This includes reimbursement for Medically Necessary Medi-Cal covered psychotherapeutic drugs administered by out-of-Network Providers for Members not otherwise excluded under this Contract;

8) Reimbursement to pharmacies for psychotherapeutic drugs must be provided through the Medi-Cal Fee-For-Service (FFS) program. To qualify for reimbursement under this provision, a pharmacy must be enrolled as a Medi-Cal Provider in the Medi-Cal FFS program;

9) Contractor must not materially delay access to Covered Services per Paragraphs 3), 4), and 5) above through the application of Utilization Review controls, such as Prior Authorization, or by requiring that Covered Services be provided through Contractor's Network, consistent with Contractor's obligation to provide timely Covered Services under this contract.

J. Contractor must use DHCS-approved standardized screening tools (including standardized screening tools specific for adults and standardized screening tools specific for Children and youth) to ensure Members seeking mental health services who are not currently receiving covered NSMHS or SMHS are referred to the appropriate delivery system for mental health services, either in Contractor's Network or the MHP's network, in accordance with the No Wrong Door policies set forth in W&I section 14184.402(h) and specified in Exhibit A, Attachment III, Subsection 4.3.12 (*Mental Health Services*).

K. If a Member becomes eligible for SMHS while receiving covered NSMHS, Contractor must continue the provision of non-duplicative, Medically Necessary NSMHS even if the Member is simultaneously accessing SMHS.

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1) Contractor must enter into a MOU with the MHP in accordance with Exhibit A, Attachment III, Section 5.6 (*MOUs with Local Government Agencies, County Programs, and Third Parties*) to ensure Medically Necessary NSMHS and SMHS provided concurrently are coordinated and non-duplicative.

2) Contractor must develop and implement written policies and procedures to ensure that Members meeting criteria for SMHS and as indicated by a DHCS-approved standardized transition tools (including standardized transition tools specific for adults and standardized transition tools specific for Children and youth) are referred to the MHP in accordance with Exhibit A, Attachment III, Subsection 4.3.12 *(Mental Health Services*). Likewise, Contractor must develop and implement written policies and procedures to ensure that Members meeting criteria for NSMHS and as indicated by a DHCS-approved standardized transition tools (including standardized transition tools specific for adults and standardized transition tools specific for Children and youth) are referred by the MHP to Contractor in accordance with Exhibit A, Attachment III, Subsection 4.3.12 *(Mental Health Services*).

L. Contractor must make best efforts to ensure that a Member's existing mental health Provider is notified during an Urgent Care situation, when possible. Contractor must allow the Member's existing mental health Provider to coordinate care with the MHP or emergency room personnel for Urgent Care.

M. Contractor must develop and implement policies and procedures for the provision of psychiatric emergencies during non-business hours.

N. Contractor must monitor and track utilization data for NSMHS as specified in Exhibit A, Attachment III, Subsection 2.3.3 (*Review of Utilization Data*).

5.5.3 Non-Sspecialty Mental Health Services Providers

A. In addition to Exhibit A, Attachment III, Subsection 5.2.1 (*Access to Network Providers and Covered Services*), Contractor must increase the number of NSMHS Providers within its Network as necessary to accommodate anticipated Enrollment growth, which DHCS will evaluate through the Network certification. Contractor may contract with any mental health care Provider to provide services within their scope of practice. The number of NSMHS Providers available must be sufficient to meet referral and appointment access standards for routine care and must meet the Timely Access Regulation per Health and Safety Code (H&S) section

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1367.03, and 28 CCR section 1300.67.2.2, in accordance with the requirements set forth in Exhibit A, Attachment III, Subsection 5.2.3.D (*Network Composition*). Contractor's NSMHS Providers must support current and desired service utilization trends for its Members.

1) Contractor must authorize and arrange for out-of-Network Providers when the provider type is unavailable within time or distance standards. Authorization of out-of-Network Providers in Contractor's Service Area(s) must be prioritized over authorization of out-of-Network Providers in adjoining Service Area(s), unless an out-of-Network Provider in an adjoining Service Area(s) is more conveniently located for a Member or meets time or distance standards.

2) Contractor may contract with a MHP to ensure access to NSMHS.

   Contractor must develop and implement policies and procedures for the secure exchange of Member Information with the MHP to facilitate referrals and Care Coordination. The policies and procedures must cover:

   a) Sharing Protected Health Information (PHI) with the MHP for SMHS and the County Department responsible for SUD treatment, including when required by law, obtaining Member authorization to release information that allows the exchange of treatment history, active treatment, and health information;

   b) Data sharing agreements with the MHP for SMHS and the County Department responsible for SUD treatment and, when required by law, a Business Associate Agreement that addresses the sharing of information related to mental health services and S**A**BIRT services; and

   c) Collecting and reporting data on Members receiving Medi-Cal NSMHS to the MHP.

B. Notwithstanding Exhibit A, Attachment III, Subsection 2.2.13 (*Credentialing and Recredentialing*), if a NSMHS Provider is accredited by the National Committee for Quality Assurance (NCQA), Contractor may deem the Provider credentialed or re-credentialed. Additionally, Contractor must develop and maintain policies and procedures that ensure that the credentials of licensed NSMHS Providers have been verified in accordance with 42 CFR section 438.214 and APL 22-013.

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C. Any time that a Member requires a Medically Necessary NSMHS that is not available within the Network, Contractor must ensure timely access to out-of-Network Providers and Telehealth Providers, in accordance with H&S section 1367.03 and 28 CCR section 1300.67.2, as necessary to meet NSMHS access requirements.

5.5.4 Emergency Mental Health and Substance Use Disorder Services

In addition to the requirements set forth in Exhibit A, Attachment III, Section 5.6 (*MOUs with Local Government Agencies, County Programs, and Third Parties*), Contractor must have a MOU with the MHP to refer Members in need of Urgent Care and Emergency Services, including person-to-person telephone transfers, to the county crisis program during their call center hours. The MOU must be executed in accordance with the requirements specified in Exhibit A, Attachment III, Sections 4.3 (*Population Health Management and Coordination of Care*) and 5.3 (*Scope of Services*).

5.5.5 Mental Health and Substance Use Disorder Services Disputes

If Contractor and an MHP cannot agree on the appropriate place of care, disputes must be resolved pursuant to APL 21-013.

A. Contractor must enter an MOU with the MHP in accordance with Exhibit A, Attachment III, Subsection 5.6.1 (*MOU Purpose*) to include a process for resolving disputes between Contractor and the MHP that includes a means for Members to receive Medically Necessary services, including NSMHS, while the dispute is being resolved.

B. Pursuant to 9 CCR section 1850.525, Contractor must not delay the provision of Medically Necessary services during the resolution of a dispute between Contractor and MHP. Contractor must comply with the rules set forth in 9 CCR section 1850.525 for determining the responsibility for managing ongoing care and financial responsibility for services provided to Members during the dispute period. When disputes concern Contractor's contention that the MHP is required to deliver SMHS to a Member either because the Member's condition would not be responsive to physical health care based treatment or because the MHP has incorrectly determined that the Member's does not meet SMHS criteria, Contractor must manage the care of the Member in accordance with 9 CCR section 1850.525 and APL 21-013 until the dispute is resolved.

C. Contractor must provide case management and Care Coordination for all Medically Necessary services, including those services that are the subject of a dispute between Contractor and an MHP.

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D. Regardless of MOU status, Contractor and the MHP must adhere to the routine dispute resolution process and expedited dispute resolution process requirements set forth in APL 21-013.

E. If DHCS renders a decision for the dispute that includes a finding that Contractor is financially liable to the MHP for services, Contractor must comply with the requirements in 9 CCR section 1850.530. If necessary, DHCS will enforce the decision, including withholding funds to meet any financial liability.

F. Contractor must monitor and track the number of disputes with MHPs. Upon request, Contractor must report all disputes to DHCS.

5.5.6 No Wrong Door for Mental Health Services

Contractor must implement policy to ensure that Members receive timely mental health services without delay regardless of the delivery system where they seek care, and are able to maintain treatment relationships with trusted Providers without interruption.

A. Contractor must provide or arrange for the provision of the following NSMHS:

1) Mental health evaluation and treatment, including individual, group, and family psychotherapy.

2) Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition.

3) Outpatient services for purposes of monitoring drug therapy.

4) Psychiatric consultation, excluding separately billable psychiatric drugs claimed by outpatient pharmacy Providers via Medi-Cal Rx.

5) Outpatient laboratory, drugs, supplies, and supplements.

B. Contractor must provide or arrange for the provision of the NSMHS listed above for the following populations after screening:

1) Members ages 21 and over with mild to moderate distress, or mild to moderate impairment of mental, emotional, or behavioral functioning resulting from mental health disorders, as defined by the current Diagnostic and Statistical Manual of Mental Disorders;

2) Members who are less than 21 years of age, to the extent that they are eligible for services through the EPSDT benefit as described in Exhibit A, Attachment III, Subsection 5.3.4.E (*EPSDT Services*) of this Contract, regardless of the level of distress or impairment, or the presence of a diagnosis; and,

3) Members of any age with potential mental health disorders not yet diagnosed.

C. Contractor must cover and pay for emergency room professional services as described in 22 CCR Section 53855.

D. In accordance with APL 21-014, Contractor must, in a Primary Care setting, provide covered SUD services, including alcohol and drug screening, assessments, brief interventions, and referral to treatment for Members aged 11 years old and older, including Members who are pregnant. Contractor must also provide or arrange for the provision of:

1) Medications for Addiction Treatment (MAT), also known as medication-assisted treatment, provided in Primary Care, inpatient hospital, emergency departments, and other contracted medical settings; and

2) Emergency Services necessary to stabilize the Member.

E. Contractor must implement standardized Screening and Transition of Care Tools for Medi-Cal Mental Health Services in accordance with APL 22-005 and APL 22-028. Contractor must update and align policies and procedures and MOUs with mental health plans to ensure compliance and communicate updates to Providers as necessary.

1) In accordance with APL 22-005, Members ages 21 and over must be screened using the Adult Screening Tool and transitioned using the Adult Transition of Care Tool.

2) In accordance with APL 22-005, Members less than 21 years of age must be screened using the Youth Screening Tool and transitioned using the Youth Transition of Care Tool.

F. Consistent with W&I section 14184.402(f) and APL 22-005, Contractor must cover clinically appropriate and covered NSMHS prevention, screening, assessment, and treatment services even when:

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1) Services are provided prior to determination of a diagnosis, during the assessment period, or prior to a determination of whether NSMHS or SMHS access criteria are met;

2) Services are not included in an individual treatment plan;

3) The Member has a co-occurring mental health condition and SUD; or

4) NSMHS and SMHS are provided concurrently, if those services are coordinated and not duplicated.

Exhibit A, ATTACHMENT III

5.6 MOUs with Local Government Agencies, County Programs, and Third Parties

5.6.1 MOU Purpose
5.6.2 MOU Requirements
5.6.3 MOU Oversight and Compliance

5.6 MOUs with Local Government Agencies, County Programs, and Third Parties

Memorandum of Understandings (MOUs) entered into pursuant to this Contract and as set forth in All Plan Letters (APLs) are binding, contractual agreements between Contractor and third parties that set forth the responsibilities and obligations of Contractor and a third party, including Local Government Agencies, county programs, and third-party entities, to coordinate and facilitate the provision of Medically Necessary services to Members, sharing data, and as applicable, avoiding the duplication of services where Members are served by multiple parties.

5.6.1 MOU Purpose

Contractor must coordinate with Local Government Agencies (LGAs), county programs, and third-party entities to ensure that Members receive all Medically Necessary services even if those services are not the financial responsibility of Contractor. In circumstances where Contractor is coordinating care and not financially responsible for the care, Contractor must negotiate in good faith and execute a MOU, incorporating all required provisions of this Contract, APLs, and MOU templates and guidance, with the following Local Government Agencies, county program and third-party entities and county programs to ensure Care Coordination, data sharing, and non-duplicative services for Members. Contractor and the LGAs, county programs, and third-party entities may incorporate requirements in addition to any requirements set forth in this Contract or any DHCS issued templates so long as such requirements do not conflict with any required provision. Contractor must use good-faith efforts to consult with persons who have direct experience with Members receiving services from the below programs in the development of the MOU.

A. Contractor must execute MOUs with Local Health Departments (LHDs) in each county within Contractor's Service Area for the following programs and services, at a minimum:

1) California Children's Services (CCS);

2) Maternal and Child Health (MCH);

3) Tuberculosis (TB) Direct Observed Therapy (DOT);

4) For Community Health Worker (CHW) services, as appropriate; and

5) All other Medically Necessary services that are the responsibility of LHDs, not otherwise specified.

B. Contractor must execute MOUs with Women, Infants, & Children (WIC) agencies in each county within Contractor's Service Area.

C. Contractor must execute MOUs with LGAs, such as the County Behavioral Health Department and County Social Services Department, in each county within Contractor's Service Area to assist with coordinating the following programs and services, at a minimum:

1) Specialty Mental Health Services (SMHS);

2) Alcohol and Substance Use Disorder (SUD) treatment services including counties participating in the Drug Medi-Cal Organized Delivery System (DMC-ODS); 3) In-Home Supportive Services (IHSS).

D. Contractor must execute MOUs to coordinate programs and services for Members with the following LGAs in each county within Contractor's Service Area, at a minimum:

1) Social services; and

2) Child welfare departments.

E. Contractor must execute MOUs to coordinate services provided by Regional Centers (RCs) for persons with Developmental Disabilities in accordance with APLs relevant to MOUs, including DHCS issued templates.

F. By July 1, 2024 (or such later date determined by DHCS), Contractor must execute MOUs with LGAs in each county within Contractor's Service Area to assist with coordinating, at a minimum, Targeted Case Management (TCM).

G. By January 1, 2025 (or such later date determined by DHCS)~~:~~,

~~1) Contractor must collaborate with and execute MOUs with Local Education Agencies (LEAs) in each county within Contractor's Service Area to ensure that Members' Primary Care Provider (PCP) cooperates and collaborates in the development of Individual Education Plans (IEP) or Individual Family Service Plans (IFSP) as required in Exhibit A, Attachment III, Subsection 4.3.16 (*School-Based Services*).~~

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~~2) Contractor must collaborate and execute MOUs, with California Department of Corrections and Rehabilitation, county jails, and youth correctional facilities.~~

~~H.~~ Contractor must execute MOUs to coordinate programs and services for Members with **First 5 County Commissions** ~~the following third-party entities in~~ each county within Contractor's Service Area, ~~at a minimum:~~.

~~1) Home and Community-Based Services (HCBS) program agencies~~;

~~2) Continuum of care programs;~~

~~3) First 5 county commissions.~~

H. By January 1, 2026 (or such later date determined by DHCS):

1) Contractor must collaborate with and execute MOUs with Local Education Agencies (LEAs) in each county within Contractor's Service Area to ensure that Members' Primary Care Provider (PCP) cooperates and collaborates in the development of Individual Education Plans (IEP) or Individual Family Service Plans (IFSP) as required in Exhibit A, Attachment III, Subsection 4.3.16 (*School-Based Services*).

2) Contractor must collaborate and execute MOUs, with California Department of Corrections and Rehabilitation, County Jails, and Youth Correctional Facilities.

5.6.2 MOU Requirements

A. MOUs must contain all the following components, at a minimum:

1) Identification of services that are the responsibilities of each party under the MOU and the populations that are to be served;

2) Identification of the oversight responsibilities of each party, including the designation of a responsible person and liaison by each party, and notification to the other party of changes to the responsible person and liaison;

3) Establishment of policies and procedures for eligibility, screening, assessment, evaluation, Medical Necessity determination, and referral systems;

4) Establishment of policies and procedures for coordinating Member care between the parties, including but not limited to, referrals to applicable Enhanced Care Management (ECM), Community Supports and/or community-based resources;

5) Establishment of policies and procedures for the timely and frequent exchange of Member Information and data, including Behavioral Health and physical health data, maintaining the confidentiality of exchanged information and data, and obtaining Member consent;

6) Establishment of policies and procedures to address and document Quality Improvement (QI) activities for services covered under the MOU, including but not limited to, any applicable performance measures and QI initiatives, reports that track cross-system referrals, Member engagement, and service utilization;

7) Contractor must post on its website the date and time the quarterly meeting occurred, and, as applicable, distribute to meeting participants a summary of any follow-up action items, changes to processes, or Corrective Actions that are necessary to fulfill obligations under this Contract and MOU.

8) Contractor must invite other party's executives to participate in quarterly meetings to facilitate appropriate committee representation, including local presence, to discuss and address Care Coordination and MOU-related issues.

9) Agreement by both parties, to the extent such non-Contractor party will agree to participate in quarterly meetings to discuss Care Coordination as well as systemic and case-specific concerns including allowing Subcontractors and Downstream Subcontractors to participate, as appropriate;

10) Establishment of policies and procedures detailing how complaints can be raised and how to resolve disputes between the parties, including but not limited to, a mutually agreed upon review process to facilitate timely resolution of disputes, differences of opinion and responsible entity for covering services until the dispute is resolved. The review process must not result in delays in Member access to services pending formal dispute resolution;

11) Establishment of policies and procedures regarding Member access to Medically Necessary services and Network Providers during non-business hours;

12) Policies and procedures for Member, Subcontractor, Downstream Subcontractor, and Network Provider education related to access to services covered under the MOU; and

13) Establishment of policies and procedures to address emergency preparedness protocols in accordance with Exhibit A, Attachment III, Article 6.0 (*Emergency Preparedness and Response*).

B. In addition to the MOU requirements listed in Paragraph A of this Subsection, MOUs must contain the following components identified in this Paragraph B, as applicable:

1) MOUs with County Mental Health Plans (MHPs)

a) The requirements contained in Welfare and Institutions Code (W&I) section 14715;

b) Policies and procedures for the delivery of SMHS, including the MHP's provision of clinical consultation with Contractor for Members being treated for mental illness;

c) Policies and procedures for the delivery of Medically Necessary Non-**S**~~s~~pecialty Mental Health Services (NSMHS) within the PCP's scope of practice;

d) Policies and procedures for the timely and frequent exchange of Member information and data, including, as applicable, Behavioral Health and physical health data, maintaining the confidentiality of exchanged information and data, and, if necessary, obtaining Member consent;

e) Policies and procedures for the delivery of Medically Necessary Covered Services to Members who require SMHS, including but not limited to:

i. Prescription Drugs when administered in an outpatient setting and not otherwise excluded under this Contract;

ii. Laboratory, radiological and radioisotope services;

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iii. Emergency room facility charges and professional services;

iv. Transportation;

v. Home health services;

vi. Drug Medi-Cal; and

vii. Medically Necessary Covered Services for Members who are patients in psychiatric inpatient hospitals or IMDs.

f) A provision that states any decision rendered by DHCS regarding a dispute between Contractor and the MHP concerning provision of Covered Services is not subject to the dispute procedures specified in Exhibit E, Section 1.21 (*Contractor's Dispute Resolution Requirements*);

g) Policies and procedures to ensure Medically Necessary NSMHS and SMHS provided concurrently are coordinated and non-duplicative; and

h) Policies and procedures to ensure that Members meeting criteria for SMHS and as indicated by a DHCS-approved standardized transition tools (including standardized transition tools specific for adults and standardized transition tools specific for Children and youth) are referred to the MHP in accordance with Exhibit A, Attachment III, Subsection 4.3.12 *(Mental Health Services*) and Exhibit A, Attachment III, Subsection 5.5.2 (*Non-**S**~~s~~pecialty Mental Health Services and Substance Use Disorder Services*). Likewise, policies and procedures to ensure that Members meeting criteria for NSMHS and as indicated by a DHCS-approved standardized transition tools (including standardized transition tools specific for adults and standardized transition tools specific for Children and youth) are referred by the MHP to Contractor in accordance with Exhibit A, Attachment III, Subsection 4.3.12 *(Mental Health Services*) and Exhibit A, Attachment III, Subsection 5.5.2 (*Non-**S**~~s~~pecialty Mental Health Services and Substance Use Disorder Services*).

i) Contractor must report to DHCS updates from quarterly meetings in a manner and frequency specified by DHCS.

C. If Contractor reimburses the third-party entities or LGAs listed in Exhibit A, Attachment III, Subsection 5.6.1 (*MOU Purpose*) for services rendered, Contractor must execute a Network Provider Agreement, Subcontractor Agreement, and/or Downstream Subcontractor Agreement, as appropriate, in accordance with Exhibit A, Attachment III, Section 3.1 (*Network Provider Agreements, Subcontractor Agreements, Downstream Subcontractor Agreements, and Contractor's Oversight Duties*).

D. Executed MOUs must be publicly posted.

E. MOUs must not be delegated, except that Contractor may delegate its obligations under the MOU to a Fully Delegated Subcontractor or Partially Delegated Subcontractor, provided that such Fully Delegated Subcontractor or Partially Delegated Subcontractor is made a party to the MOU.

5.6.3 MOU Oversight and Compliance

A. MOU Oversight Requirements

Contractor must have processes in place to maintain collaboration among the parties to the MOU and identify strategies to monitor and assess the effectiveness of MOUs as follows:

1) Conduct regular meetings, which include the designated individuals responsible for oversight and performance under the MOU, at least quarterly to address policy and practical concerns that may arise between MOU parties;

2) Resolve conflicts between MOU parties within a reasonable timeframe;

3) Designate a contact person to be responsible for the oversight and supervision of the terms of any MOUs and notify DHCS within five Working Days of any change to Contractor's liaison or responsible person as listed in the MOU;

4) Ensure Subcontractors, Downstream Subcontractors, and Network Providers comply with any applicable provisions of the MOU;

5) Provide education and training of MOU as required by Exhibit A, Attachment III, Subsection 5.6.2.A.12) above;

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6) If DHCS requests a review of any existing MOU, Contractor must submit the requested MOU within ten Working Days of receipt of the request;

7) Ensure appropriate committee representation by inviting a local presence in advance to each quarterly meeting an opportunity to discuss and address Care Coordination and MOU-related issues with county executives;

8) Ensure an appropriate level of leadership are invited to participate in MOU engagements from both Contractor and entity as appropriate; and

9) Report to DHCS updates from quarterly meetings in a manner and frequency specified by DHCS through APLs and guidance.

B. MOU Compliance Requirements

1) At a minimum, executed MOUs listed in this Exhibit A, Attachment III, Subsection 5.6.1 (*MOU Purpose*) must be submitted to DHCS.

2) To the extent Contractor does not execute MOU within the timeframe required under this Contract and relevant APLs, Contractor must submit quarterly reports to DHCS documenting its continuing good faith efforts to execute the MOU, until such time as the MOU is executed. Documentation of good faith efforts must include a description of attempts made to execute an MOU and the explanation for why the MOU has not been executed.

3) Contractor, at a minimum, must review its MOUs annually for any needed modifications or renewal of responsibilities and obligations outlined within. Contractor must submit to DHCS' Contract Manager evidence of the annual review of MOUs as well as copies of any MOUs modified or renewed as a result.

4) Contractor must report on its compliance with the MOU to Contractor's compliance officer at least on a quarterly basis.

Exhibit A, ATTACHMENT III

6.0 Emergency Preparedness and Response ~~(To Become Effective on January 1, 2025)~~

This Article's provisions~~, which will become effective on January 1, 2025,~~ make explicit DHCS' commitment to ensuring that the Medi-Cal managed care delivery system is prepared for those unforeseen circumstances that require immediate action. Specifically, Contractors must plan for and ensure continuity of business operations, delivery of essential care and services to Members, and mitigate potential harm caused by Emergencies, such as a natural or manmade disaster or public health crisis. This Article includes provisions requiring that Contractor must maintain an Emergency Preparedness and Response Plan, including a Business Continuity Plan and Member Emergency Preparedness Plan. In addition, during a federal, State, or county declared state of Emergency, Contractor must implement protocols that allow Members timely access to Covered Services including by allowing flexibility for Prior Authorization, pre-certification, and referrals.

6.1 Emergency Preparedness and Response ~~(To Become Effective on January 1, 2025)~~

6.1.1 General Requirements
6.1.2 Business Continuity Emergency Plan
6.1.3 Member Emergency Preparedness Plan
6.1.4 California's Standardized Emergency Management System
6.1.5 Reporting Requirements During an Emergency
6.1.6 DHCS Emergency Directives

6.1 Emergency Preparedness and Response

6.1.1 General Requirements

For the purposes of this Article 6.0 (*Emergency Preparedness and Response*), "Emergency" means unforeseen circumstances that require immediate action or assistance to alleviate or prevent harm or damage caused by public health crises, natural and man-made hazards, or disasters.

For the purposes of this Article 6.0 (*Emergency Preparedness and Response*), "Emergency Preparedness" means a continuous cycle of planning, organizing, training, equipping, exercising, evaluating, and taking Corrective Action in an effort to ensure effective coordination during incident response. Contractor's Emergency Preparedness process is one element of a broader national preparedness system to prevent, respond to, and recover from public health crises, natural disasters, acts of terrorism, and other disasters.

For the purposes of this Article 6.0 (*Emergency Preparedness and Response*), "Emergency Preparedness and Response Plan" means an Emergency plan put in place by Contractor to ensure continuity of its business operations, to ensure delivery of essential care and services to Members, and to help mitigate potential harm caused by an Emergency.

~~**This Article 6.0 (*Emergency Preparedness and Response*) will not become effective until January 1, 2025.** Contractor must immediately comply with all requirements in this Contract relating to this Article 6.0 (*Emergency Preparedness and Response*) set out in Exhibit A, Attachment II, Article 1.0 (*Operational Readiness Deliverables and Requirements*) upon becoming effective January 1, 2025.~~ Nothing in this Article 6.0 (*Emergency Preparedness and Response*) is intended to relieve Contractor of any other duties or requirements that would otherwise apply, such as any duties or requirements under federal and State laws and regulations relating to Emergency Preparedness.

Contractor must have in place an Emergency Preparedness and Response Plan which includes, at a minimum

A. A Business Continuity Emergency Plan, as described in Exhibit A, Attachment III, Section 6.**1.**2 *(Business Continuity Emergency Plan*)*;*

B. A Member Emergency Preparedness Plan, as described in Exhibit A, Attachment III, Section 6.**1.**3 *(Member Emergency Preparedness Plan*)*;* and

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C. Contractor's policies and procedures for complying with all of the requirements set forth in this Article 6.0 (*Emergency Preparedness and Response*).

Contractor must submit its Emergency Preparedness and Response Plan to DHCS for approval prior to the start of Contractor's operations. Contractor must submit any updates to deliverables identified in this Section to DHCS as requested.

6.1.2 Business Continuity Emergency Plan

Contractor must have a Business Continuity Emergency Plan in place to deal with any Emergency that may affect Contractor's business operations, including, but not limited to, access to Network Providers, Subcontractors, and Downstream Subcontractors; communications; staffing; supplies; and information technology concerns.

For the purposes of this Article 6.0 (*Emergency Preparedness and Response*), a "Business Continuity Emergency Plan" means a document consisting of the critical information and processes Contractor needs to continue operating during an Emergency.

Contractor must consider the availability of local resources and requirements and, upon request, coordinate with local city and county Emergency Preparedness programs when establishing its Business Continuity Emergency Plan.

At a minimum, Contractor's Business Continuity Emergency Plan must address the following:

A. Communication

Contractor must describe how it will communicate with staff, Network Providers, Subcontractors, Downstream Subcontractors, DHCS, and other essential persons and entities during an Emergency. Contractor must also include how Contractor will provide Member, Network Provider, Subcontractor, and Downstream Subcontractor access to call centers for questions; how Contractor will provide dedicated staff and resources toward the Emergency process; and how Contractor will address the continual and timely resolution of claims. Contractor must maintain Emergency contact information, telephone numbers, and other contact

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information (including contact name, title or position, physical location address, mailing address, telephone and/or cell phone, text, e-mail, and social media) for staff, Network Providers, Subcontractors, Downstream Subcontractors, and other essential persons and entities. Contractor must update this contact information as changes occur, but no less than every six months.

B. Emergency Preparedness Risk Assessment

Contractor must identify and assess potential public health crises and natural or man-made Emergencies, including, but not limited to, epidemics, pandemics, earthquakes, fires, floods, storms, hurricanes, tornados, power outages, gas leaks, bomb threats or presence of explosives, explosions, hazardous materials incidents, relocations or evacuations, assaults, intrusions, bioterrorism, injuries, riots, and information technology security incidents that could arise at any location in which Contractor conducts business operations under this Contract. When assessing the risk of a potential Emergency, Contractor must consider the likelihood of the Emergency within its Service Area and how the Emergency may disrupt Contractor's business operations. Contractor must identify and assess any essential supply chain impacts that may disrupt business operations during or after the Emergency. Contractor must update its assessment as changes occur, but at least on an annual basis.

C. Emergency Team Staffing and Responsibilities

1) Contractor must identify an Emergency team and back-up Emergency team members to carry out Contractor's Business Continuity Emergency Plan in the event of an Emergency.

2) Contractor must clearly designate the Emergency team's responsibilities during an Emergency, including, but not limited to, sending out Emergency communications to Contractor's employees, Network Providers, Subcontractors, Downstream Subcontractors, Members, managing site security staff, those staff responsible for securing utilities, and other essential persons and entities.

3) Contractor must ensure that Emergency team members know how to report their status to the Emergency team during and after an Emergency to keep Contractor informed of changing needs.

D. Cooperative Arrangements

Contractor must attempt to establish cooperative arrangements with other local health care organizations to assist and provide mutual aid during an Emergency when business operations are affected. Contractor must submit to DHCS an attestation that it will update its cooperative arrangements at least annually and submit to DHCS.

E. Training and Drills

1) Contractor must establish an Emergency training program to train new and existing staff on Contractor's Business Continuity Emergency Plan.

2) Contractor must conduct annual Business Continuity Emergency Plan drills to ensure Emergency Preparedness and to detect vulnerabilities that can be addressed before an actual Emergency arises. Contractor must submit a report to DHCS within 30 calendar days of each training drill which identifies drill activities, provides a summary of outcomes, and creates a plan to address any vulnerabilities found.

3) Contractor must, upon request, participate in mock disaster drills coordinated by governmental entities, if available, to ensure coordination during an Emergency.

4) Contractor must ensure that the equipment and supplies necessary to sustain business operations are readily available in the event of an Emergency.

F. Systems Recovery

1) Emergency Operation

Contractor must establish a plan to maintain critical business processes that protects confidential and sensitive electronic and non-electronic information, including, but not limited to, Protected Health Information (PHI), personal information, and claims information during an Emergency.

2) Data Backup

Contractor must establish procedures to backup confidential and sensitive electronic information, including, but not limited to, PHI, PI, and claims information to maintain the ability to retrieve such

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information during an Emergency. Contractor must establish a regular schedule for conducting backup procedures, storing backup information offsite, updating an inventory of backup media, and formulating an estimate for the time needed to restore lost confidential and sensitive information. At a minimum, Contractor must conduct a full backup process of its confidential and sensitive electronic information on a weekly basis and update its offsite data storage on a monthly basis.

6.1.3 Member Emergency Preparedness Plan

Contractor must establish a Member Emergency Preparedness Plan to address its Members' needs during an Emergency, including for Members in Long-Term Care facilities, Skilled Nursing Facilities, or other institutional settings; and for Members with disabilities, limitations in activities of daily living, and/or cognitive impairments.

For the purposes of this Article 6.0 (*Emergency Preparedness and Response*), a "Member Emergency Preparedness Plan" means a required subsection of the Emergency Preparedness and Response Plan that details the required coordination between Contractor and its Members, Network Providers, Subcontractors, and Downstream Subcontractors to ensure Member access to health care services in the event of an Emergency.

At a minimum, Contractor's Member Emergency Preparedness Plan must address the following:

A. Member Communication

1) Contractor must have the ability to set up a Member services call center for communication with Members before, during, and after an Emergency.

2) Contractor must establish Emergency protocols for its Member services call center. Protocols must include, but are not limited to, call scripts that account for different Member needs, staff training in crisis response, Contractor Emergency protocols that ensure access to Covered Services, and processes for escalating a call through warm hand-off connections to nurses or doctors for Members needing immediate assistance.

3) During and post-Emergency, Contractor must:

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a) Instruct Members about how to reach Contractor's nurse advice line, care coordinators, Medi-Cal Rx pharmacy services, Telehealth services, and other Contractor services and resources as deemed appropriate;

b) Notify Members about available alternative primary pharmacy, dialysis center, chemotherapy or other infusion therapy location, and other treatment sites;

c) Inform Members about how Contractor may modify its care protocols and Member benefits to ensure continued access to Medically Necessary services;

d) Provide Members with information on how to obtain medical authorizations, out-of-Network care, medication refills or Emergency supply, Durable Medical Equipment (DME) and replacements, and Medical Records; and

e) Inform Members about how to access behavioral and mental health services.

B. Continuity of Covered Services

1) Contractor must ensure that Members impacted by a federal, State, or county declared state of Emergency continue to have access to Covered Services. Contractor must take actions to ensure continued access, including but not limited to the following:

a) Relaxing time limits for Prior Authorization, pre-certification, and referrals;

b) Extending filing deadlines for Grievances and requests for Appeal in accordance with Exhibit A, Attachment III, Section 4.6 (*Member Grievance and Appeal System*);

c) Coordinating, transferring, and referring Members to alternate sources of care when Providers are closed, unable to meet the demands of a medical surge, or otherwise affected by an Emergency;

d) Authorizing Members to replace DME or medical supplies out-of-Network;

e) Allowing Members to access appropriate out-of-Network Providers if Network Providers are unavailable due to an Emergency or if the Member is outside of the Service Area due to displacement; and

f) Providing, when directed, a toll-free telephone number for displaced Members to call with questions, including questions about the loss of a Beneficiary Identification Card, access to prescription refills, and how to access health care.

2) Contractor must establish policies and procedures to immediately implement these actions as necessary or as directed by DHCS.

C. Network Provider, Subcontractor, and Downstream Subcontractor Emergency Requirements

1) Education

a) Contractor must educate Network Providers, as a part of training in accordance with Exhibit A, Attachment III, Subsection 3.2.5 (*Network Provider Training*); Subcontractors; and Downstream Subcontractors on Contractor's Emergency policies and procedures.

b) Contractor must provide Network Providers, Subcontractors, and Downstream Subcontractors with an Emergency Preparedness fact sheet and resources on general Emergency Preparedness, response, and communications protocols.

2) Communications During an Emergency

a) Contractor must have a system and process in place to be able to provide and receive information from Network Providers, Subcontractors, and Downstream Subcontractors during an Emergency.

b) Contractor must have a process in place to inform Network Providers, Subcontractors, and Downstream Subcontractors about what modifications need to be implemented during an Emergency to ensure that Members are able to access Covered Services, and how Contractor can assist Network Providers, Subcontractors, and Downstream Subcontractors in those efforts.

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3) Network Provider Agreements

a) Contractor's Network Provider Agreements must state that Network Providers are required to:

i. Annually submit evidence of adherence to Centers for Medicare & Medicaid Services (CMS) Emergency Preparedness Final Rule (FR), 81 FR 63859, and 84 FR 51732;

ii. Advise Contractor as part of the Network Provider's Emergency plan; and

iii. Notify Contractor within 24 hours of an Emergency if the Network Provider closes down, is unable to meet the demands of a medical surge, or is otherwise affected by an Emergency.

6.1.4 California's Standardized Emergency Management System

A. Contractor must cooperate with local city and county Emergency Preparedness programs within Contractor's Service Area to ensure provision of health care services.

B. Contractor must, upon request, educate and prepare staff on the California State Emergency Plan and prepare staff to participate in California's Standardized Emergency Management System (SEMS).

C. Contractor must maintain contact information for local city and county Emergency Preparedness programs within Contractor's Service Area.

D. Contractor must ensure that its medical director and Grievance and Appeals coordinator are able to receive communications from the California Health Alert Network and the California State Warning Center.

6.1.5 Reporting Requirements During an Emergency

A. Within 24 hours of a federal, State, or county declared state of Emergency located within Contractor's Service Area, Contractor must notify DHCS as to whether Contractor has experienced or expects to experience any disruption to its operations.

B. At a minimum, Contractor must report the status of its operations once a day to DHCS, or as directed by DHCS.

C. Contractor's daily report to DHCS must include, at a minimum, the following information:

1) The number of Members in Contractor's Service Area affected by the Emergency, per county, including the number of medium-to-high health risk Members, as identified through the Population Needs Assessment;

2) Information, to the extent available, relating to Network Provider site closures, including:

a) The number of Network Provider site closures by Provider type, per county;

b) The number of Members served by each closed Network Provider, per county;

c) The number of hospitalized Members who need to be transferred;

d) The location(s) of where Members were transferred; and

e) For each closed Network Provider, a list of the alternative Providers or facilities where Members can receive care.

3) The number of Contractor offices that are closed;

4) How Contractor is communicating with impacted Members, Network Providers, Subcontractors, and Downstream Subcontractors;

5) The actions Contractor has taken or will take to meet the continued health care needs of its Members; and

6) The Network Provider, Subcontractor, Downstream Subcontractor, or Member issues Contractor has received.

D. Contractor must comply with any guidance from the California Health and Human Services Agency regarding reporting on the status of Contractor's operations during an Emergency.

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6.1.6 DHCS Emergency Directives

When a federal, State, or county Emergency is declared, Contractor agrees that DHCS may, in its sole discretion, waive existing contractual requirements and institute new contractual requirements to address an Emergency pursuant to an Emergency directive. DHCS Emergency directives do not require an amendment to this Contract prior to implementation. Emergency directives to Contractor may be communicated through All Plan Letters, advisory memos, or other similar announcements and are effective when published. Unless otherwise stated, Emergency directives will remain in effect until the Emergency directive is terminated. Contractor must promptly comply with all DHCS Emergency directives.

Exhibit A, Attachment III

7.0 Operations Deliverables and Requirements

To demonstrate the requisite capabilities necessary to execute the obligations of this Contract, DHCS outlines specific deliverables that Contractor must submit to DHCS prior to the implementation of the Contract. This period is considered the Implementation Period at which time DHCS will assess the Medi-Cal managed care plan's readiness to begin operations as a Contractor. These deliverables are identified and set forth in Exhibit A, Attachment II, Section 1.0 (*Operational Readiness Deliverables and Requirements*) of the Contract and the tables that follow that Section.

This Article provides a non-exhaustive list of deliverables required to be submitted by Contractor to the DHCS and/or other entity(ies) throughout the term of the Contract to verify Contractor's continued compliance with Contract requirements. Contractor must submit all required deliverables to DHCS in a complete, accurate, and timely fashion. Contractor must submit all required deliverables to DHCS in an ADA-compliant format if identified in the tables below this section as publicly available. Contractor may be responsible for additional deliverable requirements based on changes in State and federal law and/or DHCS program needs. Contractor must meet any additional requirements, not listed in the tables below, upon DHCS' request and in the form and manner specified by DHCS. Contractor must use the calendar year to define annual, monthly, and quarterly submission timeframes unless directed otherwise.

In the event Contractor fails to submit any deliverables in accordance with the milestones and timeframes required by DHCS, DHCS may impose Sanctions and Liquidated Damages in accordance with Exhibit E, Section 1.19 (*Sanctions*) and Section 1.20 (*Liquidated Damages*) to Contractor.

EXHIBIT A, ATTACHMENT I – 1.0 DEFINITIONS

No deliverables or requirements listed for this Article.

EXHIBIT A, ATTACHMENT I – 2.0 ACRONYMS

No deliverables or requirements listed for this Article.

EXHIBIT A, ATTACHMENT II – 1.0 OPERATIONAL READINESS DELIVERABLES AND REQUIREMENTS

See specific contract Sections below for details.

EXHIBIT A, ATTACHMENT III – 1.1 PLAN ORGANIZATION AND ADMINISTRATION

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0001	Key Personnel Disclosure Form	1.1.2	Annually.		DHCS
D.0114	Medical Director Information	1.1.6	Attest to DHCS that this has been posted no later than January 1 of each year.	Posted in an easily accessible location on Contractor's Provider portal website.	Public
~~D.0002~~ **Via Notifi-cation Center**	Key Personnel Change Notification including CEO, CFO, COO, CMO, Chief Medical Director, Health Equity Officer, Compliance Officer, and Government Relations Person.	1.1.8	Within ten calendar days**.** Within 20 calendar days.	Contractor must post Medical director contact information on their provider portal website.	DHCS; Public

EXHIBIT A, ATTACHMENT III – 1.2 FINANCIAL INFORMATION

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0003	Monthly Financial Reports	1.2.2	Monthly, no later than 30 calendar days after the close of Contractor's fiscal month.	Financial Reports submitted in accordance with this Section 1.2 are public records and may be made public by DHCS.	DHCS
D.0004	Quarterly Financial Reports	1.2.2	Quarterly, no later than 45 calendar days after the close of Contractor's fiscal quarter.		DHCS
D.0005	Annual Financial Reports	1.2.2	Annually, no later than 120 calendar days after the close of Contractor's Fiscal Year.		DHCS
D.0006	Annual Forecasts	1.2.2	Annually, no later than 60 calendar days prior to the beginning of Contractor's next Fiscal Year.		DHCS
D.0007	Independent Financial Audit Report	1.2.3	Annually, no later than 120 calendar days after the close of Contractor's Fiscal Year.		DHCS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0008	Medical Loss Ratio Report (MLR)	1.2.5; 1.2.5.H	Annually Timeframe and manner determined by DHCS, but no longer than 12 months after the end of the MLR reporting year; and When there is a retroactive change to the Capitation Payments for a MLR reporting year and a new report needs to be submitted to reflect the change.		DHCS
D.0009	Community Reinvestment Plan	1.2.7	Annually.	Posted on Contractor's website.	DHCS
D.0010	Community Reinvestment Report	1.2.7	Annually.	Posted on Contractor's website.	DHCS

EXHIBIT A, ATTACHMENT III – 1.3 PROGRAM INTEGRITY AND COMPLIANCE PROGRAM

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0115	Compliance Program	1.3.1.A .9)	Annually.	On Contractor's website.	DHCS
D.0011	Preliminary Fraud, Waste, and Abuse Reports	1.3.2.D .1)	Within ten Working Days of Contractor's discovery of such Fraud, Waste, or Abuse.		DHCS
D.0012	Completed Fraud, Waste, and Abuse Investigation Report	1.3.2.D .2)	Within ten Working Days of completing Contractor's Fraud, Waste, or Abuse investigation.		DHCS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0013	Quarterly Fraud, Waste, Abuse Status Report	1.3.2.D .3)	Quarterly, ten Working Days after the close of every calendar quarter.		DHCS
D.0014	Suspended, Excluded, or Ineligible Provider Notification	1.3.4.A .6)	Within ten Working Days of removing a suspended, excluded, or ineligible Provider from its Network.		DHCS
D.0116	Disclosures	1.3.5.C	Within 60 calendar days of when it has identified any Capitation Payments or other payments it has received or paid in excess of the amounts specified in this Contract.		
D.0126	Overpayment Notification of $25 million or more	1.3.6.A	Within 60 calendar days of the date the overpayment.		DHCS
D.0131	Overpayment Notification of any amount related to Fraud, Waste, and Abuse	1.3.6.A	Within 10 calendar days of the date the overpayment.		DHCS
D.0106	Overpayment Recoveries Report	1.3.6.B	Annually.		DHCS

EXHIBIT A, ATTACHMENT III – 2.1 MANAGEMENT INFORMATION SYSTEM

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0015	Encounter Data Reporting	2.1.2	Within 60 calendar days of the date of adjudication of a claim or receipt of an Encounter as required by this Contract or as otherwise agreed upon by DHCS, or as mandated through federal law; Within six Working Days of the end of each month following the month of payment.		DHCS
D.0017	Network Provider Data Reporting	2.1.4	Within ten calendar days following the end of each month.		DHCS
D.0018	Program Data Reporting	2.1.5	Within ten calendar days following the end of each month.		DHCS
D.0019	Template Data Reporting	2.1.6	On a regular basis, or as mandated through federal law.		DHCS
D.0020	Management Information System/Data Audits	2.1.7	No less frequently than once every three years.		DHCS

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ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0016	Data Corrective Action Plans	2.1.8	Within 15 calendar days from the date of the DHCS written notice to Contractor regarding any deficiencies and problem**s** related to Contractor's data or its Management and Information System (MIS).	DHCS may publicly disclose on the DHCS website any Contractors that have entered into Corrective Action plans, or that have been subject to sanctions due to non-compliance .	DHCS; public
D.0117	Tracking Member Alternative Format Selections	2.1.9	As Requested by Member in accordance with the requirements in All Plan Letter (APL) 22-002.		DHCS

EXHIBIT A, ATTACHMENT III – 2.2 QUALITY IMPROVEMENT AND HEALTH EQUITY TRANSFORMATION PROGRAM

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0021	Written summary of Quality Improvement and Health Equity Committee (QIHEC) activities, as well as the QIHEC activities of Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors	2.2.3.D	At least quarterly.	On Contractor's website.	DHCS; Public
D.0022	Quality Improvement and Health Equity Plan	2.2.7	Annually.	On Contractor's website.	DHCS; Public
D.0026	NCQA Health Plan Accreditation and Health Equity Accreditation results	2.2.8	After every NCQA accreditation cycle (every 3 years). Within 30 calendar days of the receipt of the completed report from NCQA. Within 15 calendar days of confirmation of the site visit by NCQA.		DHCS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0024	Health plan Subcontractor and Downstream Subcontractor quality and health equity performance data	2.2.9.A .2	Annually (and as requested by DHCS).		DHCS
D.0023	Performance Improvement Project reporting	2.2.9.B	At intervals determined by DHCS. At least annually.	On the DHCS website.	DHCS; Public
D.0025	Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey results and CAHPS results for its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors	2.2.9.C	Annually after January 1, 2026.	On Contractor's website.	DHCS; Public
D.0141	EPSDT/AAP Bright Futures annual attestation for mailing/electronically sharing of DHCS supplied Medi-Cal for Kids and Teens Materials	2.2.10. B.2	Annually, by January 15th.	Yes	Eligible Members under the age of 21. New Members within 7 calendar days of Enrollment

EXHIBIT A, ATTACHMENT III – 2.3 UTILIZATION MANAGEMENT PROGRAM

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0027	Appeals Procedure	2.3.1.F	As needed when updated.	On Contractor's website.	DHCS; Public

EXHIBIT A, ATTACHMENT III – 3.1 NETWORK PROVIDER AGREEMENTS, SUBCONTRACTOR AGREEMENTS, DOWNSTREAM SUBCONTRACTOR AGREEMENTS, AND CONTRACTOR'S OVERSIGHT DUTIES

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0132	Network Provider Agreement Template	3.1.2.A .1	When updated or when a new provider type		DHCS
D.0133	Subcontractor Agreement Template	3.1.2.B .1.a	When updated or when a new provider type		DHCS
D.0134	Updates to Fully Delegated Subcontractor Agreements Template with Fully Delegated Downstream Subcontractors	3.1.2.B .1.a	As needed when updated		DHCS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0135	Updates to Fully Delegated Executed Subcontractor Agreements with Fully Delegated Downstream Subcontractors	3.1.2.B .1.b	As needed when updated		DHCS
D.0028	Delegation Reporting and Compliance Plan	3.1.3; Exh. J	Annually and at any time there is a material change as specified by DHCS within 30 calendar days from either the beginning of the annual reporting period or the material change.	On Contractor's website.	DHCS; Public
D.0029	Non-Federally Qualified HMOs Subcontractor Agreement, Downstream Subcontractor Agreement, and Network Provider Amendment Approval Request	3.1.5	At least 30 calendar days before the effective date, unless otherwise instructed by DHCS Within 60 calendar days after the date the overpayment was identified.		DHCS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0030	Federally Qualified HMOs Network Provider Agreement, Subcontractor Agreement, or Downstream Subcontractor Agreement	3.1.8	Upon DHCS request.		DHCS
D.0031	Termination Notice of Network Provider Agreement with a Safety-Net Provider	3.1.8	As needed, at least 60 calendar days prior to the effective date of termination or concurrently with the termination if Provider's license has been revoked or suspended or where the health and welfare of a Member is threatened.		DHCS
D.0118	Provider Selection	3.1.10	Upon request.		DHCS
D.0119	Delegation Model	3.1.12		On Contractor's website	

EXHIBIT A, ATTACHMENT III – 3.2 PROVIDER RELATIONS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0032	Provider Dispute Resolutions Report	3.2.2	Annually.		DHCS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0033	Most current Provider Manual	3.2.4	As needed. Annually.	Available to the Provider through Provider portals, the Internet or upon request.	Providers
D.0034	Hospital Inpatient Days Report	3.2.8	As required by Welfare and Institutions Code (W&I) section 14105.985(b)(2). Within 30 calendar days of DHCS' request.		DHCS

EXHIBIT A, ATTACHMENT III – 3.3 PROVIDER COMPENSATION ARRANGEMENTS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0035	Alternative and Value-Based Payment Models Report	3.3.1.B C	Within 90 calendar days of DHCS' request. Annually.		DHCS
D.0036	Financial Incentive Programs Report	3.3.3	As specified by DHCS.		DHCS
D.0037	Identification of Responsible Payor	3.3.4	Upon request and in a manner prescribed by DHCS.		DHCS' fiscal intermediary (FI) contractor

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0038	Documentation of services for Contractor's Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) Network Provider Agreements	3.3.7.B	Within 30 calendar days of DHCS' request.		DHCS
D.0039	Certification of Terms and Conditions for Network Provider Agreements with FQHCs and RHCs	3.3.7.B	Within 30 calendar days of DHCS' request.		DHCS
D.0040	FQHC and RHC Network Provider Agreements	3.3.7.B	Whenever any Network Provider Agreements are executed or amended.		DHCS
D.0041	Disputed Emergency Services/Post-Stabilization Care Claims	3.3.16	As needed. Within 30 calendar days of the effective date of a decision that Contractor is liable for payment of a claim.		DHCS - Office of Administrative Hearings and Appeals

EXHIBIT A, ATTACHMENT III – 4.1 MARKETING

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0042	Request to Conduct Activity Outside of Contract Requirements	4.1.2	As needed, at least 30 calendar days prior to the Marketing event.		DHCS
D.0043	Updates to Marketing Representative Training and Certification Program	4.1.1	Prior to implementation.		DHCS
D.0044	Marketing Materials	4.1.2	Prior to distribution. At least 30 calendar days prior to the Marketing activity, unless DHCS agrees to a shorter review period.		DHCS
D.0045	Marketing Plan	4.1.2	Annually. When there are any changes made to Contractor's Marketing plan.		DHCS

EXHIBIT A, ATTACHMENT III – 4.2 ENROLLMENTS AND DISENROLLMENTS

No deliverables or requirements listed for this Section.

EXHIBIT A, ATTACHMENT III – 4.3 POPULATION HEALTH MANAGEMENT AND COORDINATION OF CARE

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0046	Population Health Management Strategy	4.3.1	Annually.		DHCS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0047	Population Needs Assessment	4.3.2	At least every three years.	On Contractor's website.	DHCS; Public
D.0048	Managed Care Liaison Change Notification	4.3.24	Within five days of the change.		DHCS
D.0136	**NSMHS Outreach and Education Plan Submission to DHCS**	**4.3.12**	**Annually.**		**DHCS**
D.0137	**DHCS Approved NSMHS Outreach and Education Plan & Utilization Assessment Posting**	**4.3.12**	**Annually.**	**On Contractor's website.**	**DHCS; Public**

EXHIBIT A, ATTACHMENT III – 4.4 ENHANCED CARE MANAGEMENT

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0049	Enhanced Care Management Model of Care (MOC)	4.4.5	Contractor must submit to DHCS any Significant changes to its MOC for DHCS review and approval at least 60 calendar days in advance of any occurrence of changes or updates, in accordance with DHCS policies and guidance, including APLs.		DHCS

EXHIBIT A, ATTACHMENT III – 4.5 COMMUNITY SUPPORTS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0050	Community Supports Model of Care	4.5.5	Contractor must submit to DHCS any changes to its Community Supports MOC for DHCS review and approval at least 60 calendar days in advance of any occurrence of changes or updates, in accordance with DHCS policies and guidance, including APLs.		DHCS

EXHIBIT A, ATTACHMENT III – 4.6 MEMBER GRIEVANCE AND APPEAL SYSTEM

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0051	Receipt of ~~Standard~~Standard Grievances	4.6.2.E	Within five calendar days of receipt of the Grievance.		Member who filed a Grievance

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0052	Discrimination Grievance Information	4.6.3.C	Within ten calendar days of mailing a Discrimination Grievance resolution letter. Contractor must also submit annual attestation 2*nd* Friday of December indicating ~~MCP~~ **Contractor** submitted appropriate grievance information to OCR within ~~10~~**ten** calendar days of mailing Discrimination Grievance resolution letter.	On Contractor's website.	DHCS - Office of Civil Rights; DHCS
D.0053	Sample Notice of Action (NOA) Letter	4.6.4.C 4.6.4.E .3	Within 30 calendar days from receipt of information that is reasonably necessary to make a determination. No later than 60 calendar days from the date on the NOA.		DHCS
D.0054	Grievance Logs	4.6.9	Upon DHCS request.		DHCS and/or CMS

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EXHIBIT A, ATTACHMENT III – 5.1 MEMBER SERVICES

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0056	Nondiscrimination Notice and Language Taglines	5.1.3	Prior to use.	On Contractor's website – accessible from Contractor's home page.	DHCS
D.0057	Member Information - Provider Directory	5.1.3	Prior to initial Operations; Monthly; Every six months; and When Contractor updates the Provider Directory. One week after Contractor receives updated provider information.	On Contractor's website.	DHCS; Public
D.0058	Member Information - Member Handbook/Evidence of Coverage (EOC)	5.1.3	Before distribution to Members; When updated; or Other timeframes provided by DHCS.	On Contractor's website.	DHCS
D.0139	**Attestation whether Contractor meets 5.1.3.A & B requirements for mailing new/potential member materials within seven calendar days**	**5.1.3.A 5.1.3.B**	**Monthly by end of month.**	**No.**	**DHCS**

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0140	**Attestation whether Contractor meets annual mailing requirements**	**5.1.3.C**	**Annually by end of January.**	**No.**	**DHCS**
D.0129	EOC Attestation-Notification to DHCS that the EOC has been mailed and/or posted on the Contractor's Website.	5.1.3	Annually, by January 1.	On Contractor's website	DHCS

EXHIBIT A, ATTACHMENT III – 5.2 NETWORK AND ACCESS TO CARE

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0059	Alternative Access Standard Requests	5.2.5	At least annually and when Contractor is unable to comply with the time or distance standards set forth in W&I section 14197.04.	Contractor's website for Contractor specific results and the DHCS website with statewide results.	DHCS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0060	Network and Access Changes to Covered Services	5.2.9.A	When Contractor discovers a Provider-initiated termination impacting more than 2,000 Members; When Contractor discovers a Provider-initiated termination that affects Contractor's ability to meet network adequacy standards; When there is a change in the availability or location of Covered Services; and Within ten calendar days of Contractor discovering a Provider's exclusionary status from any database or list.		DHCS
D.0061	Notification regarding Community Based Adult Services (CBAS) Network Provider	5.2.9.A	When Contractor is unable to contract with a certified CBAS Provider; Upon termination of a CBAS Network Provider Agreement; and Within five Working Days of Contractor's decision to exclude a CBAS Provider from its Network.		DHCS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0062	Notification regarding Long-Term Care (LTC) Network Provider	5.2.9.A .4	Within 60 calendar days of termination of a LTC Provider; Immediately if the termination is a result of LTC Provider decertification by CDPH; and Within 72 hours of applicable termination of a LTC Provider.		DHCS
D.0063	Member Notice regarding Provider Termination	5.2.9.B	Prior to its release to Members.		DHCS
D.0064	Community Advisory Committee (CAC) Demographic Report	5.2.11	Annually, by April 1st.		DHCS
D.0065	CAC meeting notices	5.2.11	30 days prior to each quarterly CAC meeting, but in no event later than 72 hours prior to each meeting.	On Contractor's website.	Public
D.0066	CAC meeting minutes	5.2.11. E.3)d)	No later than 45 calendar days after each quarterly meeting.	On Contractor's website.	DHCS; Public
D.0067	Network Certification Report	5.2.13	At least annually.	On the DHCS Website.	DHCS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0068	Notification of Significant Change to Network	5.2.13.B	Any time there is a Significant Change to Contractor's Network that affects Network capacity and Contractor's ability to provide health care services.		DHCS
D.0069	Network Change Report	5.2.13	30 calendar days following the end of the reporting quarter.		DHCS
D.0112	Subcontractor and Downstream Subcontractor Certification Report	5.2.13	At least annually, if applicable.	On Contractor's website.	DHCS

EXHIBIT A, ATTACHMENT III – 5.3 SCOPE OF SERVICES

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0070	Report of Drug Use Review (DUR) Program Activities	5.3.7.H	Annually.		DHCS

EXHIBIT A, ATTACHMENT III – 5.4 COMMUNITY BASED ADULT SERVICES

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0072	CBAS Member Enrollment Report	5.4.3.A	On a quarterly basis.		DHCS
D.0113	Summary of CBAS Complaints	5.4.3.C	30 calendar days following the end of the reporting period.		DHCS
D.0073	CBAS Grievance and Appeal Reports	5.4.3.D	30 calendar days following the end of the reporting period.		DHCS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0120	CBAS Provider List	5.4.3.E	Annually.		DHCS

EXHIBIT A, ATTACHMENT III – 5.5 MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS

No deliverables or requirements listed for this Section.

EXHIBIT A, ATTACHMENT III – 5.6 MOUs WITH LOCAL GOVERNMENT AGENCIES, COUNTY PROGRAMS, AND THIRD PARTIES

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0130	Revised MOU Template	5.6.1.C .2	As needed.	After execution	DHCS
D.0128	MOU Public Posting	5.6.2.D	Upon completed execution of contract.	Executed MOUs must be publicly posted	Public and DHCS
D.0075	Status Report	5.6.3	Quarterly, beginning four months after the effective date of this Contract or within the timeframe required under this Contract and relevant APL, until all required MOUs are executed.		DHCS
D.0127	MOU Liaison Change Notification	5.6.3.A .3	Within five Working Days of any change in the designated MOUs' liaison.		DHCS
D.0121	Existing MOU	5.3.6.A .6	Within ten Working Days of receipt of the request.		DHCS
D.0076	Copy of Executed MOUs	5.6.3	Upon execution, modification or renewal.	On Contractor's website.	DHCS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0077	MOU Review Report	5.6.3.B	Annually.		DHCS, upon request

EXHIBIT A, ATTACHMENT III – 6.1 EMERGENCY PREPAREDNESS AND RESPONSE

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0078	Emergency Preparedness and Response Plan	6.1	Prior to the start of Operations.	On Contractor's website.	DHCS
D.0079	Emergency Contact Information Update	6.1.2.A	No less than every six months; and As changes occur.		DHCS
D.0080	Cooperative Agreements	6.1.2.D	At least annually.		DHCS
D.0081	Emergency Drill Report	6.1.2.E	Within 30 calendar days after the drill is completed.		DHCS
D.0082	Member Emergency Preparedness Plan Templates	6.1.3	Prior to use for each mode of communication.		DHCS
D.0083	Daily Emergency Reporting	6.1.5.B	Once a day, at a minimum, throughout the State of Emergency.		DHCS

EXHIBIT B, BUDGET DETAIL AND PAYMENT PROVISIONS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0084	Supplemental Payments Report	1.1.7. A	On a monthly basis no later than 20 calendar days following the end of each month.		DHCS
D.0085	Supplement Payment Eligibility Data	1.1.7. A	Contractor must properly submit all required data to DHCS within 12 months of the month of the service entitling Contractor to a Supplemental Payment.		DHCS
D.0086	Additional Payments Report	1.1.8. A	On a monthly basis, no later than 20 calendar days following the end of each month.		DHCS
D.0087	Additional Payments Report Eligibility Data	1.1.8. A	Contractor must properly submit all required data to DHCS within 12 months of the month of the service entitling Contractor to an additional payment.		DHCS
D.0122	Financial Performance Guarantee	1.1.12	Annually.		DHCS
D.0088	Medical Loss Ratio Remittance	1.1.15	When the ratio for the MLR reporting year does not meet the minimum MLR standard.		DHCS

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EXHIBIT C, GENERAL TERMS AND CONDITIONS

No deliverables or requirements listed for this Exhibit.

EXHIBIT D(f), SPECIAL TERMS AND CONDITIONS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0094	Request for Subcontract Authorization	5.a	Before Contractor enters into or is reimbursed for any subcontract for services costing $5,000 or more.		DHCS
D.0096	Requests for Disclosure of Confidential Information	14	As applicable.		DHCS
D.0097	Contractor Certification of Federal Fund Expenditure	17.c	As applicable.		DHCS
D.0098	Financial and Compliance Audit Reports	17.d	Within 30 calendar days after the completion of the audit.		DHCS
D.0099	Contractor Explanation for Debarment and Suspension Certification.	20	As applicable.		DHCS

EXHIBIT E, PROGRAM TERMS AND CONDITIONS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0123	Certifications - Data, Information, and Documentation Submitted to DHCS	1.1.11	Monthly.		DHCS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0100	Contractor's Analysis regarding its financial solvency	1.1.16	As needed.		DHCS
D.0101	Contractor Termination Notice due to financial insolvency	1.1.16	As needed, and at least six months prior to expected effective termination date.		DHCS
D.0124	Phaseout Transition Requirements	1.1.17.B	Within no later than 90 calendar days prior to termination or expiration of this Contract and through the Phaseout Period for each Service Area.		DHCS
D.0102	Notice of Dispute	1.1.21.B	Within 30 calendar days from the date that the alleged dispute arises or otherwise becomes known to Contractor.		DHCS
D.0103	Costs Avoidance Reports	1.1.25	Within ten calendar days of discovery By the 15th day of each month.		DHCS
D.0104	Post-Payment Recovery Report	1.1.25.H 1.1.25.J	At the tenth day of each month; and Within ten calendar days of discovery when Contractor identifies OHC unknown to DHCS.		DHCS
D.0105	Service and Utilization Information	1.1.26	Within 30 calendar days of the DHCS' request.		DHCS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0125	Litigation Support Records	1.1.27. A	Upon DHCS request.		DHCS
D.0107	DVBE Reporting Requirements	1.1.31	60 calendar days after receiving final payment, if Contractor made a commitment to achieve DVBE participation.		DHCS

EXHIBIT F, CONTRACTOR'S RELEASE

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0108	Contractor's Release	F	With the submission of final invoice(s).		DHCS

EXHIBIT G, BUSINESS ASSOCIATE ADDENDUM

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0109	Notice to DHCS of Breaches and Security Incidents	18.1.1	See contract language for details.		DHCS
D.0110	Completed Final Privacy Incident Reporting Form	18.3	Within ten Working Days of the discovery of the security incident or breach.		DHCS

EXHIBIT H, CONFLICT OF INTEREST AVOIDANCE REQUIREMENTS

No deliverables or requirements listed for this Exhibit.

EXHIBIT I, CONTRACTOR'S PARENT GUARANTY REQUIREMENTS

No deliverables or requirements listed for this Exhibit.

EXHIBIT J, DELEGATION REPORTING AND COMPLIANCE PLAN

~~ID~~	~~Deliverable Title~~	~~Ref.~~	~~Frequency~~	~~Publicly Available~~	~~Recipient~~
~~D.0111~~	~~Delegation Reporting and Compliance Plan~~	~~3.1.3; Exh. J~~	~~Annually and at any time there is a change as specified by DHCS within 30 calendar days following the annual reporting period or the material change.~~	~~On Contractor's website.~~	~~DHCS; Public~~

No deliverables or requirements listed for this Exhibit.

EXHIBIT K, EXCLUDED PROVISIONS AS TO CONTRACTORS NOT LICENSED PURSUANT TO THE KNOX-KEENE HEALTH CARE SERVICE PLAN ACT OF 1975

No deliverables or requirements listed for this Exhibit.

EXHIBIT L, REQUIREMENTS SPECIFIC TO CONTRACTOR

Any deliverables for Contractor-specific requirements will be stated in Exhibit L.

Exhibit B – Budget Detail and Payment Provisions

1.0 Budget Detail and Payment Provisions

1.1 Budget Detail and Payment Provisions

1.1.1 Budget Contingency Clause
1.1.2 Contractor Risk
1.1.3 Capitation Payment ~~Rates~~
1.1.4 Capitation Payment Rates Constitute Payment in Full
1.1.5 Determination and Redetermination of Capitation Payment Rates
1.1.6 Redetermination of Capitation Payment Rates Due to Obligation Changes
1.1.7 Supplemental Payments
1.1.8 Additional Payments
1.1.9 Recovery of Amounts Paid to Contractor
1.1.10 Reinsurance
1.1.11 Catastrophic Coverage Limitation
1.1.12 Financial Performance Guarantee
1.1.13 Medicare Coordination
1.1.14 Special Contract Provisions Related to Payment
1.1.15 Medical Loss Ratio Remittance
1.1.16 State Program Receiving Federal Financial Participation
1.1.17 Community Reinvestment
1.1.18 Quality Achievement Requirement
1.1.19 Enhanced Care Management Risk Corridor
1.1.20 Federally Qualified Health Center Alternative Payment Model Risk Corridor
~~1.1.21 Unsatisfactory Immigration Status Risk Corridor~~

1.1 Budget Detail and Payment Provisions

1.1.1 Budget Contingency Clause

Any requirement of payment or performance by DHCS and Contractor for the period of the Contract will be dependent upon the availability of future appropriations by the Legislature for the purpose of the Medi-Cal program.

A. It is mutually agreed that if the Budget Act of the current year or any subsequent years covered under this Contract does not appropriate sufficient funds for the program, DHCS has no liability to pay any funds whatsoever to Contractor or to furnish any other considerations under this Contract, and Contractor is not obligated to perform any provisions of this Contract in any year when insufficient funding may occur. Further, should funding for any Fiscal Year be reduced or deleted by the Budget Act for purposes of this program, DHCS must have the option to:

1) Cancel this Contract with no liability accruing to DHCS and no further obligation by Contractor to perform hereunder; or

2) Offer a Contract amendment to Contractor to reflect the reduced amount of available funding.

B. All payments are subject to the availability of federal appropriation of Medicaid funding.

1.1.2 Contractor Risk

Except as otherwise specified in this Contract, Contractor will assume the total risk of providing Covered Services to Members on the basis of periodic Capitation Payments paid to Contractor by DHCS for each Member. Subject to Exhibit B, Section 1.1.15 (*Medical Loss Ratio Remittance*), any funds not expended by Contractor after having fulfilled all obligations under this Contract may be retained by Contractor.

1.1.3 Capitation Payment ~~Rates~~

A. DHCS must remit to Contractor a Capitation Payment no later than 45 calendar days after the first day of each month for each Member that appears on the approved list of Members supplied to Contractor by DHCS. Capitation Payments must be made in accordance with the schedule of Capitation Payment rates set forth **in Exhibit L, Article 2.0 (*Capitation Payment Rates*)**~~below~~. For the list of aid codes included in each Rate Group **identified in Exhibit L, Article 2.0 (*Capitation Payment***

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***Rates*)**~~below~~, please see the definition of Potential Member set forth in Exhibit **L,**~~A, Attachment I~~, **Article**~~Section~~ 1.0 (*Definitions*)~~ of this Contract~~. Supplemental and Additional Payments listed **in Exhibit L, Article 2.0 (*Capitation Payment Rates*)**~~below~~ will be made in accordance to the requirements stated in Subsections 1.1.7 (*Supplemental Payments*) and 1.1.8 (*Additional Payments*) of this Exhibit.

~~**For the period January 1, 2024 – December 31, 2024**~~	~~**Orange**~~
~~**Aid Group**~~	~~**Rates**~~
~~Adult/Family/OTLIC Under 21 - SIS~~	~~$199.26~~
~~Adult/Family/OTLIC Under 21 - UIS~~	~~$109.70~~
~~Adult/Family/OTLIC 21 & Over - SIS~~	~~$401.77~~
~~Adult/Family/OTLIC 21 & Over - UIS~~	~~$309.70~~
~~SPD - SIS~~	~~$1,241.72~~
~~SPD - UIS~~	~~$735.64~~
~~BCCTP - SIS~~	~~$1,241.72~~
~~BCCTP - UIS~~	~~$735.64~~
~~SPD Dual - SIS~~	~~$584.50~~
~~SPD Dual - UIS~~	~~$161.81~~
~~LTC - SIS~~	~~$1,241.72~~
~~LTC - UIS~~	~~$735.64~~
~~LTC Dual - SIS~~	~~$584.50~~
~~LTC Dual - UIS~~	~~$161.81~~
~~Adult Expansion - SIS~~	~~$449.68~~
~~Adult Expansion - UIS~~	~~$378.90~~
~~WCM - SIS~~	~~$2,252.84~~
~~WCM - UIS~~	~~$612.50~~

~~**For the period January 1, 2024 – December 31, 2024**~~	~~**Orange**~~
~~**Supplemental and Additional Payment Groups**~~	~~**Rates**~~
~~Maternity - SIS~~	~~$8,811.73~~
~~Maternity - UIS~~	~~$8,811.73~~
~~Adult Expansion Maternity - SIS~~	~~$8,811.73~~
~~Adult Expansion Maternity - UIS~~	~~$8,811.73~~

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~~For the period January 1, 2025 – December 31, 2025~~	~~Orange~~
~~Aid Group~~	~~Rates~~
~~Adult/Family/OTLIC Under 21 - SIS~~	~~$246.69~~
~~Adult/Family/OTLIC Under 21 - UIS~~	~~$111.90~~
~~Adult/Family/OTLIC 21 & Over - SIS~~	~~$456.13~~
~~Adult/Family/OTLIC 21 & Over - UIS~~	~~$250.92~~
~~SPD - SIS~~	~~$1,386.57~~
~~SPD - UIS~~	~~$494.05~~
~~BCCTP - SIS~~	~~$1,386.57~~
~~BCCTP - UIS~~	~~$494.05~~
~~SPD Dual - SIS~~	~~$679.21~~
~~SPD Dual - UIS~~	~~$210.22~~
~~LTC - SIS~~	~~$1,386.57~~
~~LTC - UIS~~	~~$494.05~~
~~LTC Dual - SIS~~	~~$679.21~~
~~LTC Dual - UIS~~	~~$210.22~~
~~Adult Expansion - SIS~~	~~$447.71~~
~~Adult Expansion - UIS~~	~~$306.12~~
~~WCM - SIS~~	~~$2,170.52~~
~~WCM - UIS~~	~~$544.79~~

~~For the period January 1, 2025 – December 31, 2025~~	~~Orange~~
~~Supplemental and Additional Payment Groups~~	~~Rates~~
~~Maternity - SIS~~	~~$6,869.95~~
~~Maternity - UIS~~	~~$6,869.95~~
~~Adult Expansion Maternity - SIS~~	~~$6,869.95~~
~~Adult Expansion Maternity - UIS~~	~~$6,869.95~~

B. If DHCS creates a new aid code that is split or derived from an existing aid code covered under this Contract, and the aid code has a neutral Contract Revenue effect for Contractor, then the split aid code will automatically be included in the same Rate Group as the original aid code covered under this Contract. Contractor agrees to accept the Capitation Payment rate specified for the original aid code as payment in full for Members in the new aid code. DHCS must confirm all aid code splits and the rates of payment for such new aid codes in writing to Contractor as soon as practicable after such aid code splits occur.

C. In accordance with 42 Code of Federal Regulations (CFR), part 438, section 438.7, the actuarial basis for the computation of Capitation Payment rates must be set forth in DHCS' rate certification(s) for the applicable Rating Period. Subject to approval by Centers for Medicare & Medicaid Services (CMS), said rate certification(s) are hereby

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incorporated by reference and made a part of this Contract by this reference as if attached hereto in full.

1.1.4 Capitation Payment Rates Constitute Payment in Full

Except as otherwise specified in this Contract, Capitation Payment rates for each Rating Period, as calculated by DHCS and approved by CMS, are prospective rates and constitute payment in full on behalf of a Member for all Covered Services required by such Member and for all Administrative Costs incurred by Contractor in providing or arranging for such services under the terms of this Contract. Except as otherwise specified in this Contract, DHCS is not responsible for making payments associated with Contractor's losses.

1.1.5 Determination and Redetermination of Capitation Payment Rates

A. In accordance with Welfare and Institutions Code (W&I) section 14301.1, DHCS must establish Capitation Payment rates on an actuarial basis for each Rating Period, and reserves the right to redetermine and to amend such rates as necessary and appropriate.

1) DHCS must establish Capitation Payment rates in accordance with W&I section 14301.1, applicable federal and State laws and regulations, and generally accepted actuarial principles and practices.

2) DHCS reserves the right, subject to actuarial judgment and generally accepted actuarial principles and practices, to consider Contractor's performance on specified quality and equity benchmarks, as determined by DHCS and communicated to Contractors in advance of each applicable Rating Period, within the determination of Capitation Payment rates for that Rating Period.

3) If Contractor delegates financial risk for the provision of Covered Services in accordance with Exhibit A, Attachment III, Subsection 3.1.6 (*Financial Viability of Subcontractors, Downstream Subcontractors, and Network Providers*), DHCS reserves the right, subject to actuarial judgment and generally accepted actuarial principles and practices, to consider the actual payments received by Providers for providing Covered Services to Members to inform the determination of Capitation Payment rates

B. Capitation Payment rates must be effectuated through an amendment or change order to this Contract in accordance with Exhibit E, Subsection

1.1.6 (*Amendment and Change Order Process*) of this Contract, subject to the following provisions:

~~1) The amendment or change order is effective as of January 1 of each year covered by this Contract;~~

~~2) In the event there is any delay in a determination or redetermination of Capitation Payment rates so that an amendment or change order may not be processed in sufficient time to permit payment of new rates commencing January 1, payment to Contractor must continue at the rates stated in an R Letter sent to Contractor by DHCS. The R Letter serves as notification from DHCS to Contractor of the Capitation Payment rates and the time period for which these rates will be applied. The R Letter must not be considered exempt from any requirement of this Contract. Those continued payments constitute interim payment only. Upon CMS final approval of the amendment/change order and rate certification providing for the rate change, DHCS must make retroactive adjustments for those months for which interim payment was made;~~

1~~3~~) By accepting payment of new Capitation Payment rates prior to approval by CMS of the amendment/change order to this Contract implementing such new rates, Contractor stipulates to a confession of judgment for any and all amounts received in excess of the final approved rate. In the event that the final approved rate differs from the rates established by DHCS or agreed upon by Contractor and DHCS:

a) Any underpayment by DHCS must be paid to Contractor after final approval of the new rates. DHCS will provide Contractor a timeframe for payment of any underpayments;

b) Unless otherwise required by CMS, any overpayment to Contractor must be offset by DHCS' withholding from Contractor's future Contract Revenues of any amount due. DHCS may, at its sole discretion, withhold up to 100 percent of Contract Revenues for each month until any overpayment is fully recovered by the State; and

c) Contractor must review all Contract Revenues and notify DHCS of any payment errors in a form and manner specified by DHCS. If the error favors DHCS, DHCS may offset against future Contract Revenues as stated in paragraph (b) above. If the error favors Contractor, Contractor must notify

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DHCS within 365 calendar days of payment, otherwise Contractor forfeits the right to receive the corrected payment, except when Contractor demonstrates to DHCS' satisfaction, in a form and manner specified by DHCS, that Contractor could not reasonably have identified the error.

2~~4~~) If mutual agreement between DHCS and Contractor cannot be attained on Capitation Payment rates in accordance with this Paragraph B, Contractor has the right to terminate this Contract. Contractor's notification of the intent to terminate this Contract must be in writing and provided to DHCS at least nine months prior to the effective date of termination, subject to any earlier termination date negotiated in accordance with the terms set forth in Exhibit E, Subsection 1.1.16 (*Termination*) of this Contract. DHCS must pay Capitation Payment rates determined for the applicable Rating Periods until the Contract is terminated; and

3~~5~~) DHCS must make reasonable efforts to notify and consult with Contractor regarding any proposed redetermination of Capitation Payment rates in accordance with this provision or Exhibit B, Subsection 1.1.6 (*Redetermination of Capitation Payment Rates Due to Obligation Changes*) below prior to implementation of any new rates.

1.1.6 Redetermination of Capitation Payment Rates Due to Obligation Changes

Final Capitation Payment rates may be adjusted during or subsequent to the applicable Rating Period to provide for changes in obligations that result in a material projected increase or decrease of cost as determined by the certifying actuaries, in accordance with W&I section 14301.1, to Contractor. Any adjustments must be effectuated through an amendment or change order to the Contract subject to the following:

A. The amendment or change order is effective as of the first day of the month in which the change in obligations is effective, as determined by DHCS;

B. In accordance with Subsection 1.1.5 *(Determination and Redetermination of Capitation Payment Rates*) of this Exhibit B, in the event DHCS is unable to process the amendment or change order in sufficient time to permit payment of the adjusted rates as of the month in which the change in obligations is effective, payment to Contractor must continue at the rates then in effect. Upon final approval of the amendment or change

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order, DHCS must make adjustments for those months in which interim payments were made; and

C. DHCS and Contractor may negotiate an earlier termination date, pursuant to Exhibit E, Subsection 1.1.16 (*Termination)* of this Contract, in the event a change in contractual obligations is created by a State or federal change in the Medi-Cal program, or by a lawsuit that substantially alters the financial assumptions and conditions under which Contractor entered into this Contract, such that Contractor can demonstrate to the satisfaction of DHCS that it cannot remain financially solvent through the termination date provided by this Contract.

1.1.7 Supplemental Payments

A. Contractor is entitled to Supplemental Payments stated within this Section in accordance with the schedule of Supplemental Payment rates set forth **in Exhibit L, Article 2.0 (*Capitation Payment Rates*)**~~in this Exhibit B, Subsection 1.1.3 (*Capitation Payment Rates*~~ Contractor must maintain evidence of payment for qualified services entitling Contractor to Supplemental Payments. Upon audit, Contractor's failure to have supporting records may result in recoupment by DHCS of Supplemental Payments paid to Contractor.

1) On a monthly basis, by no later than 20 calendar days following the end of each month, and in a format specified by DHCS, Contractor must submit a report for Supplemental Payments. This report must identify the Members receiving services qualifying for a Supplemental Payment and for whom Contractor is claiming payment.

2) To be eligible to receive a Supplemental Payment, Contractor must properly submit all required data to DHCS within 12 months of the month of the service entitling Contractor to a Supplemental Payment.

B. **Maternity Supplemental Payments**

1) Contractor is entitled to receive maternity Supplemental Payments for Members enrolled with Contractor on the date of the delivery of a Child, including retroactive Enrollments.

2) The maternity Supplemental Payment reimburses Contractor for the projected cost of delivery as determined by DHCS.

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1.1.8 Additional Payments

A. Contractor is entitled to additional payments stated within this Section in accordance with the schedule of additional payment rates set forth below. Contractor must maintain evidence of payment for qualified services entitling Contractor to additional payments. Upon audit, Contractor's failure to have supporting records may result in recoupment by DHCS of additional payments paid to Contractor.

1) On a monthly basis, by no later than 20 calendar days following the end of each month and in a format specified by DHCS, Contractor must submit a report for additional payments. This report must identify the Members receiving services qualifying for any additional payment and for whom Contractor is claiming payment.

2) To be eligible to receive an additional payment, Contractor must properly submit all required data to DHCS within 12 months of the month of the service entitling Contractor to an additional payment.

B. Contractor is entitled to receive an IHCP payment for Members qualified to receive services in accordance with Exhibit A, Attachment III, Subsection 3.3.7.C (*Indian Health Care Providers*) of this Contract.

1) DHCS will annually publish the IHCP payment rates via an All Plan Letter (APL).

2) The IHCP payment reimburses Contractor for the amount paid to the IHCPs as required in Exhibit A, Attachment III, Subsection 3.3.7 *(Federally Qualified Health Center, Rural Health Center, and Indian Health Care Provider)* of this Contract. Payments must be based on Member utilization of qualifying services at IHCPs as reported by Contractor.

1.1.9 Recovery of Amounts Paid to Contractor

DHCS has the right to recover from Contractor amounts paid to Contractor in the following circumstances:

A. If DHCS determines that a Member has been improperly enrolled due to ineligibility of the Member to enroll in Contractor's Medi-Cal managed care health plan, a Member's residence is outside of Contractor's Service Area, or, pursuant to 22 California Code of Regulations (CCR) section 53891(a)(2), or a Member should have been disenrolled with an effective date in a prior month, DHCS may recover amounts paid to Contractor

associated with the Member for the month(s) in question. To the extent permitted by law, Contractor may seek to recover any payments made to Providers for Covered Services rendered for the month(s) in question. Contractor must inform Providers that claims for services provided to Members during the month(s) in question may be paid by the DHCS fiscal intermediary if the Member is determined eligible for the Medi-Cal program;

B. Upon request by Contractor, DHCS may allow Contractor to retain amounts paid to Contractor associated with a Member who is eligible to enroll in Contractor's Medi-Cal managed care health plan, but should have been retroactively disenrolled in accordance with Exhibit A, Attachment III, Subsection 4.2.2 (*Disenrollment*) of this Contract or under other circumstances as approved by DHCS. If Contractor retains Capitation Payments, Supplemental Payments, and any other additional payments, Contractor must provide or arrange and pay for all Medically Necessary Covered Services for the Member until such Member is disenrolled on a non-retroactive basis pursuant to the terms set forth in Exhibit A, Attachment III, Subsection 4.2.2 (*Disenrollment*) of this Contract;

C. As a result of Contractor's failure to perform contractual responsibilities to comply with mandatory federal Medicaid requirements, the United States Department of Health and Human Services (U.S. DHHS) may disallow Federal Financial Participation (FFP) for payments made by DHCS to Contractor. In this event, DHCS may recover the amounts disallowed by U.S. DHHS **and any state share associated with the claim** by **working directly with Contractor to recover the amount by either** imposing an offset to Contract Revenues **or requiring a check from Contractor**. If recovery of the full amount at one time imposes a financial hardship on Contractor, Contractor may request to repay the recoverable amounts in monthly installments over a period of consecutive months not to exceed six months. DHCS, at its sole discretion, may grant or deny such a request; and

D. If DHCS determines that any other erroneous or improper payment(s) not mentioned above has been made to Contractor, DHCS may recover all such determined amounts by the imposition of an offset to Contract Revenues. At least 30 calendar days prior to seeking any such recovery, DHCS must notify Contractor of the improper or erroneous nature of the payment, and must describe the recovery process. If recovery of the full amount at one time imposes a financial hardship on Contractor, Contractor may request to repay the recoverable amounts in monthly installments over a period of consecutive months not to exceed six months. DHCS, at its sole discretion, may grant or deny such a request.

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E. **Pursuant to Exhibit A, Attachment III, Subsection 1.3.6 *(Treatment of Overpayment Recoveries)*, if DHCS, CMS, DMFEA, federal or state departments of justice, or federal or state Inspectors General, or their agent or designee, identifies, whether through audit, investigation, or otherwise, that Contractor has made an overpayment (whether erroneous, improper, or otherwise) to any Subcontractors, Downstream Subcontractors, Network Providers, and/or Providers of Medi-Cal services, medical supplies, or drugs that Contractor has not previously identified to DHCS, DHCS will work directly with Contractor to either recover the entire amount of such overpayment by imposing an offset to Contract Revenues or require a check from Contractor. If Contractor identifies an overpayment in an amount greater than $25 million, then Contractor is entitled to retain all amounts of such overpayment up to $25 million and DHCS is entitled to retain all amounts at and above $25 million.**

1.1.10 Reinsurance

In accordance with 22 CCR section 53252, Contractor may obtain reinsurance (i.e., stop loss coverage) to ensure maintenance of adequate capital by Contractor for the cost of providing Covered Services under this Contract, subject to the following conditions:

A. Reinsurance must not reduce Contractor's liability below $5,000 per Member for any one 12-month period.

B. Reinsurance may cover both of the following:

1) The total cost of services provided to Members under emergency circumstances by non-contracted Providers, including the cost of

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inpatient care in a non-contracted facility until such time as the Member may be safely transported to a Network facility; and

2) Up to 90 percent of all expenditures related to this Contract exceeding 115 percent of Contract Revenues and third-party recoveries during any Fiscal Year of Contractor.

C. At its sole discretion and determination, and following consultation with Contractor, DHCS may require Contractor to retain appropriate reinsurance coverage for high-cost Members or services.

1.1.11 Catastrophic Coverage Limitation

DHCS may limit Contractor's liability to provide or arrange and pay for health care services for illness of, or injury to Members, resulting from or greatly aggravated by a catastrophic occurrence or disaster which occurs subsequent to Enrollment. Following the Director's invocation of this catastrophic coverage limitation, Contractor will return a prorated amount of the total Capitation Payment received by Contractor for the month. The amount returned will be determined by dividing the total Capitation Payment made to Contractor for such month by the number of days in that month, whereupon Contractor will return the amount to DHCS for each day in of the month after the Director's invocation of this catastrophic coverage limitation.

1.1.12 Financial Performance Guarantee

A. In accordance with 22 CCR section 53865, Contractor must annually provide satisfactory evidence of, and maintain, a Financial Performance Guarantee in the form specified by DHCS and in an amount of at least one million dollars ($1,000,000) or equal to at least one month's Contract Revenues for each of Contractor's Service Areas, based on Contractor's average monthly Contract Revenues calculated for the previous twelve months of Contractor's operation, except that if Contractor has been operating for less that 12 months average monthly Contract Revenues will be calculated for as many months as Contractor has been operating, whichever is higher, and subject to approval by DHCS. In its discretion, DHCS may increase the required amount of the Financial Performance Guarantee for Contractor up to an amount of two million dollars ($2,000,000) or equal to two months' Contract Revenues for each of Contractor's Service Areas, based on Contractor's average monthly Contract Revenues for the previous twelve months, except that if Contractor has been operating for less that 12 months average monthly Contract Revenues will be calculated for as many months as Contractor

has been operating, whichever is higher, for any material breach of this Contract.

B. At Contractor's request, and with DHCS approval, Contractor may establish a phase-in schedule to accumulate the required Financial Performance Guarantee. Contractor may elect to satisfy the Financial Performance Guarantee requirement by receiving payment on a post payment basis, subject to DHCS approval.

C. DHCS must take possession of the Financial Performance Guarantee in an amount sufficient to indemnify DHCS in the event that Contractor materially breaches or defaults on one or more terms in this Contract. Unless DHCS has a financial claim or offset against Contractor in which case DHCS may immediately enforce its rights under the Financial Performance Guarantee, the Financial Performance Guarantee must remain in effect through the completion of the Phaseout Period in accordance with Exhibit E, Subsection 1.1.17 (*Phaseout Requirements*).

1.1.13 Medicare Coordination

In accordance with 42 CFR section 438.3(t), Contractor must enter into a Coordination of Benefits Agreement with the Medicare program through CMS, and must agree to participate in Medicare's automated claims crossover process for full benefit dual eligible Members.

1.1.14 Special Contract Provisions Related to Payment

A. Contractor must reimburse Network Providers pursuant to the terms of each of the following applicable Pass-Through Payments established pursuant to 42 CFR section 438.6(d), in accordance with the CMS-approved rate certification, and in a form and manner specified by DHCS through APLs or other technical guidance:

1) Private Hospital and District and Municipal Public Hospital (DMPH) Pass-Through Payments, which requires Contractor to make increased payments to private hospitals and DMPHs in accordance with DHCS guidance.

2) Martin Luther King Jr. (MLK) Community Hospital Pass-Through Payment, which requires Contractor to make increased payments

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to MLK Community Hospital in Los Angeles County in accordance with W&I section 14165.50 and DHCS guidance.

3) Benioff Children's Hospital Oakland (BCHO) Pass-Through Payment, which requires Contractor to make increased payments to BCHO in Alameda County in accordance with DHCS guidance.

4) Distinct Part Nursing Facilities Pass-Through Payment, which requires Contractor to make increased payments to select publicly owned hospitals in accordance with DHCS guidance.

B. Contractor must reimburse Providers pursuant to the terms of each applicable Directed Payment Initiative in a form and manner specified by DHCS through APLs or other technical guidance. For applicable Rating Periods, DHCS will make the terms of each Directed Payment Initiative, including the Directed Payment Initiative preprint as applicable, available on the DHCS website at https://www.dhcs.ca.gov. Directed Payment Initiatives are subject to change and currently include:

1) Designated Public Hospital (DPH) Enhanced Payment Program (EPP), which requires Contractor to make uniform dollar or percentage increase payments to DPH systems for every qualifying service or assigned Member months in accordance with DHCS guidance, including but not limited to APL 21-018, the Directed Payment Initiative preprint, and W&I section 14197.4(b).

2) Private Hospital Directed Payments Program (PHDP), which requires Contractor to make uniform dollar increase payments to eligible private hospitals for every qualifying service in accordance with DHCS guidance, including but not limited to APL 21-018 and the Directed Payment Initiative preprint.

3) District Hospital Directed Payments Program (DHDP), which requires Contractor to make uniform dollar increase payments to eligible DMPHs for every qualifying service in accordance with DHCS guidance, including but not limited to APL 21-018 and the Directed Payment Initiative preprint.

4) DPH Quality Incentive Pool (QIP), which requires Contractor to make performance-based quality incentive payments to DPH systems based on DHCS' evaluation of DPH systems' performance on specified quality measures in accordance with DHCS guidance,

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including but not limited to APL 21-018, the Directed Payment Initiative preprint, and W&I section 14197.4(c).

5) DMPH QIP, which requires Contractor to make performance-based quality incentive payments to DMPH systems based on DHCS' evaluation of DMPH systems' performance on specified quality measures in accordance with DHCS guidance, including but not limited to APL 21-018, the Directed Payment Initiative preprint, and W&I section 14197.4(c).

6) Directed Payments for Developmental Screening Services, which requires Contractor to make uniform dollar increase payments to eligible Network Providers for every adjudicated claim for specified developmental screening services in accordance with DHCS guidance, including but not limited to APL 23-016, the Directed Payment Initiative preprint, and W&I section 14105.197(a)(3).

7) Directed Payments for Adverse Childhood Experiences (ACEs), which requires Contractor to pay eligible Network Providers at no less than the California Medicaid State Plan approved rates for every adjudicated claim for specified ACEs screening services in accordance with DHCS guidance, including but not limited to APL 23-017~~,~~ and W&I section 14105.197(a)(4).

8) Proposition 56 Directed Payments for Family Planning Services, which requires Contractor to make uniform dollar increase payments to eligible Providers for every adjudicated claim for specified family planning services in accordance with DHCS guidance, including but not limited to APL 23-008 and the Directed Payment Initiative preprint.

9) Organ and Bone Marrow Transplants, which requires Contractor to pay eligible contracted and non-contracted Providers amounts equivalent to the California Medicaid State Plan approved rates, or amounts equivalent to the rates published by DHCS for University of California system facilities furnishing subject services, for specified organ and bone marrow transplant services using the methodology developed and published by DHCS on an annual basis in accordance with DHCS guidance, including but not limited to APL 21-015, the Directed Payment Initiative preprint, and W&I section 14184.201(d).

10) LTC FFS-Equivalent Base Directed Payment, which requires Contractors to pay Network Providers, in specified counties where

services were traditionally covered in the FFS delivery system, at exactly the California Medicaid State Plan approved case or service rates for Skilled Nursing Facility (SNF) services and Intermediate Care Facility for the Developmentally Disabled (ICF/DD), ICF/DD-Habilitative (ICF/DD-H), and ICF/DD-Nursing (ICF/DD-N) services and Subacute (adult and pediatric) services. In all other counties, it requires Contractor to pay Network Providers at no less than the California Medicaid State Plan approved rates for SNF services and ICF/DD, ICF/DD-H, and ICF/DD-N services and Subacute (adult and pediatric) services at minimum. All payments must be made in accordance with DHCS guidance, including but not limited to APL 23-004, the Directed Payment Initiative preprint, and W&I section 14184.201(b) – (c).

11) Workforce Quality Incentive Program (WQIP), which requires Contractor to make uniform dollar increase payments to eligible Network Providers for every qualifying service adjusted based on DHCS' evaluation of their performance on specified quality and workforce measures in accordance with DHCS through APLs or other guidance, the Directed Payment Initiative preprint, and W&I section 14126.024.

12) In accordance with W&I section 5961.4(c), and for applicable dates of service, Contractor must reimburse Providers of Medically Necessary outpatient mental health or SUD treatment provided at a School Site to a Member who is a student 25 years of age or younger at least at the fee schedule rate or rates developed by the Department in accordance with W&I section 5961.4(a), as defined by DHCS in the California Medicaid State Plan, a Directed Payment Initiative, and other applicable guidance, but only to the extent Contractor is financially responsible for those School Site services under this Contract.

13) Equity and Practice Transformation Provider Directed Payment Program, which requires Contractor to pay performance-based quality incentive payments to Primary Care practices that provide pediatric, family medicine, internal medicine, or obstetrics and gynecology (OB/GYN) services Members based on DHCS' evaluation of Provider performance on specified quality measures in accordance with the Directed Payment Initiative preprint and in a form and manner specified by DHCS through APLs or other

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guidance.

14) Targeted Rate Increases require Contractor to pay eligible Network Providers at no less than the California Medicaid State Plan approved rates for specified primary care services, including those provided by physician and non-physician professionals, obstetric services, including Doula services, and **N**~~n~~on-**S**~~s~~pecialty **M**~~m~~ental **H**~~h~~ealth **S**~~s~~ervices, in accordance with W&I Section 14105.201, and in a form and manner specified by DHCS through APL 24-007 or other guidance.

15) Children's Hospital Supplemental Payment (CHSP), which requires Contractor to make uniform dollar increase payments to Children's Hospitals, as defined in W&I section 10727, for each qualifying service in accordance with DHCS guidance, including but not limited to APL 21-018 and the Directed Payment Initiative preprint.

16) Federally Qualified Health Center (FQHC) Alternative Payment Methodology (APM), which requires Contractor to make capitated payments to participating FQHCs for each Member assigned to that FQHC, in accordance with W&I, Article 4.1 (commencing with Section 14138.1) of Chapter 7 of Part 3 of Division 9, and Attachment 4.19-B, pages 6AA7-6AA17, of the California Medicaid State Plan, and direction provided by DHCS through APLs or other guidance.

C. Contractor must comply with the terms of any Risk Sharing Mechanisms instituted in accordance with 42 CFR section 438.6(b)(1), in a form and manner specified by DHCS through APLs or other technical guidance.

D. Contractor must comply with the terms of any applicable Incentive Arrangements approved by CMS under 42 CFR section 438.6(b)(2), in a form and manner specified by DHCS through APLs or other technical guidance. For applicable Rating Periods, DHCS will make the terms of each approved Incentive Arrangement available on the DHCS website. Incentive Arrangement payments must not exceed 105 percent of the approved Capitation Payments attributable to the Enrollees or services covered by the Incentive Arrangement, as specified in 42 CFR section 438.6(b)(2) and as calculated by DHCS. DHCS may impose a cap on incentive payments and/or participation in applicable Incentive Arrangements if DHCS determines that the incentive payment(s) are likely to exceed 105 percent of the approved Capitation Payments. Contractor will be required to remit to DHCS any incentive payment amounts in excess of 105 percent of approved Capitation Payments. Incentive

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Arrangements are subject to change in accordance with the requirements of 42 CFR section 438.6(b)(2). Current Incentive Arrangements include:

~~1) California Advancing and Innovating Medi-Cal (CalAIM) Incentive Payment Program, through which Contractor may earn incentive payments for achievement of specified CalAIM Incentive Payment Program milestones and metrics associated with implementation of CalAIM initiatives as determined by DHCS and in accordance with DHCS guidance, including but not limited to the CalAIM Incentive Payment Program terms specified on the DHCS website, APL 23-003, and W&I section 14184.207.~~

~~2) Student Behavioral Health Incentive Program (SBHIP), through which Contractor may earn incentive payments for achievement of specified milestones and metrics associated with targeted interventions that increase access to preventive, early intervention, and Behavioral Health Services by school-affiliated Behavioral Health Providers as determined by DHCS and in accordance with the terms on the DHCS website, W&I section 5961.3, and APL 23-035.~~

1~~3~~) The Quality Withhold and Incentive Program, which consists of a Withhold Arrangement as described in Paragraph E below, and an Incentive Arrangement through which Contractor may earn incentive payments for achievement of certain targets associated with quality scoring from Healthcare Effectiveness Data and Information Set (HEDIS®) and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) related data, as determined by DHCS and in accordance with the terms on the DHCS website, W&I section 14301.1(e) and (o)(4), and in a form and manner specified through APLs or other guidance.

E. Contractor must comply with the terms of any applicable Withhold Arrangement approved by CMS under 42 CFR section 438.6(b)(3), in a form and manner specified by DHCS through APLs or other guidance. For applicable Rating Periods, DHCS will make the terms of each approved Withhold Arrangement available on the DHCS website.

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1) The Withhold Arrangement must ensure that the Capitation Payment, minus any portion of the withhold that is not reasonably achievable, is actuarially sound as determined by an actuary. The total amount of the withhold, achievable or not, will take into consideration the financial operating needs accounting for the size and characteristics of the populations covered under this Contract, as well as Contractor's capital reserves as measured by the risk-based capital level, months of claims reserve, or other appropriate measure of reserves.

2) Current Withhold Arrangements include the Quality Withhold and Incentive Program, which consists of an Incentive Arrangement as described in this Paragraph E, and a Withhold Arrangement through which Contractor may earn back the entire Capitation Payment withheld, or portion thereof, for achievement of certain targets associated with quality scoring from HEDIS® and CAHPS® related data, as determined by DHCS and in accordance with DHCS guidance, including but not limited to the terms on the DHCS website, W&I section 14301.1(e) and (o)(4), and in a form and manner specified in APLs or other guidance.

1.1.15 Medical Loss Ratio Remittance

In accordance with W&I section 14197.2(c)(1), Contractor must provide a remittance to DHCS for a Medical Loss Ratio (MLR) reporting year if the MLR reported in accordance with Exhibit A, Attachment III, Subsection 1.2.5 (*Medical Loss Ratio*) for that MLR reporting year does not meet the minimum MLR standard of 85 percent. DHCS must validate Contractor's reported remittance amount pursuant to Exhibit A, Attachment III, Subsection 1.2.5 (*Medical Loss Ratio*) and determine the final remittance amount owed by Contractor for each MLR reporting year and rating region. Starting January 1, 2025, Contractor must impose equivalent remittance requirements on its Fully Delegated Subcontractors, Partially Delegated Subcontractors, Downstream Fully Delegated Subcontractors, and Downstream Partially Delegated Subcontractors.

1.1.16 State Program Receiving Federal Financial Participation

Should any part of the scope of work under this contract relate to a State program receiving Federal Financial Participation (FFP) that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), Contractor must cease its work on the part no longer authorized by law

after the effective date of the loss of such program authority. DHCS must adjust Capitation Payments to remove costs that are specific to any State program or activity receiving FFP that is no longer authorized by law to receive FFP. If Contractor works on a State program or activity receiving FFP that is no longer authorized by law after the date the legal authority for the work ends, Contractor will not be paid for that work. If DHCS has paid Contractor in advance to work on a no-longer-authorized State program or activity receiving FFP and under the terms of this contract the work was to be performed after the date the legal authority ended, the payment for that work should be returned to DHCS. However, if Contractor worked on a State program or activity receiving FFP prior to the date legal authority ended for that State program or activity receiving FFP, and DHCS included the cost of performing that work in its payments to Contractor, Contractor may keep the payment for that work even if the payment was made after the date the State program or activity receiving FFP lost legal authority.

1.1.17 Community Reinvestment

A. Contractor must demonstrate a commitment to the local communities in which it operates through community reinvestment activities including contributing a set percentage of its annual net income under this Contract to community reinvestment, in accordance with the plan developed pursuant to Exhibit A, Attachment III, Subsection 1.2.7 (*Community Reinvestment Plan and Report*). ~~This requirement is effective following Contractor's first year of operation as a Medi-Cal Managed Care Health Plan, as determined by DHCS.~~ The percentage of Contractor's annual net income required to be contributed must be:

1) 5 percent of the portion of Contractor's annual net income that is less than or equal to 7.5 percent of Contract Revenues for the year; and

2) 7.5 percent of the portion of Contractor's annual net income that is greater than 7.5 percent of Contract Revenues for the year.

B. If Contractor has a ~~Fully Delegated Subcontractor or Downstream Fully Delegated~~ Subcontractor **that meets community reinvestment requirements based on criteria established by DHCS through APLs or similar guidance**, Contractor must require ~~all of its Fully Delegated Subcontractors or Downstream Fully Delegated~~ **the applicable** Subcontractor~~s~~ to demonstrate a commitment to the local communities in which it operates through community reinvestment activities including contributing a set percentage of the ~~Fully Delegated Subcontractor's or Downstream Fully Delegated~~ **applicable** Subcontractor's annual net

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income under the ~~Fully Delegated Subcontractor's Subcontractor Agreement or Downstream Subcontractor's Downstream~~ Subcontractor Agreement that is attributable to Members covered under this Contract to community reinvestment, in accordance with the plan developed pursuant to Exhibit A, Attachment III, Subsection 1.2.7 (*Community Reinvestment Plan and Report*). ~~This requirement is effective following Contractor's first year of operation as a Medi-Cal Managed Care Health Plan, as determined by DHCS.~~ The percentage of the ~~Fully Delegated Subcontractor's or Downstream Fully Delegated~~ **applicable** Subcontractor's annual net income required to be contributed must be:

1) 5 percent of the portion of the ~~Fully Delegated Subcontractor's or Downstream Fully Delegated~~ **applicable** Subcontractor's annual net income that is less than or equal to 7.5 percent of the amount the ~~Fully Delegated Subcontractor or Downstream Fully Delegated~~ Subcontractor is paid under its Subcontractor Agreement ~~or Downstream Subcontractor Agreement~~ with Contractor for the year; and

2) 7.5 percent of the portion of the ~~Fully Delegated Subcontractor's or Downstream Fully Delegated~~ **applicable** Subcontractor's annual net income that is greater than 7.5 percent of the amount the ~~Fully Delegated Subcontractor or Downstream Fully Delegated~~ Subcontractor is paid under its Subcontractor Agreement ~~or Downstream Subcontractor Agreement~~ with Contractor for the year.

1.1.18 Quality Achievement Requirement

If Contractor does not meet quality outcome metrics as defined through an APL or similar guidance, it must contribute an additional 7.5 percent of its annual net income under this Contract to community reinvestment in accordance with the plan developed pursuant to Exhibit A, Attachment III, Subsection 1.2.7 (*Community Reinvestment Plan and Report*).

1.1.19 Enhanced Care Management Risk Corridor

A Risk Sharing Mechanism will be in effect for each of the Rating Periods covering dates of services from January 1, 2022, through December 31, 2025.

A. The Risk Sharing Mechanism described in this provision may result in payment by the State to Contractor or by Contractor to the State in a form and manner specified by DHCS through APLs or other technical guidance.

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B. The Risk Sharing Mechanism will be symmetrical and based on the results of an Enhanced Care Management (ECM) risk corridor calculation performed in a form and manner specified by DHCS through APLs or other technical guidance, aggregated across applicable Medi-Cal Managed Care contracts between Contractor and the State for those capitation increments, services, and populations associated with ECM, as determined by DHCS.

C. Contractor must provide and certify allowable medical expense data as necessary for the ECM risk corridor calculation in a form and manner specified by DHCS. The data and any related substantiating documentation may be subject to review and adjustment at DHCS' discretion in a form and manner specified by DHCS through APLs or other technical guidance, and may be subject to audit by the State or its designee.

D. DHCS or its designee will initiate the ECM Risk Corridor calculation for a given Rating Period no sooner than 12 months after the end of the applicable Rating Period.

E. Contractor must comply with the terms of any Risk Sharing Mechanisms instituted in accordance with 42 CFR section 438.6(b)(1), in a form and manner specified by DHCS through APLs or other technical guidance.

1.1.20 Federally Qualified Health Center Alternative Payment Model Risk Corridor

A Risk Sharing Mechanism will be in effect for each of the Rating Periods that the Federally Qualified Health Center (FQHC) Alternative Payment Model (APM) is in effect in accordance with W&I section 14138.16.

A. The Risk Sharing Mechanism described in this Subsection may result in payment by the State to Contractor or by Contractor to the State in a form and manner specified by DHCS through APLs or other technical guidance.

B. The Risk Sharing Mechanism will be symmetrical and based on the results of an FQHC APM risk corridor calculation performed in a form and manner specified by DHCS through APLs or other technical guidance, aggregated across applicable Medi-Cal managed care contracts between Contractor and the State for those capitation increments, services, and populations associated with the FQHC APM, as determined by DHCS.

C. Contractor must provide and certify allowable medical expense data as necessary for the FQHC APM risk corridor calculation in a form and manner specified by DHCS. The data and any related substantiating

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documentation may be subject to review and adjustment at DHCS' discretion in a form and manner specified by DHCS through APLs or other technical guidance, and may be subject to audit by the State or its designee.

D. DHCS or its designee will initiate the FQHC APM Risk Corridor calculation for a given Rating Period no sooner than 12 months after the end of the applicable Rating Period.

E. Contractor must comply with the terms of any Risk Sharing Mechanisms instituted in accordance with 42 CFR section 438.6(b)(1), in a form and manner specified by DHCS through APLs or other technical guidance.

~~**1.1.21 Unsatisfactory Immigration Status Risk Corridor**~~

~~A Risk Sharing Mechanism will be in effect for each of the Rating Periods covering dates of services from January 1, 2024, through December 31, 2024.~~

~~A. The Risk Sharing Mechanism described in this Subsection may result in payment by the State to Contractor or by Contractor to the State in a form and manner specified by DHCS through APLs or other technical guidance.~~

~~B. The Risk Sharing Mechanism will be symmetrical and based on the results of an Unsatisfactory Immigration Status (UIS) risk corridor calculation performed in a form and manner specified by DHCS through APLs or other technical guidance, aggregated across applicable Medi-Cal managed care contracts between Contractor and the State for those capitation increments, services, and populations associated with UIS, as determined by DHCS.~~

~~C. Contractor must provide and certify allowable medical expense data as necessary for the UIS risk corridor calculation in a form and manner specified by DHCS. The data and any related substantiating documentation may be subject to review and adjustment at DHCS' discretion in a form and manner specified by DHCS through APLs or other technical guidance, and may be subject to audit by the State or its designee.~~

~~D. DHCS or its designee will initiate the UIS risk corridor calculation for a given Rating Period no sooner than 12 months after the end of the applicable Rating Period.~~

Exhibit C – General Terms and Conditions

The entire General Terms and Conditions (GTC 04/2017) developed by the California Department of General Services (DGS) ("Exhibit C") is not included in this Contract. Instead, applicable terms and provisions from Exhibit C have been incorporated throughout this Contract.

In the event that DGS amends Exhibit C after the effective date of the Contract, Contractor agrees that DHCS, in its sole discretion, may incorporate future DGS amendments into this Contract through the issuance of an All Plan Letter (APL) or other similar instructions.

Exhibit D(f) – Special Terms and Conditions

This is version (Rev. 10/22)

Exhibit D(f)

Special Terms and Conditions

(For federally funded service contracts or agreements and grant agreements)

The use of headings or titles throughout this exhibit is for convenience only and not be used to interpret or to govern the meaning of any specific term or condition.

The terms "contract", "Contractor" and "Subcontractor" shall also mean, “agreement”, "grant", “grant agreement”, "Grantee" and "Subgrantee" respectively.

The terms “California Department of Health Care Services”, “California Department of Health Services”, ‘Department of Health Care Services”, “Department of Health Services”, “CDHCS”, “DHCS”, “CDHS”, and “DHS” shall all have the same meaning and refer to the California State agency that is a party to this Agreement.

This exhibit contains provisions that require strict adherence to various contracting laws and policies. Some provisions herein are conditional and only apply if specified conditions exist (i.e., agreement total exceeds a certain amount; agreement is federally funded, etc.). The provisions herein apply to this Agreement unless the provisions are removed by reference on the face of this Agreement, the provisions are superseded by an alternate provision appearing elsewhere in this Agreement, or the applicable conditions do not exist.

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1. Federal Equal Opportunity Requirements

(Applicable to all federally funded agreements entered into by the Department of Health Care Services)

a. The Contractor will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. The Contractor will take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Such action include, but not be limited to the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. The Contractor agrees to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the Federal Government or DHCS, setting forth the provisions of the Equal Opportunity clause, Section 503 of the Rehabilitation Act of 1973 and the affirmative action clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212). Such notices state the Contractor's obligation under the law to take affirmative action to employ and advance in employment qualified applicants without discrimination based on their race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era and the rights of applicants and employees.

b. The Contractor will, in all solicitations or advancements for employees placed by or on behalf of the Contractor, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era.

c. The Contractor will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the Federal Government or the State, advising the labor union or workers' representative of the Contractor's commitments under the provisions herein and post copies of the notice in conspicuous places available to employees and applicants for employment.

d. The Contractor will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212) and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, ‘Amending Executive Order 11246 Relating to Equal Employment Opportunity,‘ and as supplemented by regulation at 41 CFR part 60,

"Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and of the rules, regulations, and relevant orders of the Secretary of Labor.

e. The Contractor will furnish all information and reports required by Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and the Rehabilitation Act of 1973, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to its books, records, and accounts by the State and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

f. In the event of the Contractor's noncompliance with the requirements of the provisions herein or with any federal rules, regulations, or orders which are referenced herein, this Agreement may be cancelled, terminated, or suspended in whole or in part and the Contractor may be declared ineligible for further federal and State contracts in accordance with procedures authorized in Federal Executive Order No. 11246 as amended and such other sanctions may be imposed and remedies invoked as provided in Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

g. The Contractor will include the provisions of Paragraphs a through g in every subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor issued pursuant to Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or Section 503 of the Rehabilitation Act of 1973 or (38 U.S.C. 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each subcontractor or vendor. The Contractor will take such action with respect to any subcontract or purchase order as the Director of the Office of Federal Contract Compliance Programs or DHCS may direct as a means of enforcing such provisions including sanctions for noncompliance provided, however, that in the event the Contractor becomes involved in, or is threatened with litigation by a subcontractor or vendor as a result of such direction by DHCS, the Contractor may request in writing to DHCS, who, in turn, may request the United States to enter into such litigation to protect the interests of the State and of the United States.

2. Travel and Per Diem Reimbursement

(Applicable if travel and/or per diem expenses are reimbursed with agreement funds.)

Reimbursement for travel and per diem expenses from DHCS under this Agreement shall, unless otherwise specified in this Agreement, be at the rates currently in effect, as established by the California Department of Human Resources (CalHR), for nonrepresented State employees as stipulated in DHCS' Travel Reimbursement Information Exhibit. If the CalHR rates change during the term of the Agreement, the new rates apply upon their effective date and no amendment to this Agreement shall be necessary. Exceptions to CalHR rates may be approved by DHCS upon the submission of a statement by the Contractor indicating that such rates are not available to the Contractor. No travel outside the State of California shall be reimbursed without prior authorization from DHCS. Verbal authorization should be confirmed in writing. Written authorization may be in a form including fax or email confirmation.

3. Procurement Rules

(Applicable to agreements in which equipment/property, commodities and/or supplies are furnished by DHCS or expenses for said items are reimbursed by DHCS with State or federal funds provided under the Agreement.)

a. Equipment/Property definitions

Wherever the term equipment and/or property is used, the following definitions shall apply:

(1) **Major equipment/property**: A tangible or intangible item having a base unit cost of $5,000 or more with a life expectancy of one (1) year or more and is either furnished by DHCS or the cost is reimbursed through this Agreement. Software and videos are examples of intangible items that meet this definition.

(2) **Minor equipment/property:** A tangible item having a base unit cost of less than $5,000 with a life expectancy of one (1) year or more and is either furnished by DHCS or the cost is reimbursed through this Agreement.

b. Government and public entities (including State colleges/universities and auxiliary organizations), whether acting as a contractor and/or subcontractor, may secure all commodities, supplies, equipment and services related to such purchases that are required in performance of this Agreement. Said procurements are subject to Paragraphs d through h of Provision 3

c. Paragraph c of Provision 3 also apply, if equipment/property purchases are delegated to subcontractors that are nonprofit organizations or commercial businesses.

d. Nonprofit organizations and commercial businesses, whether acting as a contractor and/or subcontractor, may secure commodities, supplies, equipment/property and services related to such purchases for performance under this Agreement.

(1) Equipment/property purchases not exceed $50,000 annually.

To secure equipment/property above the annual maximum limit of $50,000, the Contractor make arrangements through the appropriate DHCS Program Contract Manager, to have all remaining equipment/property purchased through DHCS' Purchasing Unit. The cost of equipment/property purchased by or through DHCS be deducted from the funds available in this Agreement. Contractor submit to the DHCS Program Contract Manager a list of equipment/property specifications for those items that the State must procure. DHCS may pay the vendor directly for such arranged equipment/property purchases and title to the equipment/property will remain with DHCS. The equipment/property will be delivered to the Contractor's address, as stated on the face of the Agreement, unless the Contractor notifies the DHCS Program Contract Manager, in writing, of an alternate delivery address.

(2) All equipment/property purchases are subject to Paragraphs d through h of Provision 3. Paragraph b of Provision 3 also apply, if equipment/property purchases are delegated to Subcontractors that are either a government or public entity.

(3) Nonprofit organizations and commercial businesses use a procurement system that meets the following standards:

(a) Maintain a code or standard of conduct that govern the performance of its officers, employees, or agents engaged in awarding procurement contracts. No employee, officer, or agent shall participate in the selection, award, or administration of a procurement, or bid contract in which, to his or her knowledge, he or she has a financial interest.
(b) Procurements be conducted in a manner that provides, to the maximum extent practical, open, and free competition.

(c) Procurements be conducted in a manner that provides for all of the following:

[1] Avoid purchasing unnecessary or duplicate items.

[2] Equipment/property solicitations be based upon a clear and accurate description of the technical requirements of the goods to be procured.

[3] Take positive steps to utilize small and veteran owned businesses.

e. Unless waived or otherwise stipulated in writing by DHCS, prior written authorization from the appropriate DHCS Program Contract Manager will be required before the Contractor will be reimbursed for any purchase of $5,000 or more for commodities, supplies, equipment/property, and services related to such purchases. The Contractor must provide in its request for authorization all particulars necessary, as specified by DHCS, for evaluating the necessity or desirability of incurring such costs. The term "purchase" excludes the purchase of services from a subcontractor and public utility services at rates established for uniform applicability to the general public.

f. In special circumstances, determined by DHCS (e.g., when DHCS has a need to monitor certain purchases, etc.), DHCS may require prior written authorization and/or the submission of paid vendor receipts for any purchase, regardless of dollar amount. DHCS reserves the right to either deny claims for reimbursement or to request repayment for any Contractor and/or subcontractor purchase that DHCS determines to be unnecessary in carrying out performance under this Agreement.

g. The Contractor and/or subcontractor must maintain a copy or narrative description of the procurement system, guidelines, rules, or regulations that will be used to make purchases under this Agreement. The State reserves the right to request a copy of these documents and to inspect the purchasing practices of the Contractor and/or subcontractor at any time.

h. For all purchases, the Contractor and/or subcontractor must maintain copies of all paid vendor invoices, documents, bids and other information used in vendor selection, for inspection or audit. Justifications supporting the absence of bidding (i.e., sole source purchases) also be maintained on file by the Contractor and/or subcontractor for inspection or audit.

i. DHCS may, with cause (e.g., with reasonable suspicion of unnecessary purchases or use of inappropriate purchase practices, etc.), withhold, cancel, modify, or retract the delegated purchase authority granted under Paragraphs b and/or c of Provision 3 by giving the Contractor no less than 30 calendar days written notice.

4. Equipment/Property Ownership / Inventory / Disposition

(Applicable to agreements in which equipment/property is furnished by DHCS and/or when said items are purchased or reimbursed by DHCS with State or federal funds provided under the Agreement.)

a. Wherever the term equipment and/or property is used in Provision 4, the definitions in Paragraph a of Provision 3 apply.

Unless otherwise stipulated in this Agreement, all equipment and/or property that is purchased/reimbursed with agreement funds or furnished by DHCS under the

terms of this Agreement be considered State equipment and the property of DHCS.

(1) **Reporting of Equipment/Property Receipt**

DHCS requires the reporting, tagging and annual inventorying of all equipment and/or property that is furnished by DHCS or purchased/reimbursed with funds provided through this Agreement.

Upon receipt of equipment and/or property, the Contractor report the receipt to the DHCS Program Contract Manager. To report the receipt of said items and to receive property tags, Contractor use a form or format designated by DHCS' Asset Management Unit. If the appropriate form (i.e., Contractor Equipment Purchased with DHCS Funds) does not accompany this Agreement, Contractor request a copy from the DHCS Program Contract Manager.

(2) **Annual Equipment/Property Inventory**

If the Contractor enters into an agreement with a term of more than twelve months, the Contractor submit an annual inventory of State equipment and/or property to the DHCS Program Contract Manager using a form or format designated by DHCS' Asset Management Unit. If an inventory report form (i.e., Inventory/Disposition of DHCS-Funded Equipment) does not accompany this Agreement, Contractor request a copy from the DHCS Program Contract Manager. Contractor:

(a) Include in the inventory report, equipment and/or property in the Contractor's possession and/or in the possession of a subcontractor (including independent consultants).

(b) Submit the inventory report to DHCS according to the instructions appearing on the inventory form or issued by the DHCS Program Contract Manager.

(c) Contact the DHCS Program Contract Manager to learn how to remove, trade-in, sell, transfer or survey off, from the inventory report, expired equipment and/or property that is no longer wanted, usable or has passed its life expectancy. Instructions will be supplied by either the DHCS Program Contract Manager or DHCS' Asset Management Unit.

b. Title to State equipment and/or property not be affected by its incorporation or attachment to any property not owned by the State.

c. Unless otherwise stipulated, DHCS be under no obligation to pay the cost of restoration, or rehabilitation of the Contractor's and/or Subcontractor's facility which may be affected by the removal of any State equipment and/or property.

d. The Contractor and/or Subcontractor maintain and administer a sound business program for ensuring the proper use, maintenance, repair, protection, insurance and preservation of State equipment and/or property.

(1) In administering this provision, DHCS may require the Contractor and/or Subcontractor to repair or replace, to DHCS' satisfaction, any damaged, lost or stolen State equipment and/or property. In the event of State equipment and/or miscellaneous property theft, Contractor and/or Subcontractor immediately file a theft report with the appropriate police agency or the California Highway Patrol and Contractor promptly submit one copy of the theft report to the DHCS Program Contract Manager.

e. Unless otherwise stipulated by the Program funding this Agreement, equipment and/or property purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, only be used for performance of this Agreement or another DHCS agreement.

Within sixty (60) calendar days prior to the termination or end of this Agreement, the Contractor provide a final inventory report of equipment and/or property to the DHCS Program Contract Manager and, at that time, query DHCS as to the requirements, including the manner and method, of returning State equipment and/or property to DHCS. Final disposition of equipment and/or property be at DHCS expense and according to DHCS instructions. Equipment and/or property disposition instructions be issued by DHCS immediately after receipt of the final inventory report. At the termination or conclusion of this Agreement, DHCS may at its discretion, authorize the continued use of State equipment and/or property for performance of work under a different DHCS agreement.

f. **Motor Vehicles**

(Applicable only if motor vehicles are purchased/reimbursed with agreement funds or furnished by DHCS under this Agreement.)

(1) If motor vehicles are purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, within thirty (30) calendar days prior to the termination or end of this Agreement, the Contractor and/or Subcontractor return such vehicles to DHCS and deliver all necessary documents of title or registration to enable the proper transfer of a marketable title to DHCS.

(2) If motor vehicles are purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, the State of California be the legal owner of said motor vehicles and the Contractor be the registered owner. The Contractor and/or a subcontractor may only use said vehicles for performance and under the terms of this Agreement.

(3) The Contractor and/or Subcontractor agree that all operators of motor vehicles, purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, hold a valid State of California driver's license. In the event that ten or more passengers are to be transported in any one vehicle, the operator also hold a State of California Class B driver's license.

(4) If any motor vehicle is purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, the Contractor and/or Subcontractor, as applicable, provide, maintain, and certify that, at a minimum, the following type and amount of automobile liability insurance is in effect during the term of this Agreement or any extension period during which any vehicle remains in the Contractor's and/or Subcontractor's possession:

Automobile Liability Insurance

(a) The Contractor, by signing this Agreement, hereby certifies that it possesses or will obtain automobile liability insurance in the amount of $1,000,000 per occurrence for bodily injury and property damage combined. Said insurance must be obtained and made effective upon the delivery date of any motor vehicle, purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, to the Contractor and/or Subcontractor.

(b) The Contractor and/or Subcontractor, as soon as practical, furnish a copy of the certificate of insurance to the DHCS Program Contract Manager. The certificate of insurance identify the DHCS contract or agreement number for which the insurance applies.

(c) The Contractor and/or Subcontractor agree that bodily injury and property damage liability insurance, as required herein, remain in effect at all times during the term of this Agreement or until such time as the motor vehicle is returned to DHCS.

(d) The Contractor and/or Subcontractor agree to provide, at least thirty (30) days prior to the expiration date of said insurance coverage, a copy of a new certificate of insurance evidencing continued coverage, as indicated herein, for not less than the remainder of the term of this Agreement, the term of any extension or continuation thereof, or for a period of not less than one (1) year.

(e) The Contractor and/or Subcontractor, if not a self-insured government and/or public entity, must provide evidence, that any required certificates of insurance contain the following provisions:

[1] The insurer will not cancel the insured's coverage without giving thirty (30) calendar days prior written notice to the State (California

Department of Health Care Services).

[2] The State of California, its officers, agents, employees, and servants are included as additional insureds, but only with respect to work performed for the State under this Agreement and any extension or continuation of this Agreement.

[3] The insurance carrier notify the California Department of Health Care Services (DHCS), in writing, of the Contractor's failure to pay premiums; its cancellation of such policies; or any other substantial change, including, but not limited to, the status, coverage, or scope of the required insurance. Such notices contain a reference to each agreement number for which the insurance was obtained.

(f) The Contractor and/or Subcontractor is hereby advised that copies of certificates of insurance may be subject to review and approval by the Department of General Services (DGS), Office of Risk and Insurance Management. The Contractor be notified by DHCS, in writing, if this provision is applicable to this Agreement. If DGS approval of the certificate of insurance is required, the Contractor agrees that no work or services shall be performed prior to obtaining said approval.

(g) In the event the Contractor and/or Subcontractor fails to keep insurance coverage, as required herein, in effect at all times during vehicle possession, DHCS may, in addition to any other remedies it may have, terminate this Agreement upon the occurrence of such event.

5. Subcontract Requirements

(Applicable to agreements under which services are to be performed by subcontractors including independent consultants.)

a. Prior written authorization will be required before the Contractor enters into or is reimbursed for any subcontract for services costing $5,000 or more. Except as indicated in Paragraph a(3) herein, when securing subcontracts for services exceeding $5,000, the Contractor obtain at least three bids or justify a sole source award.

(1) The Contractor must provide in its request for authorization, all information necessary for evaluating the necessity or desirability of incurring such cost.

(2) DHCS may identify the information needed to fulfill this requirement.

(3) Subcontracts performed by the following entities or for the service types listed below are exempt from the bidding and sole source justification requirements:

(a) A local governmental entity or the federal government,

(b) A State college or State university from any State,

(c) A Joint Powers Authority,

(d) An auxiliary organization of a California State University or a California community college,

(e) A foundation organized to support the Board of Governors of the California Community Colleges,

(f) An auxiliary organization of the Student Aid Commission established under Education Code § 69522,

(g) Firms or individuals proposed for use and approved by DHCS' funding Program via acceptance of an application or proposal for funding or pre/post contract award negotiations,

(h) Entities and/or service types identified as exempt from advertising and competitive bidding in State Contracting Manual Chapter 5 Section 5.80 Subsection B.2.

b. DHCS reserves the right to approve or disapprove the selection of subcontractors and with advance written notice, require the substitution of subcontractors and require the Contractor to terminate subcontracts entered into in support of this Agreement.

(1) Upon receipt of a written notice from DHCS requiring the substitution and/or termination of a subcontract, the Contractor take steps to ensure the completion of any work in progress and select a replacement, if applicable, within 30 calendar days, unless a longer period is agreed to by DHCS.

c. Actual subcontracts (i.e., written agreement between the Contractor and a subcontractor) of $5,000 or more are subject to the prior review and written approval of DHCS. DHCS may, at its discretion, elect to waive this right. All such waivers be confirmed in writing by DHCS.

d. Contractor maintain a copy of each subcontract entered into in support of this Agreement and, upon request by DHCS, make copies available for approval, inspection, or audit.

e. DHCS assumes no responsibility for the payment of subcontractors used in the performance of this Agreement. Contractor accepts sole responsibility for the payment of subcontractors used in the performance of this Agreement.

f. The Contractor is responsible for all performance requirements under this Agreement even though performance may be carried out through a subcontract.

g. The Contractor ensure that all subcontracts for services include provision(s)

requiring compliance with applicable terms and conditions specified in this Agreement.

h. The Contractor agrees to include the following clause, relevant to record retention, in all subcontracts for services:

"(Subcontractor Name) agrees to maintain and preserve, until three years after termination of (Agreement Number) and final payment from DHCS to the Contractor, to permit DHCS or any duly authorized representative, to have access to, examine or audit any pertinent books, documents, papers and records related to this subcontract and to allow interviews of any employees who might reasonably have information related to such records."

i. Unless otherwise stipulated in writing by DHCS, the Contractor be the subcontractor's sole point of contact for all matters related to performance and payment under this Agreement.

j. Contractor, as applicable, advise all subcontractors of their obligations pursuant to the following numbered provisions of this Exhibit: 1, 2, 3, 4, 5, 6, 7, 8, 10, 11, 12, 13, 14, 17, 19, 20, 24, 32 and/or other numbered provisions herein that are deemed applicable.

6. Income Restrictions

Unless otherwise stipulated in this Agreement, the Contractor agrees that any refunds, rebates, credits, or other amounts (including any interest thereon) accruing to or received by the Contractor under this Agreement be paid by the Contractor to DHCS, to the extent that they are properly allocable to costs for which the Contractor has been reimbursed by DHCS under this Agreement.

7. Audit and Record Retention

(Applicable to agreements in excess of $10,000.)

a. The Contractor and/or Subcontractor maintain books, records, documents, and other evidence, accounting procedures and practices, sufficient to properly reflect all direct and indirect costs of whatever nature claimed to have been incurred in the performance of this Agreement, including any matching costs and expenses. The foregoing constitutes "records" for the purpose of this provision.

b. The Contractor's and/or subcontractor's facility or office or such part thereof as may be engaged in the performance of this Agreement and his/her records be subject at all reasonable times to inspection, audit, and reproduction.

c. Contractor agrees that DHCS, the Department of General Services, the Bureau of State Audits, or their designated representatives including the Comptroller General of the United States have the right to review and to copy any records

and supporting documentation pertaining to the performance of this Agreement. Contractor agrees to allow the auditor(s) access to such records during normal business hours and to allow interviews of any employees who might reasonably have information related to such records. Further, the Contractor agrees to include a similar right of the State to audit records and interview staff in any subcontract related to performance of this Agreement. (Government Code Section 8546.7, Public Contract Code (PCC) Sections 10115 et seq., Code of California Regulations Title 2, Section 1896.77.) The Contractor comply with the above and be aware of the penalties for violations of fraud and for obstruction of investigation as set forth in PCC Section10115.10.

d. The Contractor and/or Subcontractor preserve and make available his/her records (1) for a period of six years for all records related to Disabled Veteran Business Enterprise (DVBE) participation (Military and Veterans Code 999.55), if this Agreement involves DVBE participation, and three years for all other contract records from the date of final payment under this Agreement, and (2) for such longer period, if any, as is required by applicable statute, by any other provision of this Agreement, or by subparagraphs (1) or (2) below.

   (1) If this Agreement is completely or partially terminated, the records relating to the work terminated be preserved and made available for a period of three years from the date of any resulting final settlement.

   (2) If any litigation, claim, negotiation, audit, or other action involving the records has been started before the expiration of the three-year period, the records be retained until completion of the action and resolution of all issues which arise from it, or until the end of the regular three-year period, whichever is later.

e. The Contractor and/or Subcontractor may, at its discretion, following receipt of final payment under this Agreement, reduce its accounts, books and records related to this Agreement to microfilm, computer disk, CD ROM, DVD, or other data storage medium. Upon request by an authorized representative to inspect, audit or obtain copies of said records, the Contractor and/or Subcontractor must supply or make available applicable devices, hardware, and/or software necessary to view, copy and/or print said records. Applicable devices may include, but are not limited to, microfilm readers and microfilm printers, etc.

f. The Contractor, if applicable, comply with the Single Audit Act and the audit requirements set forth in 2 C.F.R. § 200.501 (2014).

8. Site Inspection

The State, through any authorized representatives, has the right at all reasonable times to inspect or otherwise evaluate the work performed or being performed hereunder including subcontract supported activities and the premises in which it is being performed. If any inspection or evaluation is made of the premises of the Contractor or Subcontractor, the Contractor provide and require Subcontractors to

provide all reasonable facilities and assistance for the safety and convenience of the authorized representatives in the performance of their duties. All inspections and evaluations be performed in such a manner as will not unduly delay the work.

9. Federal Contract Funds

(Applicable only to that portion of an agreement funded in part or whole with federal funds.)

a. It is mutually understood between the parties that this Agreement may have been written before ascertaining the availability of congressional appropriation of funds, for the mutual benefit of both parties, in order to avoid program and fiscal delays which would occur if the Agreement were executed after that determination was made.

b. This agreement is valid and enforceable only if sufficient funds are made available to the State by the United States Government for the fiscal years covered by the term of this Agreement. In addition, this Agreement is subject to any additional restrictions, limitations, or conditions enacted by the Congress or any statute enacted by the Congress which may affect the provisions, terms or funding of this Agreement in any manner.

c. It is mutually agreed that if the Congress does not appropriate sufficient funds for the program, this Agreement be amended to reflect any reduction in funds.

d. DHCS has the option to invalidate or cancel the Agreement with 30-days advance written notice or to amend the Agreement to reflect any reduction in funds.

10. Termination

a. **For Cause**

The State may terminate this Agreement, in whole or in part, and be relieved of any payments should the Contractor fail to perform the requirements of this Agreement at the time and in the manner herein provided. In the event of such termination, the State may proceed with the work in any manner deemed proper by the State. All costs to the State be deducted from any sum due the Contractor under this Agreement and the balance, if any, be paid to the Contractor upon demand. If this Agreement is terminated, in whole or in part, the State may require the Contractor to transfer title, or in the case of licensed software, license, and deliver to the State any completed deliverables, partially completed deliverables, and any other materials, related to the terminated portion of the Contract, including but not limited to, computer programs, data files, user and operations manuals, system and program documentation, training programs related to the operation and maintenance of the system, and all information necessary for the reimbursement of any outstanding Medicaid claims. The State

pay contract price for completed deliverables delivered and accepted and items the State requires the Contractor to transfer as described in this paragraph above.

b. **For Convenience**

The State retains the option to terminate this Agreement, in whole or in part, without cause, at the State's convenience, without penalty, provided that written notice has been delivered to the Contractor at least ninety (90) calendar days prior to such termination date. In the event of termination, in whole or in part, under this paragraph, the State may require the Contractor to transfer title, or in the case of licensed software, license, and deliver to the State any completed deliverables, partially completed deliverables, and any other materials related to the terminated portion of the contract including but not limited to, computer programs, data files, user and operations manuals, system and program documentation, training programs related to the operation and maintenance of the system, and all information necessary for the reimbursement of any outstanding Medicaid claims. The Contractor will be entitled to compensation upon submission of an invoice and proper proof of claim for the services and products satisfactorily rendered, subject to all payment provisions of the Agreement. Payment is limited to expenses necessarily incurred pursuant to this Agreement up to the date of termination.

11. Intellectual Property Rights

a. **Ownership**

(1) Except where DHCS has agreed in a signed writing to accept a license, DHCS be and remain, without additional compensation, the sole owner of any and all rights, title and interest in all Intellectual Property, from the moment of creation, whether or not jointly conceived, that are made, conceived, derived from, or reduced to practice by Contractor or DHCS and which result directly or indirectly from this Agreement.

(2) For the purposes of this Agreement, Intellectual Property means recognized protectable rights and interest such as: patents, (whether or not issued) copyrights, trademarks, service marks, applications for any of the foregoing, inventions, trade secrets, trade dress, logos, insignia, color combinations, slogans, moral rights, right of publicity, author's rights, contract and licensing rights, works, mask works, industrial design rights, rights of priority, know how, design flows, methodologies, devices, business processes, developments, innovations, good will and all other legal rights protecting intangible proprietary information as may exist now and/or here after come into existence, and all renewals and extensions, regardless of whether those rights arise under the laws of the United States, or any other state, country or jurisdiction.

(a) For the purposes of the definition of Intellectual Property, "works" means all literary works, writings and printed matter including the medium by which they are recorded or reproduced, photographs, art work, pictorial and graphic representations and works of a similar nature, film, motion pictures, digital images, animation cells, and other audiovisual works including positives and negatives thereof, sound recordings, tapes, educational materials, interactive videos and any other materials or products created, produced, conceptualized and fixed in a tangible medium of expression. It includes preliminary and final products and any materials and information developed for the purposes of producing those final products. Works does not include articles submitted to peer review or reference journals or independent research projects.

(3) In the performance of this Agreement, Contractor will exercise and utilize certain of its Intellectual Property in existence prior to the effective date of this Agreement. In addition, under this Agreement, Contractor may access and utilize certain of DHCS' Intellectual Property in existence prior to the effective date of this Agreement. Except as otherwise set forth herein, Contractor not use any of DHCS' Intellectual Property now existing or hereafter existing for any purposes without the prior written permission of DHCS. Except as otherwise set forth herein, neither the Contractor nor DHCS give any ownership interest in or rights to its Intellectual Property to the other Party. If during the term of this Agreement, Contractor accesses any third-party Intellectual Property that is licensed to DHCS, Contractor agrees to abide by all license and confidentiality restrictions applicable to DHCS in the third-party's license agreement.

(4) Contractor agrees to cooperate with DHCS in establishing or maintaining DHCS' exclusive rights in the Intellectual Property, and in assuring DHCS' sole rights against third parties with respect to the Intellectual Property. If the Contractor enters into any agreements or subcontracts with other parties in order to perform this Agreement, Contractor require the terms of the Agreement(s) to include all Intellectual Property provisions. Such terms must include, but are not limited to, the subcontractor assigning and agreeing to assign to DHCS all rights, title and interest in Intellectual Property made, conceived, derived from, or reduced to practice by the subcontractor, Contractor or DHCS and which result directly or indirectly from this Agreement or any subcontract.

(5) Contractor further agrees to assist and cooperate with DHCS in all reasonable respects, and execute all documents and, subject to reasonable availability, give testimony and take all further acts reasonably necessary to acquire, transfer, maintain, and enforce DHCS' Intellectual Property rights and interests.

b. **Retained Rights / License Rights**

(1) Except for Intellectual Property made, conceived, derived from, or reduced to practice by Contractor or DHCS and which result directly or indirectly from this Agreement, Contractor retain title to all of its Intellectual Property to the extent such Intellectual Property is in existence prior to the effective date of this Agreement. Contractor hereby grants to DHCS, without additional compensation, a permanent, non-exclusive, royalty free, paid-up, worldwide, irrevocable, perpetual, non-terminable license to use, reproduce, manufacture, sell, offer to sell, import, export, modify, publicly and privately display/perform, distribute, and dispose Contractor's Intellectual Property with the right to sublicense through multiple layers, for any purpose whatsoever, to the extent it is incorporated in the Intellectual Property resulting from this Agreement, unless Contractor assigns all rights, title and interest in the Intellectual Property as set forth herein.

(2) Nothing in this provision shall restrict, limit, or otherwise prevent Contractor from using any ideas, concepts, know-how, methodology or techniques related to its performance under this Agreement, provided that Contractor's use does not infringe the patent, copyright, trademark rights, license or other Intellectual Property rights of DHCS or third party, or result in a breach or default of any provisions of this Exhibit or result in a breach of any provisions of law relating to confidentiality.

c. **Copyright**

(1) Contractor agrees that for purposes of copyright law, all works [as defined in Paragraph a, subparagraph (2)(a) of this provision] of authorship made by or on behalf of Contractor in connection with Contractor's performance of this Agreement be deemed "works made for hire". Contractor further agrees that the work of each person utilized by Contractor in connection with the performance of this Agreement will be a "work made for hire," whether that person is an employee of Contractor or that person has entered into an agreement with Contractor to perform the work. Contractor enter into a written agreement with any such person that: (i) all work performed for Contractor be deemed a "work made for hire" under the Copyright Act and (ii) that person assign all right, title, and interest to DHCS to any work product made, conceived, derived from, or reduced to practice by Contractor or DHCS and which result directly or indirectly from this Agreement.

(2) All materials, including, but not limited to, visual works or text, reproduced or distributed pursuant to this Agreement that include Intellectual Property made, conceived, derived from, or reduced to practice by Contractor or DHCS and which result directly or indirectly from this Agreement, include DHCS' notice of copyright, which read in 3mm or larger typeface: "© [Enter Current Year e.g., 2010, etc.], California Department of Health Care Services. This material may not be reproduced or disseminated without prior written permission from the California Department of Health Care Services." This notice should be placed prominently on the materials and set apart from other matter on the

page where it appears. Audio productions contain a similar audio notice of copyright.

d. **Patent Rights**

With respect to inventions made by Contractor in the performance of this Agreement, which did not result from research and development specifically included in the Agreement's scope of work, Contractor hereby grants to DHCS a license as described under Section b of this provision for devices or material incorporating, or made through the use of such inventions. If such inventions result from research and development work specifically included within the Agreement's scope of work, then Contractor agrees to assign to DHCS, without additional compensation, all its right, title and interest in and to such inventions and to assist DHCS in securing United States and foreign patents with respect thereto.

e. **Third-Party Intellectual Property**

Except as provided herein, Contractor agrees that its performance of this Agreement not be dependent upon or include any Intellectual Property of Contractor or third party without first: (i) obtaining DHCS' prior written approval; and (ii) granting to or obtaining for DHCS, without additional compensation, a license, as described in Section b of this provision, for any of Contractor's or third-party's Intellectual Property in existence prior to the effective date of this Agreement. If such a license upon these terms is unattainable, and DHCS determines that the Intellectual Property should be included in or is required for Contractor's performance of this Agreement, Contractor obtain a license under terms acceptable to DHCS.

f. **Warranties**

(1) Contractor represents and warrants that:

(a) It is free to enter into and fully perform this Agreement.

(b) It has secured and will secure all rights and licenses necessary for its performance of this Agreement.

(c) Neither Contractor's performance of this Agreement, nor the exercise by either Party of the rights granted in this Agreement, nor any use, reproduction, manufacture, sale, offer to sell, import, export, modification, public and private display/performance, distribution, and disposition of the Intellectual Property made, conceived, derived from, or reduced to practice by Contractor or DHCS and which result directly or indirectly from this Agreement will infringe upon or violate any Intellectual Property right, non-disclosure obligation, or other proprietary right or interest of any third-party or entity now existing under the laws of, or hereafter existing or issued by, any state, the United States, or any foreign country. There is

currently no actual or threatened claim by any such thirdparty based on an alleged violation of any such right by Contractor.

(d) Neither Contractor's performance nor any part of its performance will violate the right of privacy of, or constitute a libel or slander against any person or entity.

(e) It has secured and will secure all rights and licenses necessary for Intellectual Property including, but not limited to, consents, waivers or releases from all authors of music or performances used, and talent (radio, television and motion picture talent), owners of any interest in and to real estate, sites, locations, property or props that may be used or shown.

(f) It has not granted and not grant to any person or entity any right that would or might derogate, encumber, or interfere with any of the rights granted to DHCS in this Agreement.

(g) It has appropriate systems and controls in place to ensure that State funds will not be used in the performance of this Agreement for the acquisition, operation or maintenance of computer software in violation of copyright laws.

(h) It has no knowledge of any outstanding claims, licenses or other charges, liens, or encumbrances of any kind or nature whatsoever that could affect in any way Contractor's performance of this Agreement.

(2) DHCS makes no warranty that the intellectual property resulting from this agreement does not infringe upon any patent, trademark, copyright or the like, now existing or subsequently issued.

g. **Intellectual Property Indemnity**

(1) Contractor indemnify, defend and hold harmless DHCS and its licensees and assignees, and its officers, directors, employees, agents, representatives, successors, and users of its products, ("Indemnitees") from and against all claims, actions, damages, losses, liabilities (or actions or proceedings with respect to any thereof), whether or not rightful, arising from any and all actions or claims by any third party or expenses related thereto (including, but not limited to, all legal expenses, court costs, and attorney's fees incurred in investigating, preparing, serving as a witness in, or defending against, any such claim, action, or proceeding, commenced or threatened) to which any of the Indemnitees may be subject, whether or not Contractor is a party to any pending or threatened litigation, which arise out of or are related to (i) the incorrectness or breach of any of the representations, warranties, covenants or agreements of Contractor pertaining to Intellectual Property; or (ii) any Intellectual Property infringement, or any other type of actual or alleged

infringement claim, arising out of DHCS' use, reproduction, manufacture, sale, offer to sell, distribution, import, export, modification, public and private performance/display, license, and disposition of the Intellectual Property made, conceived, derived from, or reduced to practice by Contractor or DHCS and which result directly or indirectly from this Agreement. This indemnity obligation apply irrespective of whether the infringement claim is based on a patent, trademark or copyright registration that issued after the effective date of this Agreement. DHCS reserves the right to participate in and/or control, at Contractor's expense, any such infringement action brought against DHCS.

(2) Should any Intellectual Property licensed by the Contractor to DHCS under this Agreement become the subject of an Intellectual Property infringement claim, Contractor will exercise its authority reasonably and in good faith to preserve DHCS' right to use the licensed Intellectual Property in accordance with this Agreement at no expense to DHCS. DHCS have the right to monitor and appear through its own counsel (at Contractor's expense) in any such claim or action. In the defense or settlement of the claim, Contractor may obtain the right for DHCS to continue using the licensed Intellectual Property; or, replace or modify the licensed Intellectual Property so that the replaced or modified Intellectual Property becomes non-infringing provided that such replacement or modification is functionally equivalent to the original licensed Intellectual Property. If such remedies are not reasonably available, DHCS be entitled to a refund of all monies paid under this Agreement, without restriction or limitation of any other rights and remedies available at law or in equity.

(3) Contractor agrees that damages alone would be inadequate to compensate DHCS for breach of any term of this Intellectual Property Exhibit by Contractor. Contractor acknowledges DHCS would suffer irreparable harm in the event of such breach and agrees DHCS be entitled to obtain equitable relief, including without limitation an injunction, from a court of competent jurisdiction, without restriction or limitation of any other rights and remedies available at law or in equity.

h. **Federal Funding**

In any agreement funded in whole or in part by the federal government, DHCS may acquire and maintain the Intellectual Property rights, title, and ownership, which results directly or indirectly from the Agreement; except as provided in 37 Code of Federal Regulations part 401.14; however, the federal government shall have a non-exclusive, nontransferable, irrevocable, paid-up license throughout the world to use, duplicate, or dispose of such Intellectual Property throughout the world in any manner for governmental purposes and to have and permit others to do so.

i. **Survival**

The provisions set forth herein shall survive any termination or expiration of this Agreement or any project schedule.

12. Air or Water Pollution Requirements

Any federally funded agreement and/or subcontract in excess of $100,000 must comply with the following provisions unless said agreement is exempt by law.

a. Government contractors agree to comply with all applicable standards, orders, or requirements issued under section 306 of the Clean Air Act (42 USC 7606) section 508 of the Clean Water Act (33 U.S.C. 1368), Executive Order 11738, and Environmental Protection Agency regulations.

b. Institutions of higher education, hospitals, nonprofit organizations and commercial businesses agree to comply with all applicable standards, orders, or requirements issued under the Clean Air Act (42 U.S.C. 7401 et seq.), as amended, and the Clean Water Act (33 U.S.C. 1251 et seq.), as amended.

13. Prior Approval of Training Seminars, Workshops or Conferences

Contractor obtain prior DHCS approval of the location, costs, dates, agenda, instructors, instructional materials, and attendees at any reimbursable training seminar, workshop, or conference conducted pursuant to this Agreement and of any reimbursable publicity or educational materials to be made available for distribution. The Contractor acknowledge the support of the State whenever publicizing the work under this Agreement in any media. This provision does not apply to necessary staff meetings or training sessions held for the staff of the Contractor or Subcontractor to conduct routine business matters.

14. Confidentiality of Information

a. The Contractor and its employees, agents, or subcontractors protect from unauthorized disclosure names and other identifying information concerning persons either receiving services pursuant to this Agreement or persons whose names or identifying information become available or are disclosed to the Contractor, its employees, agents, or subcontractors as a result of services performed under this Agreement, except for statistical information not identifying any such person.

b. The Contractor and its employees, agents, or subcontractors not use such identifying information for any purpose other than carrying out the Contractor's obligations under this Agreement.

c. The Contractor and its employees, agents, or subcontractors promptly transmit to the DHCS Program Contract Manager all requests for disclosure of such identifying information not emanating from the client or person.

d. The Contractor not disclose, except as otherwise specifically permitted by this Agreement or authorized by the client, any such identifying information to anyone other than DHCS without prior written authorization from the DHCS Program Contract Manager, except if disclosure is required by State or federal law.

e. For purposes of this provision, identity include, but not be limited to name, identifying number, symbol, or other identifying particular assigned to the individual, such as finger or voice print or a photograph.

f. As deemed applicable by DHCS, this provision may be supplemented by additional terms and conditions covering personal health information (PHI) or personal, sensitive, and/or confidential information (PSCI). Said terms and conditions will be outlined in one or more exhibits that will either be attached to this Agreement or incorporated into this Agreement by reference.

15. Documents, Publications and Written Reports

(Applicable to agreements over $5,000 under which publications, written reports and documents are developed or produced. Government Code Section 7550.)

Any document, publication or written report (excluding progress reports, financial reports and normal contractual communications) prepared as a requirement of this Agreement contain, in a separate section preceding the main body of the document, the number and dollar amounts of all contracts or agreements and subcontracts relating to the preparation of such document or report, if the total cost for work by nonemployees of the State exceeds $5,000.

16. Dispute Resolution Process

a. A Contractor grievance exists whenever there is a dispute arising from DHCS' action in the administration of an agreement. If there is a dispute or grievance between the Contractor and DHCS, the Contractor must seek resolution using the procedure outlined below.

(1) The Contractor should first informally discuss the problem with the DHCS Program Contract Manager. If the problem cannot be resolved informally, the Contractor direct its grievance together with any evidence, in writing, to the program Branch Chief. The grievance state the issues in dispute, the legal authority or other basis for the Contractor's position and the remedy sought. The Branch Chief render a decision within ten (10) Working Days after receipt of the written grievance from the Contractor. The Branch Chief respond in writing to the Contractor indicating the decision and reasons therefore. If the Contractor disagrees with the Branch Chief's decision, the Contractor may appeal to the second level.

(2) When appealing to the second level, the Contractor must prepare an appeal indicating the reasons for disagreement with Branch Chief's decision. The

Contractor **must** include with the appeal a copy of the Contractor's original statement of dispute along with any supporting evidence and a copy of the Branch Chief's decision. The appeal be addressed to the Deputy Director of the division in which the branch is organized within ten (10) Working Days from receipt of the Branch Chief's decision. The Deputy Director of the division in which the branch is organized or his/her designee meet with the Contractor to review the issues raised. A written decision signed by the Deputy Director of the division in which the branch is organized or his/her designee be directed to the Contractor within twenty (20) working days of receipt of the Contractor's second level appeal.

b. If the Contractor wishes to appeal the decision of the Deputy Director of the division in which the branch is organized or his/her designee, the Contractor follow the procedures set forth in Health and Safety Code Section 100171.

c. Unless otherwise stipulated in writing by DHCS, all dispute, grievance and/or appeal correspondence be directed to the DHCS Program Contract Manager.

d. There are organizational differences within DHCS' funding programs and the management levels identified in this dispute resolution provision may not apply in every contractual situation. When a grievance is received and organizational differences exist, the Contractor be notified in writing by the DHCS Program Contract Manager of the level, name, and/or title of the appropriate management official that is responsible for issuing a decision at a given level.

17. Financial and Compliance Audit Requirements

a. The definitions used in this provision are contained in Section 38040 of the Health and Safety Code, which by this reference is made a part hereof.

b. Direct service contract means a contract or agreement for services contained in local assistance or subvention programs or both (see Health and Safety [H&S] Code Section 38020). Direct service contracts do not include contracts, agreements, grants, or subventions to other governmental agencies or units of government nor contracts or agreements with regional centers or area agencies on aging (H&S Code Section 38030).

c. The Contractor, as indicated below, agrees to obtain one of the following audits:

(1) ***If the Contractor is a nonprofit organization (as defined in H&S Code Section 38040)*** and receives **$25,000 or more** from any State agency under a direct service contract or agreement; the Contractor agrees to obtain an annual single, organization wide, financial and compliance audit. Said audit be conducted according to Generally Accepted Auditing Standards. This audit does not fulfill the audit requirements of Paragraph c(3) below. The audit be completed by the 15th day of the fifth month following the end of the Contractor's fiscal year, **and/or**

(2) ***If the Contractor is a nonprofit organization (as defined in H&S Code Section 38040)*** and receives **less than $25,000** per year from any State agency under a direct service contract or agreement, the Contractor agrees to obtain a biennial single, organization wide financial and compliance audit, unless there is evidence of fraud or other violation of State law in connection with this Agreement. This audit does not fulfill the audit requirements of Paragraph c(3) below. The audit be completed by the 15th day of the fifth month following the end of the Contractor's fiscal year, **and/or**

(3) ***If the Contractor is a State or Local Government entity or Nonprofit organization*** and expends $750,000 or more in federal awards, the Contractor agrees to obtain an annual single, organization wide, financial and compliance audit according to the requirements specified in 2 C.F.R. 200.501 entitled "Audit Requirements". An audit conducted pursuant to this provision will fulfill the audit requirements outlined in Paragraphs c(1) and c(2) above. The audit be completed by the end of the ninth month following the end of the audit period. The requirements of this provision apply if:

(a) The Contractor is a recipient expending federal awards received directly from federal awarding agencies, or

(b) The Contractor is a subrecipient expending federal awards received from a pass-through entity such as the State, County or community based organization.

(4) If the Contractor submits to DHCS a report of an audit other than a 2 C.F.R. 200.501audit, the Contractor must also submit a certification indicating the Contractor has not expended $750,000 or more in federal funds for the year covered by the audit report.

d. Two copies of the audit report be delivered to the DHCS program funding this Agreement. The audit report must identify the Contractor's legal name and the number assigned to this Agreement. The audit report be due within 30 days after the completion of the audit. Upon receipt of said audit report, the DHCS Program Contract Manager forward the audit report to DHCS' Audits and Investigations Unit if the audit report was submitted under Section 16.c(3), unless the audit report is from a City, County, or Special District within the State of California whereby the report will be retained by the funding program.

e. The cost of the audits described herein may be included in the funding for this Agreement up to the proportionate amount this Agreement represents of the Contractor's total revenue. The DHCS program funding this Agreement must provide advance written approval of the specific amount allowed for said audit expenses.

f. The State or its authorized designee, including the Bureau of State Audits, is responsible for conducting agreement performance audits which are not financial

and compliance audits. Performance audits are defined by Generally Accepted Government Auditing Standards.

g. Nothing in this Agreement limits the State's responsibility or authority to enforce State law or regulations, procedures, or reporting requirements arising thereto.

h. Nothing in this provision limits the authority of the State to make audits of this Agreement, provided however, that if independent audits arranged for by the Contractor meet Generally Accepted Governmental Auditing Standards, the State rely on those audits and any additional audit work and build upon the work already done.

i. The State may, at its option, direct its own auditors to perform either of the audits described above. The Contractor will be given advance written notification, if the State chooses to exercise its option to perform said audits.

j. The Contractor **must** include a clause in any agreement the Contractor enters into with the audit firm doing the single organization wide audit to provide access by the State or Federal Government to the working papers of the independent auditor who prepares the single organization wide audit for the Contractor.

k. Federal or State auditors have "expanded scope auditing" authority to conduct specific program audits during the same period in which a single organization wide audit is being performed, but the audit report has not been issued. The federal or State auditors review and have access to the current audit work being conducted and will not apply any testing or review procedures which have not been satisfied by previous audit work that has been completed.

   The term "expanded scope auditing" is applied and defined in the U.S. General Accounting Office (GAO) issued Standards for *Audit of Government Organizations, Programs, Activities and Functions*, better known as the "yellow book".

18. Human Subjects Use Requirements

(Applicable only to federally funded agreements/grants in which performance, directly or through a subcontract/subaward, includes any tests or examination of materials derived from the human body.)

By signing this Agreement, Contractor agrees that if any performance under this Agreement or any subcontract or subagreement includes any tests or examination of materials derived from the human body for the purpose of providing information, diagnosis, prevention, treatment or assessment of disease, impairment, or health of a human being, all locations at which such examinations are performed meet the requirements of 42 U.S.C. Section 263a (CLIA) and the regulations thereunder.

19. Novation Requirements

If the Contractor proposes any novation agreement, DHCS act upon the proposal within 60 days after receipt of the written proposal. DHCS may review and consider the proposal, consult and negotiate with the Contractor, and accept or reject all or part of the proposal. Acceptance or rejection of the proposal may be made orally within the 60-day period and confirmed in writing within five days of said decision. Upon written acceptance of the proposal, DHCS will initiate an amendment to this Agreement to formally implement the approved proposal.

20. Debarment and Suspension Certification

(Applicable to all agreements funded in part or whole with federal funds.)

a. By signing this Agreement, the Contractor/Grantee agrees to comply with applicable federal suspension and debarment regulations including, but not limited to 2 CFR Part 180, 2 CFR Part 376

b. By signing this Agreement, the Contractor certifies to the best of its knowledge and belief, that it and its principals:

(1) Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any federal department or agency;

(2) Have not within a three-year period preceding this application/proposal/agreement been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, State or local) violation of federal or State antitrust statutes; or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, tax evasion, receiving stolen property, making false claims, obstruction of justice, or the commission of any other offense indicating a lack of business integrity or business honesty that seriously affects its business honesty;

(3) Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (federal, State or local) with commission of any of the offenses enumerated in Paragraph b(2) herein; and

(4) Have not within a three-year period preceding this application/proposal/agreement had one or more public transactions (federal, State or local) terminated for cause or default.

(5) Have not, within a three-year period preceding this application/proposal/agreement, engaged in any of the violations listed under 2 CFR Part 180, Subpart C as supplemented by 2 CFR Part 376.

(6) not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under federal regulations (i.e., 48 CFR part 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State.

(7) Will include a clause entitled, "Debarment and Suspension Certification" that essentially sets forth the provisions herein, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

c. If the Contractor is unable to certify to any of the statements in this certification, the Contractor submit an explanation to the DHCS Program Contract Manager.

d. The terms and definitions herein have the meanings set out in 2 CFR Part 180 as supplemented by 2 CFR Part 376.

e. If the Contractor knowingly violates this certification, in addition to other remedies available to the Federal Government, the DHCS may terminate this Agreement for cause or default.

21. Smoke-Free Workplace Certification

(Applicable to federally funded agreements/grants and subcontracts/subawards, that provide health, day care, early childhood development services, education or library services to children under 18 directly or through local governments.)

a. Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by federal programs either directly or through State or local governments, by federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed.

b. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible party.

c. By signing this Agreement, Contractor or Grantee certifies that it will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The prohibitions herein are effective December 26, 1994.

d. Contractor or Grantee further agrees that it will insert this certification into any

subawards (subcontracts or subgrants) entered into that provide for children's services as described in the Act.

22. Drug Free Workplace Act of 1988

The Federal government implemented the Drug Free Workplace Act of 1988 in an attempt to address the problems of drug abuse on the job. It is a fact that employees who use drugs have less productivity, a lower quality of work, and a higher absenteeism, and are more likely to misappropriate funds or services. From this perspective, the drug abuser may endanger other employees, the public at large, or themselves. Damage to property, whether owned by this entity or not, could result from drug abuse on the job. All these actions might undermine public confidence in the services this entity provides. Therefore, in order to remain a responsible source for government contracts, the following guidelines have been adopted:

a. The unlawful manufacture, distribution, dispensation, possession or use of a controlled substance is prohibited in the work place.

b. Violators may be terminated or requested to seek counseling from an approved rehabilitation service.

c. Employees must notify their employer of any conviction of a criminal drug statue no later than five days after such conviction.

d. Although alcohol is not a controlled substance, it is nonetheless a drug. It is the policy that abuse of this drug will also not be tolerated in the workplace.

e. Contractors of federal agencies are required to certify that they will provide drug-free workplaces for their employees.

23. Covenant Against Contingent Fees

(Applicable only to federally funded agreements.)

The Contractor warrants that no person or selling agency has been employed or retained to solicit/secure this Agreement upon an agreement of understanding for a commission, percentage, brokerage, or contingent fee, except *bona fide* employees or *bona fide* established commercial or selling agencies retained by the Contractor for the purpose of securing business. For breach or violation of this warranty, DHCS have the right to annul this Agreement without liability or in its discretion to deduct from the Agreement price or consideration, or otherwise recover, the full amount of such commission, percentage, and brokerage or contingent fee.

24. Payment Withholds

(Applicable only if a final report is required by this Agreement. Not applicable to government entities.)

Unless waived or otherwise stipulated in this Agreement, DHCS may, at its discretion, withhold 10 percent (10%) of the face amount of the Agreement, 50 percent (50%) of the final invoice, or $3,000 whichever is greater, until DHCS receives a final report that meets the terms, conditions and/or scope of work requirements of this Agreement.

25. Performance Evaluation

(Not applicable to grant agreements.)

DHCS may, at its discretion, evaluate the performance of the Contractor at the conclusion of this Agreement. If performance is evaluated, the evaluation not be a public record and remain on file with DHCS. Negative performance evaluations may be considered by DHCS prior to making future contract awards.

26. Officials Not to Benefit

No members of or delegate of Congress or the State Legislature shall be admitted to any share or part of this Agreement, or to any benefit that may arise therefrom. This provision shall not be construed to extend to this Agreement if made with a corporation for its general benefits.

27. Four-Digit Date Compliance

(Applicable to agreements in which Information Technology (IT) services are provided to DHCS or if IT equipment is procured.)

Contractor warrants that it will provide only Four-Digit Date Compliant (as defined below) Deliverables and/or services to the State. “Four Digit Date compliant” Deliverables and services can accurately process, calculate, compare, and sequence date data, including without limitation date data arising out of or relating to leap years and changes in centuries. This warranty and representation is subject to the warranty terms and conditions of this Contract and does not limit the generality of warranty obligations set forth elsewhere herein.

28. Prohibited Use of State Funds for Software

(Applicable to agreements in which computer software is used in performance of the work.)

Contractor certifies that it has appropriate systems and controls in place to ensure that State funds will not be used in the performance of this Agreement for the acquisition, operation or maintenance of computer software in violation of copyright laws.

29. Use of Disabled Veteran's Business Enterprises (DVBE)

(Applicable to agreements over $10,000 in which the Contractor committed to achieve DVBE participation. Not applicable to agreements and amendments specifically exempted from DVBE requirements by DHCS.)

a. The State Legislature has declared that a fair portion of the total purchases and contracts or subcontracts for property and services for the State be placed with disabled veteran business enterprises.

b. All DVBE participation attachments, however labeled, completed as a condition of bidding, contracting, or amending a subject agreement, are incorporated herein and made a part of this Agreement by this reference.

c. Contractor agrees to use the proposed DVBEs, as identified in previously submitted DVBE participation attachments. Contractor understands and agrees to comply with the requirements set forth in Military and Veterans Code Section 999 et seq. in that should award of this contract be based on part on its commitment to use the DVBE subcontractor(s) identified in its bid or offer, per Military and Veterans Code section 999.5(g), a DVBE subcontractor may only be replaced by another DVBE subcontractor and must be approved by both DHCS and the Department of General Services (DGS) prior to the commencement of any work by the proposed subcontractor. Changes to the scope of work that impact the DVBE subcontractor(s) identified in the bid or offer and approved DVBE substitutions will be documented by contract amendment.

d. Requests for DVBE subcontractor substitution must include:

   (1) A written explanation of the reason for the DVBE substitution.

   (2) A written description of the business enterprise that will be substituted, including its DVBE certification status.

   (3) A written description of the work to be performed by the substituted DVBE subcontractor and an identification of the percentage share/dollar amount of the overall contract that the substituted subcontractor will perform.

e. Failure of the Contractor to seek substitution and adhere to the DVBE participation level identified in the bid or offer may be cause for contract termination, recovery of damages under rights and remedies due to the State, and penalties as outlined in Military and Veterans Code § 999.9; Public Contract Code (PCC) §10115.10, or PCC §4110 (applies to public works only).

f. Upon completion of this Contract, DHCS requires the Contractor to certify using the Prime Contractor's Certification – DVBE Subcontracting Report (STD 817), al of the following:

   (1) The total amount the prime contractor received under the agreement;

(2) The name, address, Contract number and certification ID Number of the DVBE(s) that participated in the performance of this Contract;

(3) The amount and percentage of work the prime Contractor committed to provide to one or more DVBE(s) under the requirements of the Contract and the total payment each DVBE received from the prime Contractor;;

(4) That all payments under the Contract have been made to the DVBE(s); and

(5) The actual percentage of DVBE participation that was achieved. Upon request, the prime Contractor must provide proof of payment for the work.

g. If for this Contract the Contractor made a commitment to achieve the DVBE participation goal, DHCS will withhold $10,000 from the final payment, or the full payment if less than $10,000, until the Contractor complies with the certification requirements above. A Contractor that fails to comply with the certification requirement must, after written notice, be allowed to cure the defect. Notwithstanding any other law, if, after at least 15 calendar days but not more than 30 calendar days from the date of written notice, the prime Contractor refuses to comply with the certification requirements, DHCS will permanently deduct $10,000 from the final payment, or the full payment if less than $10,000. (Mil. & Vet. Code § 999.7.)

h. A person or entity that knowingly provides false information will be subject to a civil penalty for each violation. (Mil. & Vet. Code § 999.5(d); Govt. Code § 14841.)

i. Contractor agrees to comply with the rules, regulations, ordinances, and statutes that apply to the DVBE program as defined in Section 999 of the Military & Veterans Code, including, but not limited to, the requirements of Section 999.5(d). (PCC§ 10230.)

30. Use of Small, Minority Owned and Women's Businesses

(Applicable to that portion of an agreement that is federally funded and entered into with institutions of higher education, hospitals, nonprofit organizations or commercial businesses.)

Positive efforts be made to use small businesses, minority-owned firms and women's business enterprises, whenever possible (i.e., procurement of goods and/or services). Contractors take all of the following steps to further this goal.

a. Ensure that small businesses, minority-owned firms, and women's business enterprises are used to the fullest extent practicable.

b. Make information on forthcoming purchasing and contracting opportunities available and arrange time frames for purchases and contracts to encourage and

facilitate participation by small businesses, minority-owned firms, and women's business enterprises.

c. Consider in the contract process whether firms competing for larger contracts intend to subcontract with small businesses, minority-owned firms, and women's business enterprises.

d. Encourage contracting with consortiums of small businesses, minority-owned firms and women's business enterprises when a contract is too large for one of these firms to handle individually.

e. Use the services and assistance, as appropriate, of such organizations as the Federal Small Business Administration and the U.S. Department of Commerce's Minority Business Development Agency in the solicitation and utilization of small businesses, minority-owned firms and women's business enterprises.

31. Alien Ineligibility Certification

(Applicable to sole proprietors entering federally funded agreements.)

By signing this Agreement, the Contractor certifies that he/she is not an alien that is ineligible for State and local benefits, as defined in Subtitle B of the Personal Responsibility and Work Opportunity Act. (8 U.S.C. 1601, et seq.)

32. Union Organizing

(Applicable only to grant agreements.)

Grantee, by signing this Agreement, hereby acknowledges the applicability of Government Code Sections 16645 through 16649 to this Agreement. Furthermore, Grantee, by signing this Agreement, hereby certifies that:

a. No State funds disbursed by this grant will be used to assist, promote or deter union organizing.

b. Grantee account for State funds disbursed for a specific expenditure by this grant, to show those funds were allocated to that expenditure.

c. Grantee, where State funds are not designated as described in b herein, allocate, on a pro-rata basis, all disbursements that support the grant program.

d. If Grantee makes expenditures to assist, promote or deter union organizing, Grantee will maintain records sufficient to show that no State funds were used for those expenditures, and that Grantee provide those records to the Attorney General upon request.

33. Contract Uniformity (Fringe Benefit Allowability)

(Applicable only to nonprofit organizations.)

Pursuant to the provisions of Article 7 (commencing with Section 100525) of Chapter 3 of Part 1 of Division 101 of the Health and Safety Code, DHCS sets forth the following policies, procedures, and guidelines regarding the reimbursement of fringe benefits.

a. As used herein fringe benefits shall mean an employment benefit given by one's employer to an employee in addition to one's regular or normal wages or salary.

b. As used herein, fringe benefits do not include:

(1) Compensation for personal services paid currently or accrued by the Contractor for services of employees rendered during the term of this Agreement, which is identified as regular or normal salaries and wages, annual leave, vacation, sick leave, holidays, jury duty and/or military leave/training.

(2) Director's and executive committee member's fees.

(3) Incentive awards and/or bonus incentive pay.

(4) Allowances for off-site pay.

(5) Location allowances.

(6) Hardship pay.

(7) Cost-of-living differentials

c. Specific allowable fringe benefits include:

(1) Fringe benefits in the form of employer contributions for the employer's portion of payroll taxes (i.e., FICA, SUI, SDI), employee health plans (i.e., health, dental and vision), unemployment insurance, worker's compensation insurance, and the employer's share of pension/retirement plans, provided they are granted in accordance with established written organization policies and meet all legal and Internal Revenue Service requirements.

d. To be an allowable fringe benefit, the cost must meet the following criteria:

(1) Be necessary and reasonable for the performance of the Agreement.

(2) Be determined in accordance with generally accepted accounting principles.

(3) Be consistent with policies that apply uniformly to all activities of the Contractor.

e. Contractor agrees that all fringe benefits be at actual cost.

f. Earned/Accrued Compensation

(1) Compensation for vacation, sick leave and holidays is limited to that amount earned/accrued within the agreement term. Unused vacation, sick leave and holidays earned from periods prior to the agreement term cannot be claimed as allowable costs. See Provision f (3)(a) for an example.

(2) For multiple year agreements, vacation and sick leave compensation, which is earned/accrued but not paid, due to employee(s) not taking time off may be carried over and claimed within the overall term of the multiple years of the Agreement. Holidays cannot be carried over from one agreement year to the next. See Provision f (3)(b) for an example.

(3) For single year agreements, vacation, sick leave and holiday compensation that is earned/accrued but not paid, due to employee(s) not taking time off within the term of the Agreement, cannot be claimed as an allowable cost. See Provision f (3)(c) for an example.

(a) **Example No. 1:**

If an employee, John Doe, earns/accrues three weeks of vacation and twelve days of sick leave each year, then that is the maximum amount that may be claimed during a one year agreement. If John Doe has five weeks of vacation and eighteen days of sick leave at the beginning of an agreement, the Contractor during a one-year budget period may only claim up to three weeks of vacation and twelve days of sick leave as actually used by the employee. Amounts earned/accrued in periods prior to the beginning of the Agreement are not an allowable cost.

(b) **Example No. 2:**

If during a three-year (multiple year) agreement, John Doe does not use his three weeks of vacation in year one, or his three weeks in year two, but he does actually use nine weeks in year three; the Contractor would be allowed to claim all nine weeks paid for in year three. The total compensation over the three-year period cannot exceed 156 weeks (3 x 52 weeks).

(c) **Example No. 3:**

If during a single year agreement, John Doe works fifty weeks and used one week of vacation and one week of sick leave and all fifty-two weeks have been billed to DHCS, the remaining unused two weeks of vacation and seven days of sick leave may not be claimed as an allowable cost.

34. Suspension or Stop Work Notification

a. DHCS may, at any time, issue a notice to suspend performance or stop work under this Agreement. The initial notification may be a verbal or written directive issued by the funding Program's Contract Manager. Upon receipt of said notice, the Contractor is to suspend and/or stop all, or any part, of the work called for by this Agreement.

b. Written confirmation of the suspension or stop work notification with directions as to what work (if not all) is to be suspended and how to proceed will be provided within 30 Working Days of the verbal notification. The suspension or stop work notification remain in effect until further written notice is received from DHCS. The resumption of work (in whole or part) will be at DHCS' discretion and upon receipt of written confirmation.

   (1) Upon receipt of a suspension or stop work notification, the Contractor immediately comply with its terms and take all reasonable steps to minimize or halt the incurrence of costs allocable to the performance covered by the notification during the period of work suspension or stoppage.

   (2) Within 90 days of the issuance of a suspension or stop work notification, DHCS either:

      (a) Cancel, extend, or modify the suspension or stop work notification; or

      (b) Terminate the Agreement as provided for in the Cancellation / Termination clause of the Agreement.

c. If a suspension or stop work notification issued under this clause is canceled or the period of suspension or any extension thereof is modified or expires, the Contractor may resume work only upon written concurrence of funding Program's Contract Manager.

d. If the suspension or stop work notification is cancelled and the Agreement resumes, changes to the services, deliverables, performance dates, and/or contract terms resulting from the suspension or stop work notification shall require an amendment to the Agreement.

e. If a suspension or stop work notification is not canceled and the Agreement is cancelled or terminated pursuant to the provision entitled Cancellation / Termination, DHCS allow reasonable costs resulting from the suspension or stop work notification in arriving at the settlement costs.

f. DHCS shall not be liable to the Contractor for loss of profits because of any suspension or stop work notification issued under this clause.

35. Public Communications

"Electronic and printed documents developed and produced, for public communications follow the following requirements to comply with Section 508 of the Rehabilitation Act and the American with Disabilities Act:

a. Ensure visual-impaired, hearing-impaired and other special needs audiences are provided material information in formats that provide the most assistance in making informed choices."

36. Compliance with Statutes and Regulations

a. The Contractor must comply with all California and federal law, regulations, and published guidelines, to the extent that these authorities contain requirements applicable to Contractor's performance under the Agreement.

b. These authorities include, but are not limited to, Title 2, Code of Federal Regulations (CFR) Part 200, subpart F, Appendix II; Title 42 CFR Part 431, subpart F; Title 42 CFR Part 433, subpart D; Title 42 CFR Part 434; Title 45 CFR Part 75, subpart D; and Title 45 CFR Part 95, subpart F. To the extent applicable under federal law, this Agreement incorporate the contractual provisions in these federal regulations and they supersede any conflicting provisions in this Agreement.

37. Lobbying Restrictions and Disclosure Certification

(Applicable to federally funded agreements in excess of $100,000 per Section 1352 of the 31, U.S.C.)

a. Certification and Disclosure Requirements

(1) Each person (or recipient) who requests or receives a contract or agreement, subcontract, grant, or subgrant, which is subject to Section 1352 of the 31, U.S.C., and which exceeds $100,000 at any tier, file a certification (in the form set forth in Attachment 1, consisting of one page, entitled "Certification Regarding Lobbying") that the recipient has not made, and will not make, any payment prohibited by Paragraph b of this provision.

(2) Each recipient file a disclosure (in the form set forth in Attachment 2, entitled "Standard Form-LLL 'disclosure of Lobbying Activities'") if such recipient has made or has agreed to make any payment using nonappropriated funds (to include profits from any covered federal action) in connection with a contract, or grant or any extension or amendment of that contract, or grant, which would be prohibited under Paragraph b of this provision if paid for with appropriated funds.

(3) Each recipient file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affect

the accuracy of the information contained in any disclosure form previously filed by such person under Paragraph a(2) herein. An event that materially affects the accuracy of the information reported includes:

(a) A cumulative increase of $25,000 or more in the amount paid or expected to be paid for influencing or attempting to influence a covered federal action;

(b) A change in the person(s) or individuals(s) influencing or attempting to influence a covered federal action; or

(c) A change in the officer(s), employee(s), or member(s) contacted for the purpose of influencing or attempting to influence a covered federal action.

(4) Each person (or recipient) who requests or receives from a person referred to in Paragraph a(1) of this provision a contract or agreement, subcontract, grant or subgrant exceeding $100,000 at any tier under a contract or agreement, or grant file a certification, and a disclosure form, if required, to the next tier above.

(5) All disclosure forms (but not certifications) be forwarded from tier to tier until received by the person referred to in Paragraph a(1) of this provision. That person forward all disclosure forms to DHCS Program Contract Manager.

b. Prohibition

Section 1352 of Title 31, U.S.C., provides in part that no appropriated funds may be expended by the recipient of a federal contract or agreement, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any of the following covered federal actions: the awarding of any federal contract or agreement, the making of any federal grant, the making of any federal loan, entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract or agreement, grant, loan, or cooperative agreement.

Attachment 1
CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge and belief, that:

1. No federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the making, awarding or entering into of this federal contract, federal grant, or cooperative agreement, and the extension, continuation, renewal, amendment, or modification of this federal contract, grant, or cooperative agreement.

2. If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency of the United States Government, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this federal contract, grant, or cooperative agreement, the undersigned complete and submit Standard Form LLL, “Disclosure of Lobbying Activities" in accordance with its instructions.

3. The undersigned require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontractors, subgrants, and contracts under grants and cooperative agreements) of $100,000 or more, and that all subrecipients certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S.C., any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Name of Contractor	Printed Name of Person Signing for Contractor
Contract / Grant Number	Signature of Person Signing for Contractor
Date	Title

After execution by or on behalf of Contractor, please return to:

California Department of Health Care Services

DHCS reserves the right to notifiy the contractor in writing of an alternate submission address.

Attachment 2

CERTIFICATION REGARDING LOBBYING

Approved by OMB (0348-0046)

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352

(See reverse for public burden disclosure)

1. Type of Federal Action:	2. Status of Federal Action:	3. Report Type:
_ a. contract b. grant c. cooperative agreement d. loan e. loan guarantee f. loan insurance	_ a. bid/offer/application b. initial award c. post-award	_ a. initial filing b. material change For Material Change Only: Year ___ quarter date of last report ___.

4. Name and Address of Reporting Entity:	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:
☐Prime ☐Subawardee Tier __, if known: Congressional District, If known:	Congressional District, If known:
6. Federal Department/Agency	7. Federal Program Name/Description:
	CDFA Number, if applicable:
8. Federal Action Number, if known:	9. Award Amount, if known:
10.a. Name and Address of Lobbying Registrant *(If individual, last name, first name, MI)*:	b. Individuals Performing Services *(including address if different from 10a. (Last name, First name, MI):*

11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be available for public inspection. Any person that fails to file the required disclosure shall be subject to a not more than $100,000 for each such failure.	
Signature:	
Print Name:	
Title:	
Telephone Number:	
Date:	
Federal Use Only	Authorized for Local Reproduction Standard Form-LLL (Rev. 7-97)

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form be completed by the reporting entity, whether subawardee or prime federal recipient, at the initiation or receipt of a covered federal action, or a material change to a previous filing, pursuant to title 31 U.S.C. section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered federal action. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered federal action.

2. Identify the status of the covered federal action.

3. Identify the appropriate classification of this report. If this is a followup report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered federal action.

4. Enter the full name, address, city, state and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if itis, or expects to be,a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grants.

5. If the organization filing the report in item 4 checks "Subawardee," then enter the full name, address, city, state and zip code of the prime federal recipient. Include Congressional District, if known.

6. Enter the name of the federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.

7. Enter the federal program name or description for the covered federal action (item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.

8. Enter the most appropriate federal identifying number available for the federal action identified in item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract, grant, or loan award number; the application/proposal control number assigned by the Federal agency). Include prefixes, e.g., "RFP-DE-90-001".

9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in item 4 or 5.

10. (a) Enter the full name, address, city, state and zip code of the lobbying registrant under the Lobbying Disclosure Act of 1995 engaged by the reporting entity identified in item 4 to influence the covered Federal action.

    (b) Enter the full names of the individual(s) performing services, and include full address if different from 10 (a). Enter Last Name, First Name, and Middle Initial (MI).

11. The certifying official sign and date the form, print his/her name, title, and telephone number.

According to the Paperwork Reduction Act, as amended, no persons are required to respond to a collection of information unless it displays a valid OMB Control Number. The valid OMB control number for this information collection is OMB No. 0348-0046. Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0046), Washington, DC 20503.

Exhibit E – Program Terms and Conditions

1.0 Program Terms and Conditions

1.1 Program Terms and Conditions

1.1.1 Governing Law
1.1.2 DHCS Guidance
1.1.3 Contract Interpretation
1.1.4 Assignments, Mergers, Acquisitions
1.1.5 Independent Contractor
1.1.6 Amendment and Change Order Process
1.1.7 Delegation of Authority
1.1.8 Authority of the State
1.1.9 Fulfillment of Obligations
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1.1.21 Contractor's Dispute Resolution Requirements
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1.1.27 Litigation Support
1.1.28 Equal Opportunity Employer
1.1.29 Federal and State Nondiscrimination Requirements
1.1.30 Discrimination Prohibitions
1.1.31 Small Business Participation and Disabled Veteran Business Enterprises Reporting Requirements
1.1.32 Conflict of Interest Avoidance Requirements
1.1.33 Guaranty Provision
1.1.34 Priority of Provisions
1.1.35 Additional Incorporated Provisions – Narrative Proposals
1.1.36 Miscellaneous Provisions
1.1.37 Data Sharing

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Exhibit E - Program Terms and Conditions

1.1.1 Governing Law

A. Contractor must comply with all applicable federal and State law.

B. All Contract disputes and determinations must be decided under California law.

C. The venue and forum for any action involving a Contract dispute will be in the Superior Court for the State of California, County of Sacramento.

D. Applicability of the Knox-Keene Act

1) A Contractor who is licensed as a health care service plan pursuant to the Knox-Keene Health Care Service Plan Act of 1975 ~~(KKA)~~ ~~(~~and its implementing regulations (28 California Code of Regulations (CCR) section 1000, *et seq*.) **(KKA)** ~~-~~must comply with all applicable provisions of the KKA.

2) A Contractor who is not licensed to operate as a health care service plan pursuant to the KKA must perform all acts and satisfy all requirements under the KKA to the same extent as Contractors who are licensed pursuant to the KKA, except as otherwise expressly provided in this Contract. A Contractor who is not licensed to operate as a health care service plan under the KKA is not required by this Contract to perform or satisfy the following:

a) Any provision of the KKA which requires the submission of a report of any kind to the Department of Managed Health Care (DMHC) or obliges a health care service plan to seek approval from DMHC, including, but not limited to, the Independent Medical Review processes set out in section 1370.4 and Article 5.55 of the KKA;

b) Any provision under Article 3 of the KKA related to licensure; and

c) The provisions set forth in Exhibit K of this Contract. Exhibit K is not an exhaustive or exclusive list, and other provisions of the KKA may also be excluded from the Contract pursuant to this Exhibit E, Subsection 1.1.1 (*Governing Law*) or other provisions of this Contract.

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3) Both KKA-licensed Contractors and non-KKA-licensed Contractors are subject to the following provisions:

   a) Nothing in this Exhibit E, Subsection 1.1.1 (*Governing Law*) is intended to relieve Contractor of any other duties or requirements that would otherwise apply; and

   b) In the event that a provision of this Contract sets a standard or requirement that is higher, or affords a greater benefit or right to a Member than that which the KKA provides, the Contract provisions prevail.

1.1.2 DHCS Guidance

Contractor must comply with all DHCS guidance, including but not limited to All Plan Letters (APLs), PLs, the California Medicaid State Plan, and the Medi-Cal Provider Manual.

A. APLs and PLs

Contractor must comply with all existing and future APLs and PLs as follows:

1) APLs and PLs existing on the effective date of the Contract will be considered part of the Contract as if fully set forth herein;

2) APLs and PLs issued or revised subsequent to the effective date of the Contract can provide clarification of existing contractual obligations;

3) APLs and PLs issued or revised subsequent to the effective date of the Contract can provide instructions regarding implementation of mandated obligations, including but not limited to implementation of changes in State or federal statutes or regulations, or pursuant to judicial interpretation; and

4) APLs and PLs issued by DHCS pursuant to statutory authority to issue guidance in lieu of regulations will have the same force and effect as regulations and may set forth new obligations.

5) APLs and PLs cited and incorporated by reference into the Contract also include any subsequent revisions to the APL or PL.

B. California Medicaid State Plan

Unless otherwise specified in this Contract, Contractor will comply with all applicable provisions of the California Medicaid State Plan, as amended. In the event there is a conflict between the California Medicaid State Plan and this Contract, the California Medicaid State Plan will control. The California Medicaid State Plan and any amendments thereto, can be viewed at the California's Medicaid State Plan (Title XIX) web page.

C. Medi-Cal Provider Manual

Unless otherwise specified in this Contract, Contractor must comply with all current and applicable provisions of the Medi-Cal Provider Manual. In the event that the Medi-Cal Provider Manual conflicts with this Contract, APLs and PLs, and/or any applicable federal or State laws, the Contract, the APL or PL, or the applicable law will control. The Medi-Cal Provider Manual can be viewed online.

1.1.3 Contract Interpretation

A. Conflict with Law

Any provision of this Contract that is in conflict with current or future applicable federal or State laws or regulations is hereby amended to conform to the provisions of those laws and regulations. Such amendment of the Contract will be effective on the effective date of the statutes or regulations necessitating it and will be binding on Contractor even though such amendment may not yet have been put in writing, formally agreed upon, and executed by Contractor and DHCS.

If changes in federal or State law result in a material change to the Contract, the amendment may constitute grounds for termination of this Contract in accordance with Exhibit E, Subsection 1.1.16 (*Termination*). The parties will be bound by the terms of the amendment until the effective date of the termination.

B. Word Usage

Unless the context of this Contract clearly requires otherwise, (a) the plural and singular numbers will each be deemed to include the other; (b) the masculine, feminine, and neuter genders will each be deemed to include the others; (c) "shall," "will," "must," or "agrees" are mandatory, and "may" is permissive; (d) "or" is not exclusive; and (e) "includes" and "including" are not limiting.

C. Ambiguities

If it is necessary to interpret the text of this Contract to address potential ambiguities, all applicable laws may be used as aids in interpreting the Contract. However, DHCS and Contractor agree that any such applicable laws will not be interpreted to create additional contractual obligations upon either DHCS or Contractor, unless such applicable laws are expressly incorporated into this Contract in some section other than this Section. This Contract is the product of mutual negotiation, and if any ambiguities should arise in the interpretation of this Contract, both parties will be deemed authors of this Contract.

D. Unenforceable Provisions

In the event that any provision of this Contract is unenforceable or held to be unenforceable, then DHCS and Contractor agree that all other provisions of this Contract have force and effect and will not be affected thereby.

E. Timeliness

Time is of the essence in this Contract.

F. Entire Agreement

This written Contract, any amendments thereto, and DHCS guidance as identified in Exhibit E, Subsection 1.1.2 (*DHCS Guidance*), will constitute the entire agreement between the parties. No oral representations will be binding on either party unless such representations are put in writing and made an amendment to this Contract.

1.1.4 Assignments, Mergers, Acquisitions

Contractor is prohibited from assigning this Contract, either in whole or in part, without the express written consent of DHCS in the form of a formal written amendment signed by DHCS, Contractor, and the third-party assignee (See also, Exhibit A, Attachment III, Subsection 3.1.2 (*DHCS Approval of Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements).* Contractor must also obtain the express written consent of DHCS prior to entering into a merger or acquisition, whether or not Contractor is the merging party or the acquiring party.

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1.1.5 Independent Contractor

Contractor and their employees and agents, in the performance of this Contract, will act in an independent capacity and not as officers or employees or agents of DHCS.

1.1.6 Amendment and Change Order Process

A. General Provisions

The parties recognize that during the term of this Contract, the Medi-Cal managed care program is a dynamic program requiring ongoing changes to its operations and that the scope and complexity of changes will vary widely over the term of this Contract. Contractor must develop a system which has the capability to implement such changes in an orderly and timely manner. This is an essential contract performance obligation.

B. Proposal of Contract Changes

Except for required amendments pursuant to Exhibit E, Subsection 1.1.3.A (*Contract Interpretation*) should either party, during the life of this Contract, desire a change in this Contract, that change must be proposed in writing to the other party. The other party must acknowledge receipt of the proposal within ten calendar days of receipt of the proposal. The party proposing any such change will have the right to withdraw the proposal any time prior to acceptance or rejection by the other party. Any proposal must set forth an explanation of the reason and basis for the proposed change and the text of the desired amendment to this Contract.

1) Regardless of the party desiring the change, DHCS will be responsible for drafting the proposed amendment and providing it to Contractor for review and comment prior to the language being finalized and submitted to CMS for approval.

2) DHCS will determine Contractor's Capitation Payment rates for each Rating Period and, as necessary, subsequent revised rates for the same Rating Period, as stated in Exhibit B, Subsection 1.1.5 (*Determination and Redetermination of Capitation Payment Rates*).

C. Implementation of Contract Capitation Payments

DHCS may, at any time within the general scope of this Contract and by written notice, implement Capitation Payment rates through amendments to the Contract upon approval from CMS. Capitation Payment rates that

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are tied to proposed changes to the terms or requirements of the Contract effective within the Rating Period will be included in an amendment to the Contract.

D. Contractor's Obligation to Implement

Notwithstanding approval by CMS of proposed changes to this Contract, Contractor will comply with changes mandated by DHCS. In the case of changes mandated by regulations, statutes, federal guidelines, or judicial interpretation, Contractor must immediately begin implementation of any change proposed in an amendment to this Contract or through an APL. If DHCS implements an amendment or APL, Contractor must implement the required changes and accept current Capitation Payments as stated in Exhibit B, Section 1.5 (*Determination and Redetermination of Capitation Payment Rates*) while discussions relevant to any Capitation Payment rate adjustment, if applicable, are taking place.

1.1.7 Delegation of Authority

DHCS intends to implement this Contract through a single administrator, called the "DHCS Contracting Officer." The Director will appoint its DHCS Contracting Officer. The DHCS Contracting Officer, under the direction of the Director and on behalf of DHCS, will make all determinations and take all actions as are appropriate under this Contract, subject to the limitations of applicable federal and State laws and regulations. The DHCS Contracting Officer may delegate their authority to act to an authorized representative through written notice to Contractor.

Contractor will designate a single administrator (Contractor's Representative) to implement this Contract. Contractor's Representative, on behalf of Contractor, will make all determinations and take all actions as are appropriate to implement this Contract, subject to the limitations of the Contract, federal and State laws and regulations. Contractor's Representative may delegate their authority to act to an AR through written notice to the DHCS Contracting Officer. Contractor's Representative will be empowered to legally bind Contractor to all agreements reached with DHCS.

Contractor will designate Contractor’s Representative in writing and must notify the DHCS Contracting Officer in accordance with Exhibit E, Subsection 1.1.12 (*Notices*).

1.1.8 Authority of the State

A. Subject to federal and State laws and regulations, DHCS has sole authority to establish, define, and determine the reasonableness, necessity, level, and scope of Covered Services available under the Medi-Cal managed care program administered through this Contract or coverage for such benefits, or the eligibility of Members or Providers to participate in the Medi-Cal managed care program.

B. DHCS has sole authority to establish or interpret policy and its application related to administration of the Medi-Cal program.

C. Contractor must not make any limitations, exclusions, or changes in benefits or benefit coverage; any changes in definition or interpretation of benefits; or any changes in the administration of the Contract related to the scope of benefits, allowable coverage for those benefits; or eligibility of Members or Providers to participate in the program, without the express, written direction or approval of the DHCS Contracting Officer.

1.1.9 Fulfillment of Obligations

Contractor must not waive any covenant, condition, duty, obligation, or undertaking contained in or made a part of this Contract except by written agreement of the parties. Forbearance or indulgence in any other form or manner by either party in any regard whatsoever will not constitute a waiver of the covenant, condition, duty, obligation, or undertaking to be kept, performed or discharged by the party to which the same may apply. Until performance or satisfaction of all covenants, conditions, duties, obligations, and undertakings is complete, the other party will have the right to invoke any remedy available under this Contract, or under law, notwithstanding such forbearance or indulgence.

1.1.10 Obtaining DHCS Approval

A. DHCS Approval of Deliverables Prior to Commencement of Operations

Prior to commencement of operations, Contractor must obtain written approval from DHCS for all deliverables, including but not limited to protocols, policies, and procedures, set forth in Exhibit A, Attachment III, Article 7.0 (*Operations Deliverables and Requirements*).

B. DHCS Approval of Protocols, Policies, and Procedures

In addition to the deliverables identified in Exhibit A, Attachment III, Article 7.0 (*Operations Deliverables and Requirements*) of this Contract, DHCS

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reserves the right to review and approve or disapprove Contractor's protocols, policies, and procedures. DHCS may, from time to time, request changes to Contractor's existing protocols, policies, and procedures. DHCS will issue such requests through APLs or other similar instructions. The deliverables, protocols, policies, and procedures referenced in this Exhibit E, Subsections 1.1.10.A and B (*Obtaining DHCS Approval*), will be subject to the DHCS approval process set forth in Exhibit E, Subsection 1.1.10.C (*Obtaining DHCS Approval*), below.

C. DHCS Approval Process

Within 60 calendar days of receipt, DHCS will make all reasonable efforts to approve in writing Contractor's deliverables, protocols, policies, and procedures; provide Contractor with a written explanation of disapproval; or provide a written estimated date of completion of DHCS' review process.

If DHCS does not complete its review of submitted materials within 60 calendar days of receipt, or within the estimated date of completion of DHCS review, Contractor may elect to implement or use the materials at Contractor's sole risk and subject to possible subsequent disapproval by DHCS. This Exhibit E, Subsection 1.1.10.C (*Obtaining DHCS Approval*) will not be construed to imply DHCS approval of any materials that have not received written DHCS approval. This Section will not apply to Subcontractor Agreements, Downstream Subcontractor Agreements, or Network Provider Agreements subject to DHCS approval in accordance with Exhibit A, Attachment III, Subsection 3.1.2 (*DHCS Approval of Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements*).

1.1.11 Certifications

A. For each data submission required by 42 Code of Federal Regulations (CFR) section 438.604, Contractor must comply with the requirements of 42 CFR section 438.606 and APL 17-005. Contractor must submit its certification of compliance concurrently with the submission of its data, documentation or information pursuant to 42 CFR section 438.606(c). Contractor's certification(s) must be certified by Contractor's Chief Executive Officer (CEO); Chief Financial Officer (CFO); or an individual who reports directly to the CEO or CFO with delegated authority to sign for the CEO or CFO. Contractor's CEO or CFO is solely responsible for the truth, accuracy and completeness of Contractor's certification.

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1) Contractor's data submissions must be in a form and manner specified by DHCS:

   a) Encounter Data as set forth in 42 CFR section 438.604(a)(1); and

   b) Data used by the State to certify actuarial soundness of Capitation Payment rates as set forth in 42 CFR section 438.604(a)(2).

2) Medical Loss Ratio (MLR) data as set forth in 42 CFR section 438.604(a)(3);

3) Financial data regarding provisions against risk of insolvency as set forth in 42 CFR section 438.604(a)(4);

4) Documentation described in 42 CFR section 438.207(b) used to certify compliance with this Contract's requirements for accessibility and availability of services, including Network adequacy;

5) Contractor's information on ownership and control, including its Subcontractors, Downstream Subcontractors, and Network Providers, as set forth in 42 CFR sections 438.608(c)(2), 438.602(c), and 455.104;

6) The annual report of overpayment recoveries as required in 42 CFR section 438.608(d)(3);

7) Network Data as required in Exhibit A, Attachment III, Subsection 2.1.4 (*Network Provider Data Reporting*);

8) Documentation confirming compliance with this Contract's interoperability requirements and APL 22-026 that is certified by Contractor's CEO or CFO and in accordance with submission requirements in APL 17-005; and

9) Any other data, documentation, or information requested by DHCS relating to the performance of Contractor's obligations under this Contract.

B. The Contractor Certification Clauses (CCC) contained in the Department of General Services form document CCC 04/2017 are hereby incorporated by reference and made a part of this Contract by this reference as if attached hereto.

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1.1.12 Notices

All notices to be given under this Contract must be in writing and are deemed given when sent certified mailed or electronic mail (email) to DHCS or Contractor. DHCS and Contractor will designate email addresses for notices sent via email. Notices sent certified mail must be addressed to the following DHCS and Contractor addresses:

California Department of Health Care Services
Managed Care Operations Division

Attn: DHCS Contract Manager
MS 4407
P.O. Box 997413
Sacramento, CA 95899-7413

Orange County Health Authority, A Public Agency
dba CalOptima Health
Attn: Contractor Representative
505 City Parkway West
Orange, CA 92868

1.1.13 Term

A. The Contract will be effective January 1, 2024, and will continue in full force and effect through December 31, ~~2025~~**2026**, subject to Exhibit B, Subsection 1.1.1 (*Budget Contingency Clause*), CMS waiver approval, and Exhibit D(f), Section 9 (*Federal Contract Funds*).

B. If Contractor has not already commenced operations, the term of this Contract consists of the following three periods:

1) The Implementation Period;

2) The Operations Period; and

3) The Phaseout Period.

C. The Operations Period will commence at the conclusion of the Implementation Period, subject to DHCS acceptance of Contractor's readiness to begin the Operations Period. The term of the Operations Period is subject to the termination requirements of Exhibit E, Subsections 1.1.16 (*Termination*) and 1.1.19~~,~~ (*Sanctions*), and subject to the limitation provisions of Exhibit B, Subsection 1.1.1 (*Budget Contingency Clause*).

D. The Phaseout Period will commence on the date the Operations Period or Contract extension ends. The Phaseout Period will extend until all activities required during the Phaseout Period for each Service Area are fully completed to the satisfaction of DHCS, in its sole discretion.

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E. If Contractor has commenced operations as of the effective date of this Contract, the term of the Contract consists of the Operations Period and the Phaseout Period. The term of the Operations Period is subject to the termination requirements of Exhibit E, Subsections 1.1.16 (*Termination*) and 1.1.19 (*Sanctions*) below and subject to the limitation requirements of Exhibit B, Subsection 1.1.1 (*Budget Contingency Clause*).

1.1.14 Service Area

The Service Area covered under this Contract includes:

Orange County

Unless otherwise specified in this Contract, all Contract provisions apply separately to each Service Area. This Contract may expire for some Service Areas and remain in effect for others with each Service Area having its own Operations and Phaseout Periods.

1.1.15 Contract Extension

DHCS has the exclusive option to extend the term of the Contract for any Service Area during the last 12 months of the Contract, as determined by the original expiration date or by a new expiration date if an extension option has been exercised. Contractor will be given at least nine months prior written notice of DHCS' decision on whether it will exercise this option to extend the Contract for each Service Area.

Contractor will provide written notification to DHCS of its intent to accept or reject the Contract extension within five Working Days of the receipt of the notice from DHCS.

1.1.16 Termination

A. DHCS-Initiated Terminations

1) Mandatory Termination

a) DHCS must terminate this Contract in the event of any of the following:

i. The Secretary of the U.S. Department of Health & Human Services (U.S. DHHS) determines that Contractor does not meet the requirements for

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participation in the Medicaid program (42 United States Code (USC) section 1396);

ii. DMHC finds that Contractor no longer qualifies for licensure under the KKA (Health and Safety Code (H&S) section 1340 *et seq.*), if licensure is required; or

iii. The Director determines the health and welfare of Members is jeopardized by continuation of the Contract.

b) Termination pursuant to Subsection 1.16.A.1 (*Mandatory Termination*) will be effective immediately. Termination under this Section 1.16.A does not relieve Contractor of its obligations under Exhibit E, Section 1.17 (*Phaseout Requirements*).

2) Termination for Cause

a) DHCS may terminate this Contract and be relieved of any payments should Contractor fail to perform the requirements of this Contract. In the event of such termination, DHCS may proceed with providing the services required under this Contract in any manner deemed proper by DHCS. All costs to the State will be deducted from any sum due Contractor under this Contract and the balance, if any, will be paid to Contractor upon demand.

b) DHCS will provide Contractor with at least 60 calendar days' notice prior to the effective date of termination, unless Potential Member harm requires a shorter notice period. Contractor agrees that this notice provision is reasonable. Termination under this Subsection does not relieve Contractor of its obligations under Exhibit E, Subsection 1.1.17 (*Phaseout Requirements*).

c) DHCS will terminate this Contract under this Subsection, pursuant to the provisions of W&I section 14197.7 and 22 CCR section 53873.

d) Contractor may dispute termination decisions under this Exhibit E, Subsection 1.1.16 (*Termination*), through the

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dispute resolution process pursuant to Exhibit E, Subsection 1.1.21 (*Contractor's Dispute Resolution Requirements*).

3) Permissive Termination

Following a merger or acquisition involving Contractor in which Contractor did not obtain DHCS' express written consent pursuant to Exhibit E, Subsection 1.1.4 (*Assignments, Mergers, Acquisitions*), whether Contractor is the merging party or the acquiring party, DHCS, in its sole discretion, retains the right to terminate this Contract.

a) DHCS will provide written notice of termination to Contractor at least 60 calendar days prior to the effective date of termination.

b) Contractor must fully perform all Contract obligations prior to the effective date of termination. Contractor will not be entitled to additional reimbursement for the services provided following notice of termination until the termination effective date.

c) Termination under this Subsection does not relieve Contractor of its Phaseout Requirement obligations as stated in Exhibit E, Subsection 1.1.17 (*Phaseout Requirements*).

4) Termination Without Cause

a) DHCS may terminate this Contract and award a new contract for one or more of the Service Areas to another Medi-Cal managed care plan during one of the amendment periods as described in Exhibit E, Subsection 1.1.15 (*Contract Extension*).

b) Notwithstanding any other provision in this Contract, DHCS may terminate this Contract in whole or in part at any time at DHCS' sole discretion.

c) DHCS will notify Contractor of termination under this Exhibit E, Subsection 1.1.16 (*Termination*) at least six months prior to the effective date of termination to allow for all Phaseout Requirements to be completed.

B. Contractor-Initiated Terminations

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Contractor may only terminate this Contract under one or more of the following circumstances:

1) For Rating Periods subsequent to Calendar Year 2024, if Contractor does not accept the Capitation Payment rates determined by DHCS, or if DHCS decides to negotiate the Capitation Payment rates and the parties do not agree on the rates; or

2) When a change in contractual obligations is created by a State or federal change in the Medi-Cal program or a lawsuit that substantially alters the financial assumptions and conditions under which Contractor entered into this Contract, such that Contractor can demonstrate to the satisfaction of DHCS that it cannot remain financially solvent through the term of the Contract, the following will apply:

    a) Contractor will submit a detailed written financial analysis to DHCS supporting its conclusions that it cannot remain financially solvent. At DHCS' request, Contractor will submit or otherwise make available to DHCS all of Contractor's financial work papers, financial reports, financial books and other records, bank statements, computer records, and any other information requested by DHCS to evaluate Contractor's financial analysis;

    b) DHCS and Contractor may negotiate an earlier termination date than the termination date set forth in this Subsection 1.16.B, if Contractor can demonstrate to the satisfaction of DHCS that it cannot remain financially solvent until the termination date that would otherwise be established under this Subsection;

    c) Contractor must provide at least a six-month written notice of termination under this Exhibit E, Subsection 1.1.16 (*Termination*). The effective date of termination will be December 31 of the year in which Contractor gives notice, unless the date of notice is less than six months before December 31. In that event, termination under this Exhibit E, Subsection 1.1.16 (*Termination*) will be effective no earlier than December 31 of the following year.

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d) Termination under these circumstances does not relieve Contractor of its obligations as stated in Exhibit E, Subsection 1.1.17 (*Phaseout Requirements).*

C. Termination of Obligations

Contractor's obligations to provide Covered Services under this Contract or under any Contract extension terminate on the date the Operations Period ends.

D. Notice to Members of Transfer of Care

Following notice of termination by either DHCS or Contractor, notice to the Member will be directed by DHCS. Contractor will not send any notices to its Members regarding the termination unless it receives prior approval from DHCS.

1.1.17 Phaseout Requirements

A. DHCS will retain Capitation Payment for each Service Area from Contractor's Capitation Payment for the last four months of the Operations Period for each Service Area, or Contractor must provide a performance bond to DHCS of an equal amount, until all Directive Payment Initiatives and Supplemental Payments have been calculated and processed by DHCS and all activities required during the Phaseout Period for each Service Area are fully completed to the satisfaction of DHCS, in its sole discretion.

Upon DHCS' processing of all Directive Payment Initiatives and Supplemental Payments and the completion of all Phaseout Period activities for each Service Area, the withhold will be paid to Contractor or the performance bond will be released. If Contractor fails to meet any requirements of the Phaseout Period for each Service Area, DHCS will deduct the costs of the remaining activities from the withhold amount and continue to withhold payment until all activities are completed.

B. The objective of the Phaseout Period is to ensure that, in connection with the expiration or termination of this Contract, Contractor ensures an orderly transfer of necessary data and history records to DHCS or to a successor Medi-Cal managed care plan. Contractor will not provide services to Members during the Phaseout Period.

Within no later than 90 calendar days prior to termination or expiration of this Contract and through the Phaseout Period for each Service Area,

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Contractor must assist DHCS in the transition of Members and in ensuring, to the extent possible, continuity of Member-Provider relationships. In doing this, Contractor will make available to DHCS, without additional compensation, copies of each Member's Medical Records and files, and any other pertinent information, including information maintained by any Subcontractor, Downstream Subcontractor, or Network Provider, necessary to provide effected Members with case management and continuity of care. In no circumstances will a Medi-Cal Member be billed for this activity.

C. Phaseout for this Contract includes processing, payment, and monetary and data reconciliations necessary regarding Provider claims for Covered Services.

1) Phaseout for this Contract includes the completion of all financial and reporting obligations of Contractor. Contractor will remain liable for the processing and payment of invoices and other claims for payment for Covered Services and other services provided to Members prior to the expiration or termination of this Contract. Contractor must timely submit to DHCS all reports required in Exhibit A, Attachment III, Article 7.0 (*Operations Deliverables and Requirements*) for the period from the last submitted report through the expiration or termination date, and Contractor will be obligated to cooperate with DHCS with regard to the reconciliation of Contractor's Encounter Data Reporting and Network Provider Data Reporting for up to two years following the expiration or termination of this Contract.

2) All data and information provided by Contractor will be accompanied by a letter, signed by the responsible authority, certifying, under penalty of perjury, to the accuracy and completeness of the materials provided.

D. The Phaseout Period will commence on the date the Operations Period of the Contract or Contract extension ends. Phaseout related activities are non-payable obligations and services.

1.1.18 Indemnification

A. As a condition of entering into this Contract, Contractor agrees to indemnify, defend and hold harmless the State, DHCS and its officers, agents, and employees from any and all claims and losses accruing or resulting from any and all Network Providers, Subcontractors, Downstream Subcontractors, suppliers, laborers, and any other person,

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firm, or corporation furnishing or supplying work services, materials, or supplies in connection with the performance of this Contract, and from any and all claims and losses accruing or resulting to any person, firm or corporation who may be injured or damaged by Contractor in the performance of this Contract.

B. Contractor further agrees to indemnify, defend, and hold harmless the State, DHCS and its officers, agents, and employees from any and all claims and losses, any and all attorneys' fees and costs, judgments, damages, and any Administrative Costs incurred by DHCS or a Member from any and all litigation, arbitration or mediation resulting directly, indirectly, or arising out of Contractor's denial, delay, or modification of requested Covered Services.

C. Contractor further agrees to indemnify, defend, and hold harmless the State, DHCS and its officers, agents and employees from any and all claims and losses, any and all attorneys' fees and costs, including DHCS' defense costs, judgments, damages, any Administrative Costs incurred from claims that Contractor violated the Telephone Consumer Protection Act of 1991, 47 USC section 227 *et seq*., and/or related Federal Communications Commission regulations in the performance of this Contract.

D. Contractor further agrees to indemnify, defend and hold harmless the State, DHCS and its officers, agents and employees from any and all claims and losses, any and all attorneys' fees and costs, judgments, damages, any Administrative Costs incurred to the extent DHCS is required to provide notice to affected Members and Potential Members, and any other costs associated with any actual or alleged breach, by Contractor and any vendor, Subcontractor, Downstream Subcontractor, or Network Provider Contractor contracts with in the performance of this Contract, of the following statutes and regulations: the of the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 ("the HITECH Act"), 42 USC section 17921 *et seq.*, and their implementing privacy and security regulations at 45 CFR parts 160 and 164 and the Information Practices Act, and Civil Code (CC) section 1798 *et seq.* by Contractor.

E. DHCS is authorized to withhold any and all attorneys' fees and costs, judgments, damages, any Administrative Costs incurred pursuant to this indemnification agreement, from Contractor's next Capitation Payment or any other method to recoup DHCS' costs from Contractor.

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1.1.19 Sanctions

A. Contractor is subject to sanctions and civil penalties for the specific conduct set forth in 42 CFR sections 438.700, 438.702, 438.704, 438.706, and 438.708. DHCS is also authorized to impose additional sanctions on Contractor pursuant to 42 CFR section 438.702(b) as set forth in W&I section 14197.7, APL 23-012, and any other applicable law.

B. Monetary sanctions imposed pursuant to W&I section 14197.7 may be separately and independently assessed and may also be assessed for each day Contractor fails to correct an identified deficiency. For deficiencies that impact Members and Potential Members, each impacted Member or Potential Member constitutes a separate violation for the purposes of imposing a monetary sanction.

C. Good cause for imposing monetary sanctions includes but is not limited to a breach of this Contract, a violation of a legal obligation (including, but not limited to, obligations imposed by statute, regulation, APL, PL, or other DHCS Guidance), a finding of deficiency that results in an improper denial or delay in the delivery of health care services, potential endangerment of a Member's care, disruption in Contractor's Network, failure to approve continuity of care for a Member, failure to timely and correctly reimburse claims, or a delay in required reporting to DHCS. Further grounds for imposing sanctions include, but are not limited to, those set forth in 42 CFR section 438.700 et seq., W&I section 14197.7, and APL 23-012.

D. DHCS may identify findings of noncompliance or good cause through any means, including, but not limited to, findings in audits; investigations; contract compliance reviews; Quality Improvement System monitoring; routine monitoring; facility site surveys; Encounter Data submissions; Grievances and Appeals; Network adequacy reviews; assessments of timely access requirements; reviews of utilization data; health plan rating systems; State Hearing decisions; IMR decisions; complaints from Members, Providers, Network Providers, Subcontractors, Downstream Subcontractors, other stakeholders, or whistleblowers; and Contractor's self-disclosures.

E. Sanctions in the form of denial of payments provided for under this Contract for new Members will be taken, when and for as long as, payment for those Members is denied by CMS under 42 CFR section 438.730.

F. DHCS may also impose nonmonetary sanctions as set forth in 42 CFR section 438.700 et seq., W&I section 14197.7, APL 23-012, and any other applicable law.

G. DHCS is not required to impose a Corrective Action plan on Contractor before imposing any of the sanctions set forth in this Section or in State and federal law.

H. DHCS may impose sanctions in addition to any monetary damages recovered pursuant to Exhibit E, Subsection 1.1.20 (*Liquidated Damages*).

1.1.20 Liquidated Damages

A. If Contractor breaches this Contract, DHCS will be entitled to all legal and equitable remedies available under the law, including monetary damages in the form of actual, consequential, direct, indirect, special, and/or liquidated damages.

B. Contractor agrees that any breach of this Contract, including but not limited to a breach due to Contractor's delay in implementing new program requirements or plan readiness requirements or Contractor's failure to meet its Quality or Network Adequacy obligations, may result in damage to the State or DHCS that is difficult to quantify. In the event of such a breach, Contractor agrees that the Director is authorized to impose liquidated damages on Contractor in the amount of $25,000 for each separate and distinct breach in addition to liquidated damages in the amount of $25,000 for each day Contractor fails to remedy the breach, which the Parties agree bears a reasonable relationship to the range of actual damages the Parties anticipate would flow from such a breach.

C. Contractor acknowledges that DHCS' authority to impose monetary sanctions and other intermediate sanctions pursuant to 42 CFR section 438.700 *et seq*. and W&I section 14197.7, as set forth in Exhibit E, Subsection 1.1.19 (*Sanctions*), is separate and distinct, and that DHCS may recover damages for Contractor's breach, including liquidated damages, in addition to any sanctions imposed under Exhibit E, Subsection 1.1.19 *(Sanctions).*

1.1.21 Contractor's Dispute Resolution Requirements

Contractor must comply with and exhaust the requirements of this Section when it initiates a contract dispute with DHCS. This Exhibit E, Subsection 1.1.21 (*Contractor's Dispute Resolution Requirements*) does not apply to challenges to sanctions as described in Exhibit E, Subsection 1.1.19 *(Sanctions)* liquidated

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damages as described in Exhibit E, Subsection 1.1.20 *(Liquidated Damages)*, or any other contract compliance action initiated by DHCS. Contractor's filing of a Notice of Dispute, as defined in Paragraph B of this Section, does not preclude DHCS from withholding or recouping the value of the amount in dispute from Contractor, or from offsetting the amount in dispute from subsequent Capitation Payment(s).

A. Resolution of Dispute by Negotiation

Contractor agrees to make best efforts to resolve all alleged contractual issues by negotiation and mutual agreement at the DHCS Contracting Officer level before appealing to the DHCS Office of Administrative Hearings and Appeals (OAHA). Contractor must exhaust OAHA's appeal process before filing a writ in Sacramento County Superior Court. During the negotiations to resolve Contractor's issues, DHCS and Contractor may agree, in writing, to an extension of time for continuing negotiations to resolve Contractor's dispute before the decision of the DHCS Contracting Officer is issued.

B. Notice of Dispute

Within 30 calendar days from the date that the alleged dispute arises or otherwise becomes known to Contractor, Contractor must serve a written notice of dispute to the DHCS Contract Manager. Contractor's failure to serve its notice of dispute within 30 calendar days from the date the alleged dispute arises or otherwise becomes known to Contractor constitutes a waiver of all issues raised in Contractor's notice of dispute.

Contractor's notice of dispute must include, based on the most accurate information and substantiating documentation available to Contractor, the following:

1) That the dispute is subject to the procedures in this Exhibit E, Subsection 1.1.21 (*Contractor's Dispute Resolution Requirements*);

2) The date, nature, and circumstances of the alleged conduct that is subject of the dispute;

3) The names, phone numbers, functions, and conduct of every Subcontractor, Downstream Subcontractor, Network Provider, DHCS/State official or employee involved in or knowledgeable of the alleged issue(s) that is the subject of the dispute;

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4) The identification of any substantiating documents and the substance of any oral communications that are relevant to the alleged conduct;
5) Copies of all substantiating documentation and any other evidence attached to its notice of dispute;

6) The factual and legal bases supporting Contractor's notice of dispute;

7) The cost impact to Contractor directly attributable to the alleged conduct, if any; and

8) Contractor's desired remedy.

After Contractor submits its notice of dispute with all accurate available substantiating documentation, Contractor must comply with 22 CCR section 53851(d) and diligently continue performance of its obligations under this Contract, including compliance with contract requirements that are the subject of, or related to, Contractor's notice of dispute.

If Contractor requests and DHCS agrees, Contractor's notice of dispute may be decided by an alternate dispute officer (ADO). DHCS will designate an ADO who was not directly involved in the alleged conduct that prompted Contractor's notice of dispute.

Any appeal of the DHCS Contracting Officer's decision to OAHA or a writ seeking review of OAHA's decision in Sacramento County Superior Court is limited to the issues and arguments set forth and properly documented in Contractor's notice of dispute, that were not waived or resolved.

C. Timeframes

The DHCS Contracting Officer or ADO will have 90 calendar days to review Contractor's initial notice of dispute and available substantiating documentation and issue a decision unless there is a written agreement between DHCS and Contractor to extend that time. If the DHCS Contracting Officer or ADO determines that additional substantiating documentation is required, they will provide Contractor with a written request identifying the issue(s) requiring additional supporting documentation. Contractor must provide that additional substantiating documentation no later than 30 calendar days from receipt of the request.

Unless Contractor and the DHCS Contracting Officer or ADO agree to an extension of time, in writing, Contractor's failure to provide additional

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substantiating documentation, or otherwise notify the DHCS Contracting Officer or ADO that no additional documents exist, within 30 calendar days from the request, constitutes Contractor's waiver of all issues raised in Contractor's notice of dispute.

Issues raised by Contractor in the notice of dispute will be decided by the DHCS Contracting Officer or the ADO within 90 calendar days from receipt of Contractor's substantiating documentation or within 60 calendar days from receipt of all additionally requested substantiating documentation from Contractor, whichever is later.

D. The DHCS Contracting Officer's or ADO's Decision

1) If the DHCS Contracting Officer or the ADO finds in favor of Contractor, they may:

a) Correct the conduct which prompted Contractor's notice of dispute; or

b) Require performance of the disputed conduct and, if there is a cost impact sufficient to constitute a material change in obligations pursuant to the payment provisions under Exhibit B, Subsection 1.1.1 (*Budget Contingency Clause*), direct DHCS to comply with that Exhibit. In the event of such a finding DHCS will not owe interest on any underpayment found due and owing pursuant to the notice of dispute.

2) If DHCS' Contracting Officer or the ADO denies Contractor's notice of dispute, they are authorized to direct the manner of Contractor's future contractual performance.

E. Appeal of the DHCS Contracting Officer's or ADO's Decision

1) Contractor will have 30 calendar days following the receipt of DHCS Contracting Officer's or ADO's decision to appeal the decision to the Director, through OAHA. All of Contractor's appeals will be governed by H&S section 100171, except Government Code (GC) section 11511 relating to depositions will not apply. The venue of OAHA appeals will be in Sacramento.

2) All of Contractor's appeals must be in writing and must be filed with OAHA and a copy sent to the Chief Counsel of DHCS and DHCS Contract Manager. Contractor's appeal will be deemed filed on the date it is received by OAHA. Contractor's appeal must specifically

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set forth the unresolved issues that remain in dispute and issues that have not been waived because of Contractor's failure to provide all substantiating documentation to DHCS, as specified in Exhibit E, Subsection 1.1.21 (*Contractor's Dispute Resolution Requirements*). Additionally, Contractor's appeal is solely limited to the issues raised in its notice of dispute that have not been resolved or waived.

3) Contractor has the burden of proof of demonstrating that its position is correct and must show by a preponderance of evidence that:

   a) DHCS acted improperly such that it breached this Contract; and

   b) Contractor sustained a cost impact directly related to DHCS' breach.

4) OAHA's jurisdiction is limited to issues and arguments raised in the notice of dispute that were not waived either by the untimely filing of the notice of dispute or statement of disputed issues, or by Contractor's failure to provide all requested substantiating documentation requested by DHCS Contracting Officer or ADO or otherwise resolved by Contractor and DHCS.

5) Contractor's failure to timely appeal the decision to OAHA constitutes a waiver by Contractor of all issues raised in Contractor's notice of dispute. This waiver of claims also precludes the filing of a writ in Sacramento Superior Court, or any other court.

F. No Obligation to Pay Interest

If Contractor prevails on its notice of dispute pursuant to a DHCS Contracting Officer's or ADO's decision, an OAHA decision, or an order or decision issued by any State or federal court, including any State or federal court of appeal, or any order, decision, opinion, or award issued in any other forum, DHCS will not be required to pay interest on any amounts found to be due or owing to Contractor arising out of the notice of dispute.

G. Contractor's Duty to Perform

Contractor must comply with all requirements of 22 CCR section 53851(d) and all obligations under this Contract, including continuing Contract requirements that are the subject of, or related to, Contractor's notice of

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dispute until there is a final decision from the DHCS Contracting Officer, the ADO or a decision on an appeal in Sacramento County Superior Court.

H. Waiver of Claims

Contractor waives all claims or issues if it fails to timely submit a notice of dispute with all substantiating documents within the timeframes noted in Subsection 1.1.21.C, above. Contractor also waives all claims or issues set forth in its notice of dispute if it fails to timely submit all additional substantiating documentation within 30 calendar days of the DHCS Contracting Officer's or ADO's request, or if it fails to timely appeal the DHCS Contracting Officer's or ADO's decision in the manner and within the time specified in this Subsection 1.1.21. Contractor's waiver includes all damages whether direct or consequential in nature.

1.1.22 Inspection and Audit of Records and Facilities

A. Recordkeeping Requirements

1) Records to be Maintained

Contractor must maintain all records and documents necessary to disclose how Contractor discharges its obligations under this Contract. These records and documents will disclose the quantity of Covered Services provided under this Contract, the quality of those services, the manner and amount of payment made for those services, the persons eligible to receive Covered Services, the manner in which Contractor administered its daily business, and the cost thereof.

Contractor must maintain all working papers, reports submitted to (DHCS, DMHC, Division of Medi-Cal Fraud & Elder Abuse (DMFEA), United States Department of Health & Human Services (U.S. DHHS), and United States Department of Justice (US DOJ), financial records, books of account, Medical Records, prescription files, laboratory results, Subcontractor Agreements, Downstream Subcontractor Agreements, and Network Provider Agreements, information systems and procedures, and any other documentation pertaining to medical and non-medical services rendered to Members.

In addition, and in accordance with 42 CFR section 438.3(u), Contractor must retain the following information for no less than ten years and allow auditing entities to inspect and audit:

a) Member Grievance and Appeal records as required in 42 CFR section 438.416;

b) Base data as defined in 42 CFR section 438.5(c);

c) MLR reports as required in 42 CFR section 438.8(k); and

d) Data, information, and documentation specified in 42 CFR sections 438.604, 438.606, 438.608, and 438.610.

2) Records Retention Period

Notwithstanding any other records retention time period set forth in this Contract, Contractor must maintain all records and documents described in this Exhibit E, Subsection 1.1.22 (*Inspection and Audit of Records and Facilities*) for a minimum of ten years from the final date of the Phaseout Period or from the date of completion of any audit, whichever is later, in accordance with 42 CFR sections 438.3(h) and (u) and 438.230(c).

B. Right to Audit and Inspect Records and Facilities

1) Authorized Agencies

Contractor agrees that the following agencies, including but not limited to, DHCS, the Centers for Medicare & Medicaid Services (CMS), U.S. DHHS, U.S. DHHS Office of the Inspector General, the Comptroller General of the United States, US DOJ, DMFEA, DMHC, the External Quality Review Organization (EQRO) contractor, and all other agencies authorized under State and federal law (authorized agencies), and their duly authorized representatives or designees, will have the right to audit and inspect the records **and** documents in the form or manner in which the authorized agencies request, and facilities of Contractor, and its Subcontractors, Downstream Subcontractors, and Network Providers.

2) Right to Audit and Inspect at Any Time

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DHCS, and its designees, and other authorized agencies and their designees, may, at any time, inspect and audit any and all records, documents, contracts, computers, or other electronic systems maintained by Contractor, and its Subcontractors, Downstream Subcontractors, and Network Providers in the form or manner in which the authorized agencies request, and may, at any time, inspect the premises, facilities, and equipment pertaining directly or indirectly to the delivery of Medi-Cal services pursuant to 42 CFR sections 438.3(h) and (u) and 438.230(c), and other applicable State and federal law.

3) Scope of Inspection

DHCS and other authorized agencies may, at any time, audit, inspect, and monitor, Contractor, and its Subcontractors, Downstream Subcontractors, and Network Providers, to assure compliance with any provision of this Contract; evaluate the quality, appropriateness, and timeliness of services performed under this Contract; and for any other reasonable purpose.

Upon request, and through the end of the records retention period specified in Exhibit E, Subsection 1.1.22.A.2 (*Inspection and Audit of Records and Facilities*), Contractor must furnish any record, or copy of it, to DHCS or any other auditing entity listed in this Exhibit E, Subsection 1.1.22 (*Inspection and Audit of Records and Facilities*), at Contractor's sole expense.

4) Right to Audit and Inspect Exists for Ten Years

The right to audit and inspect under this this Exhibit E, Subsection 1.1.22 (*Inspection and Audit of Records and Facilities*) exists for ten years from the final date of the Contract Phaseout Period or from the date of completion of any audit, whichever is later, in accordance with 42 CFR sections 438.3(h) and (u) and 438.230(c).

5) Additional Facility Inspection Rights

In addition to Exhibit D(f), Section 8 (*Site Inspection*) in order to ensure compliance with this Contract, and for any other reasonable purpose, Contractor agrees to the following:

a) DHCS, and its authorized representatives and designees, and authorized agencies, and their authorized representatives and designees, will have the right to access

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the premises and facilities of Contractor, and the premises and facilities of its Subcontractors, Downstream Subcontractors, and Network Providers, with or without notice, including, but not limited to, the management information systems operations site or such other places where duties and obligations under the Contract are performed.

b) Staff designated by DHCS, and the designated staff of other authorized agencies, must be provided access to security areas of all Contractor, and its Subcontractors, Downstream Subcontractors,' and Network Providers, . Contractor must provide, and must require any and all of its Subcontractors, Downstream Subcontractors, and Network Providers to provide, reasonable cooperation and assistance to auditing representatives in the performance of their duties.

c) DHCS may conduct unannounced inspections and audits of the premises and facilities of Contractor, and its Subcontractors, Downstream Subcontractors, and Network Providers, selected at DHCS' sole discretion, to verify compliance of these sites with DHCS requirements.

1.1.23 Confidentiality of Information

In addition to Exhibit D(f), Section 14 (*Confidentiality of Information*), Contractor also agrees to the following duties and responsibilities with respect to confidentiality of information and data:

A. Notwithstanding any other provision of this Contract, names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with 42 CFR section 431.300 *et seq.*, W&I section 14100.2, and regulations adopted thereunder. For the purpose of this Contract, all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to Members will be protected by Contractor.

Contractor may release Medical Records in accordance with applicable law pertaining to the release of this type of information. Contractor is not required to report to DHCS requests for Medical Records made in accordance with applicable law, unless the law requires such reporting.

B. With respect to any identifiable information obtained by Contractor, or its Subcontractors, Downstream Subcontractors, or Network Providers,

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concerning a Member under this Contract, Contractor will ensure the following:

1) Any such information will not be used for any purpose other than carrying out the express terms of this Contract;

2) All requests for disclosure of such information will be promptly transmitted to DHCS, except requests for Medical Records in accordance with applicable law;

3) Any such information will not be disclosed, except as otherwise specifically permitted by this Contract, to any party other than DHCS without DHCS' prior written authorization specifying that the information is releasable under 42 CFR section 431.300 *et seq.*, W&I section 14100.2, and regulations adopted thereunder; and

4) At the termination of this Contract, the return all such information to DHCS or maintain such information as directed by DHCS.

C. Contractor will have provisions in its Subcontractor Agreements and Network Provider Agreements requiring Subcontractors, Downstream Subcontractors, and Network Providers to comply with this Exhibit E, Subsection 1.1.23 (*Confidentiality of Information*).

1.1.24 Pilot Projects

DHCS may establish pilot projects to test alternative managed care models tailored to suit the needs of populations with special health care needs. The operation of these pilot projects may result in the disenrollment of Members that participate. Implementation of a pilot project may affect Contractor’s obligations under this Contract. Any changes in the obligations of Contractor that are necessary for the operation of a pilot project in Contractor’s Service Area will be implemented through a contract amendment.

1.1.25 Cost Avoidance and Post-Payment Recovery of Other Health Coverage

A. Contractor must Cost Avoid or make a Post-Payment Recovery **(**PPR) for the reasonable value of services paid by Contractor and rendered to a Member whenever a Member's Other Health Coverage (OHC) covers the same services, fully or partially. However, in no event may Contractor Cost Avoid or seek PPR for the reasonable value of services from a Third-Party Tort Liability (TPTL) action or make a claim against the estates of deceased Members.

B. Contractor must, at a minimum, utilize the Medi-Cal eligibility record for Cost Avoidance and PPR purposes.

C. Contractor retains all monies for PPR when Contractor initiates and completes recovery within 12 months from the date of payment of a service. Any monies for PPR obtained after the 12 months following the date of payment of a service are considered Medi-Cal recoveries and must be remitted to DHCS.

D. If Contractor initiates an active repayment plan with Network Providers or third-party insurance carriers that is agreed upon prior to, and extends beyond 12 months from, the date of payment of a service, Contractor will be allowed to retain the recovered monies.

E. Contractor must coordinate benefits with other coverage programs and entitlements, recognizing the OHC as primary and the Medi-Cal program as the payer of last resort, except for services in which Medi-Cal is required to be the primary payer.

F. If Contractor does not perform PPR for a Member with OHC, Contractor must demonstrate to DHCS, upon request, that the cost of PPR exceeds the total Contract Revenues Contractor projects it would receive from such activity.

G. Cost Avoidance

1) Contractor must not pay claims for services provided to a Member whose Medi-Cal eligibility record indicates third-party coverage, designated by an OHC code or Medicare coverage, without proof that the Provider has first exhausted all sources of other payments. Acceptable forms of proof that all sources of payment have been exhausted or do not apply include a denial letter from the OHC for the service, an explanation of benefits indicating that the service is not covered by the OHC, or documentation demonstrating that Provider has billed the OHC and received no response for at least 90 calendar days.

2) Contractor must ensure that Providers do not refuse to provide Covered Services to Members, when OHC is indicated on a Member’s Medi-Cal eligibility record.

3) Contractor must allow Providers to direct bill services that meet DHCS' requirements for direct billing without attempting to Cost Avoid those services. Cost Avoidance is not required prior to payment for services provided to Members with OHC codes A or N. More information on services that qualify for direct billing can be found in the Medi-Cal Provider Manual, Part 2 – General Medicine, section "Other Health Coverage (OHC): CPT-4 and HCPCS Codes (oth hlth cpt)".

4) Prior to delivering services, Contractor must ensure that Providers review the Member's Medi-Cal eligibility record for third-party coverage, designated by OHC or Medicare coverage code. If the Member's Medi-Cal eligibility record indicates OHC and the requested service is covered by OHC, Contractor must ensure that Providers notify the Member to seek the service from OHC.

5) When Contractor denies a claim due to OHC, Contractor must include OHC information in its notice of claim denial to Provider. OHC information includes, but is not limited to, the name of the OHC or Medicare carrier, and contact or billing information of the OHC.

H. Reporting Requirements for Cost Avoidance

Contractor must report new OHC information not found on the Medi-Cal eligibility record or that is different from what is reflected on the Medi-Cal eligibility record to DHCS within ten calendar days of discovery. Contractor must report discrepancies in the Medi-Cal record by either completing and submitting an OHC removal or addition form found online at https://www.dhcs.ca.gov or reporting OHC information to DHCS in batch updates. Batch updates regarding OHC information are processed by DHCS on a weekly basis. Contractor may contact its DHCS Contract Manager for more information regarding this process.

I. Post-Payment Recovery

1) Contractor must pay Provider's claim and then seek to recover the cost of the claim by billing the liable third parties in either of the following circumstances:

a) The Member had OHC code A on their Medi-Cal eligibility record at the time of service; or

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b) For services defined by DHCS as preventive pediatric services.

2) When Contractor discovers that a service was provided to a Member with OHC designated in the Medi-Cal eligibility record, and Contractor did not properly Cost Avoid the service, then Contractor must bill the OHC for the cost of actual services rendered. If OHC is discovered retroactively, Contractor must also bill the OHC for the cost of actual services rendered.

3) Contractor must bill the liable OHC for the cost of services provided to Members. Billing and recoupment must be completed within 12 months from the date of payment of a service.

4) Monies recovered by DHCS or DHCS' contracted recovery agent starting on the first day of the 13th month after the date of payment of a service will be retained by DHCS.

J. Reporting Requirements

Contractor must submit a monthly PPR Report to DHCS via Secure File Transfer Protocol (SFTP) by the 15th day of each month in a format specified by DHCS in APLs. This report must contain claims and recovery information and any other information specified by DHCS in APLs.

K. Contractor must have written policies and procedures implementing all of the requirements of this Subsection 1.1.25 (*Cost Avoidance and Post-Payment Recovery of Other Health Coverage*).

1.1.26 Third-Party Tort and Workers' Compensation Liability

Contractor must not make a claim for recovery of the value of Covered Services rendered to a Member in cases or instances involving casualty insurance, tort, Workers' Compensation, or class action claims. Contractor's failure to comply with this provision is non-delegable. In the event that Contractor's failure to comply with this provision negatively impacts DHCS' ability to recover its full statutory lien, DHCS reserves the right to deduct any losses from Contractor's Capitation Payments. To assist DHCS in exercising DHCS' exclusive responsibility for recovering casualty insurance, tort, Workers' Compensation, or class action claims, Contractor must meet the following requirements:

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A. Within 30 calendar days of DHCS' request, submit all requested service and utilization information and, when requested, copies of paid invoices/claims for its Members, including information from Network Providers, out-of-Network Providers, Subcontractors, and Downstream Subcontractors. Service and utilization information and copies of paid invoices/claims must set out any services provided by Contractor, including, but not limited to, physical, mental, and dental health services. Records must include services provided on a Fee-For-Service, capitated basis, and any other payment arrangements, regardless of whether a payment was made or denied. The reasonable value of the services must be calculated as the usual, customary, and reasonable charge made to the general public for similar services, or the amount paid to Network Providers or out-of-Network Providers for similar services. No additional payment will be made to Contractor for compliance with this provision.

B. Submit the requested service and utilization information and paid invoices/claims in a form and manner specified by DHCS through DHCS designated SFTP, in compliance with the electronic format and process, as set forth in APLs . Contractor must include the attestation in a form and manner specified by DHCS signed by the custodian of records or a designee with knowledge of the Member Information provided to DHCS, as set forth in APLs.

C. Notify DHCS using the appropriate online notification form at the Third Party Liability and Recovery Division Online Forms page, https://dhcs.ca.gov/PIForms, within ten calendar days of receiving a request from attorneys, insurers, or Members for a lien, pursuant to DHCS' recovery rights. These requirements do not relieve Contractor of other legal duties to Contractor's Members or other entities, including, without limitation, the duty to respond to Members' requests for their own Protected Health Information pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

D. Use the TPLManagedCare@dhcs.ca.gov inbox for all communications regarding Contractor's service and utilization information and copies of paid invoices/claims file submissions, to submit questions or comments related to the preparation and submission of these reports, and for issues related to accessing the SFTP folders.

E. Have written policies and procedures implementing all of the requirements of this Exhibit E, Subsection 1.1.26 (*Third-Party Tort and Workers' Compensation Liability*).

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1.1.27 Litigation Support

A. Records

Upon request by DHCS, Contractor must timely gather, preserve, and provide, in the form and manner specified by DHCS, any information, subject to any lawful privileges, in the possession of Contractor or its Subcontractors, Downstream Subcontractors, or Network Providers , relating to threatened or pending litigation by or against DHCS. If Contractor asserts that any requested documents are covered by a lawful privilege, Contractor must:

1) Sufficiently identify the claimed privileged documents to reasonably identify the documents; and

2). State the privilege being claimed that supports withholding production of the document.

Contractor agrees to promptly provide DHCS with a copy of any documents provided to any party in any litigation by or against DHCS. Contractor acknowledges that time is of the essence in responding to such a request. Contractor will use its best efforts to immediately notify DHCS of any subpoenas, document production requests, or requests for records received by Contractor or its Subcontractors, Downstream Subcontractors, or Network Providers related to this Contract or the Subcontractor Agreements, Downstream Subcontractor Agreements, and Network Provider Agreements entered into under this Contract.

B. Document Authentication and Testimony

Contractor will make its personnel and employees available to DHCS to authenticate documents, provide testimony as a witness, act as a “person most knowledgeable,” and assist in other ways as requested by DHCS, in connection with litigation, Public Record Acts requests, subpoenas, inquiries, and/or audits by federal and State agencies and departments, and inquiries by third-parties, as requested by DHCS. No additional payments will be paid to Contractor for the activities described in this Exhibit E, Subsection 1.1.27 (*Litigation Support*).

1.1.28 Equal Opportunity Employer

Contractor must comply with all applicable federal and State employment discrimination laws. Contractor, must:

A. In all solicitations or advertisements for employees placed by or on behalf of Contractor, state that it is an equal opportunity employer;

B. Send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding, a DHCS-approved notice, advising the labor union or workers' representative of its commitment as an equal opportunity employer and post copies of the notice in conspicuous places available to employees and applicants for employment;

C. Not unlawfully discriminate against any employee or applicant for employment because of race, religious creed, color, national origin, ancestry, physical disability, mental disability, medical condition, genetic information, marital status, sex, gender, gender identity, gender expression, age, sexual orientation, or military and veteran status;

D. Ensure that the evaluation and treatment of its employees and applicants for employment are free of such discrimination and comply with the provisions of the Fair Employment and Housing Act (GC §12900 *et seq*.), and the applicable regulations promulgated thereunder (2 CCR § 11000 *et seq.*). The applicable regulations of the Fair Employment and Housing Council implementing GC section 12990, set forth in Subchapter 5 of Division 4.1 of Title 2 of the California Code of Regulations are incorporated into this Contract by reference and made a part hereof as if set forth in full;

E. Give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement; and

F. Include the nondiscrimination and compliance provisions of this clause in all contracts to perform work under the Contract, in accordance with 2 CCR section 11105.

1.1.29 Federal and State Nondiscrimination Requirements

Contractor must:

A. Comply with federal nondiscrimination requirements in Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972; the Age Discrimination Act of 1975; Sections 504 and 508 of the Rehabilitation Act of 1973, as amended; Titles II and III of the Americans with Disabilities Act of 1990, as amended; Section 1557 of the Patient Protection and Affordable Care Act of 2010; and federal implementing

regulations promulgated under the above-listed statutes; and

B. Comply with California nondiscrimination requirements, including, without limitation, the Unruh Civil Rights Act, GC sections 7405 and 11135, W&I section 14029.91, and State implementing regulations.

1.1.30 Discrimination Prohibitions

A. Member Discrimination Prohibition

Contractor must not unlawfully discriminate against Members or Potential Members on the basis of any characteristic protected under federal or State nondiscrimination law, including sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, or identification with any other persons or groups defined in Penal Code section 422.56, in accordance with the statutes identified in Exhibit E, Subsection 1.1.29 (*Federal and State Nondiscrimination Requirements*) above, rules and regulations promulgated pursuant thereto, or as otherwise provided by law. For the purpose of this Contract, discrimination includes, but is not limited to, unlawfully:

1) Denying any Member Covered Services or availability of a Facility;

2) Providing a Member with any Covered Service that is different, or is provided in a different manner or at a different time from that which is provided to other Members under this Contract except where medically indicated;

3) Subjecting a Member to segregation, separate treatment, or harassment in any manner related to the receipt of any Covered Service;

4) Restricting or harassing a Member in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any Covered Service; treating a Member or Potential Member differently from others in determining whether they satisfy any admission, Enrollment, quota, eligibility, membership; or adding other requirements or conditions which Members must meet in order to be provided any Covered Service;

5) Assigning times or places for the provision of services on the basis of the sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, or identification with any other persons or groups defined in Penal Code section 422.56, to the Members to be served;

6) Utilizing criteria or methods of administration which have the effect of subjecting individuals to discrimination;

7) Failing to make Auxiliary Aids available, or to make reasonable accommodations in policies, practices, or procedures, when necessary to avoid discrimination on the basis of disability; and

8) Failing to ensure meaningful access to programs and activities for Limited English Proficient (LEP) Members and Potential Members.

B. Member Affirmative Action

Contractor must take affirmative action to ensure that Members are provided Covered Services without regard to sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, or identification with any other persons or groups defined in Penal Code section 422.56, except as needed to provide equal access to LEP Members or Members with disabilities, or where medically indicated. For the purposes of this Section, genetic information includes the carrying of a gene which may, under some circumstances, be associated with disability in that person's offspring, but which causes no adverse effects on the carrier. Such genes will include, but are not limited to, Tay-Sachs trait, sickle cell trait, thalassemia trait, and X-linked hemophilia.

C. Discrimination Related To Health Status

Contractor must not discriminate against Members or Potential Members on the basis of their health status or requirements for health care services during Enrollment, re-Enrollment or disenrollment. Contractor must not terminate the Enrollment of a Member based on an adverse change in the Member’s health.

1.1.31 Small Business Participation and Disabled Veteran Business Enterprises Reporting Requirements

A. Contractor must comply with applicable requirements of California law relating to Disabled Veteran Business Enterprises (DVBE) commencing at Public Contract (PC) Code section 10230.

B. If for this Contract, Contractor made a commitment to achieve small business participation, then Contractor must annually and within 60 calendar days of receiving final payment under this Contract report to DHCS the actual percentage of small business participation that was achieved (GC § 14841).

C. If for this Contract, Contractor made a commitment to achieve DVBE participation, then Contractor must annually and within 60 calendar days of receiving final payment under this Contract certify in a report to DHCS:

1) The total amount Contractor received under the Contract;

2) The name and address of the DVBE(s) that participated in the performance of the Contract;

3) The amount each DVBE received from Contractor;

4) That all payments under the Contract have been made to the DVBE; and

5) The actual percentage of DVBE participation that was achieved. (Military and Veterans Code § 999.5(d); GC § 14841

1.1.32 Conflict of Interest Avoidance Requirements

Contractor will comply with all requirements relating to Contractor's obligations to avoid conflicts of interest as described in Exhibit H (*Conflict of Interest Avoidance Requirements*).

1.1.33 Guaranty Provision

If Contractor is a subsidiary of another entity, Contractor must submit a guaranty from any entity in Contractor's chain of ownership that is publicly traded. If no such parent entity is publicly traded, the guaranty must be submitted by a parent entity at a level in the chain of ownership that is acceptable to DHCS. The guaranty must meet all requirements set forth in Exhibit I (*Contractor's Parent Guaranty Requirements*) of this Contract and be

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in a form satisfactory to DHCS, and provide for the full and prompt performance of all covenants, terms and conditions, and agreements throughout the term of the Contract.

1.1.34 Priority of Provisions

In the event of a conflict between the provisions of Exhibit D(f) (*Special Terms and Conditions*) and any other Exhibits of this Contract, the provisions in the other Exhibits will prevail over the provisions in Exhibit D(f). Additionally, where Exhibit D(f) contains provisions on the same subject matter as a provision in another Exhibit of this Contract, the language in the other Exhibit preempt and prevail over the language in Exhibit D(f).

In the event of a conflict between any Article summary (Articles 2.0, 3.0, 4.0, 5.0, 6.0, and 7.0) and a more specific term in this Contract, the more specific term will prevail over the Article summary.

1.1.35 Additional Incorporated Provisions – Proposals

Any and all final Proposals, including Exhibits and Attachments (collectively referred to as “Proposal”), submitted by Contractor in response to the Request for Proposal 20-10029 (RFP), or any subsequent Requests for Proposal in connection with any managed care contract, are hereby incorporated by reference into this Contract. DHCS is relying on Contractor’s representations in Contractor’s Proposal in awarding contracts, and, accordingly, DHCS may enforce such representations against Contractor, including, but not limited to, representations that it will perform in a certain manner, provide enhanced services, and/or meet more stringent requirements than those required in the Contract. Contractor is required to obtain written approval from DHCS before implementing any such enhanced services or requirements reflected in Contractor’s Proposal. In the event the Proposal(s) does not address Contract requirements, the Contract will govern.

1.1.36 Miscellaneous Provisions

A. Antitrust Claims

By signing this Contract, Contractor hereby certifies that if these services or goods are obtained by means of a competitive bid, Contractor must comply with the Antitrust Claims requirements of the GC sections 4550 *et seq.*.

B. Child Support Compliance Act

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Contractor recognizes the importance of Child and family support obligations and must fully comply with all applicable State and federal laws relating to Child and family support enforcement (Chapter 8 (commencing with section 5200) of Part 5 of Division 9 of the Family Code).

C. Priority Hiring Considerations

Contractor must give priority consideration in filling vacancies in positions funded by the Contract to qualified recipients of aid under W&I section 11200 in accordance with PC section 10353.

D. Interoperability

1) Contractor must comply with the CMS Interoperability and Patient Access Final Rule, as set forth in 42 CFR sections 406, 407, 422, 423, 431, 438, 457, 482 and 485, and 45 CFR section 156.

2) Contractor must ensure that its contracted hospitals comply with the electronic notification requirements as set forth in 42 CFR section 482.24(d).

3) Contractor must participate in the California Health and Human Services Data Exchange Framework to exchange health information or provide access to health information to and from various entities in real time as set forth in H&S section 130290.

E. Electronic Visit Verification

All Network Providers who are eligible must comply with Electronic Visit Verification (EVV) requirements.

1) Contractor must collaborate with DHCS, and take action as required by DHCS, to comply with and ensure that its Subcontractors, Downstream Subcontractors, and Network Providers comply with federal requirements for Electronic Visit Verification (EVV) set forth in 42 USC section 1396b(l) and with State requirements for EVV set forth in W&I section 14043.51, Section 12006(a) of the Federal Cures Act, and APL 22-014.

2) Contractor must implement and ensure that its applicable Subcontractors, Downstream Subcontractors, and Network Providers implement a State-approved EVV solution, as required, for personal care services and home health care services provided in a Member's home.

3) Contractor must verify that all Network Providers capture and transmit the following six mandatory data components when providing Personal Care Services and Home Health Care Services in a Member's home:

   a) The type of service performed;

   b) The individual receiving the service;

   c) The date of the service;

   d) The location of service delivery;

   e) The individual providing the service; and

   f) The time the service begins and ends.

4) Contractor must monitor and ensure all Network Providers comply with the EVV requirements when rendering personal care services and home health care services, subject to federal EVV requirements in accordance with APL 22-014 and the established guidelines below:

   a) Monitor providers for compliance with the EVV requirements and Information Notice(s), and alert DHCS to any compliance issues.

   b) Supply Providers with technical assistance and training on EVV compliance.

   c) Require Providers to comply with an approved corrective action plan.

   d) Deny payment if the Provider is not complying with EVV requirements and arrange for Members to receive services from a Provider who does comply.

1.1.37 Data Sharing

A. General Statement

Contractor must transfer all data in compliance with the terms of this Contract, including but not limited to the requirements of Exhibit G (*Business Associate Addendum*). Nothing in this Contract is exhaustive,

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exclusive, or limiting of DHCS' ability to provide data to Contractor or receive data from Contractor should DHCS determine, in its sole discretion, that the data is necessary and appropriate for Contractor to perform its duties under this Contract.

B. Post-Termination/Expiration Transactions; Survival of Terms

When this Contract terminates or expires, Contractor must continue to exchange data in order to facilitate an orderly phaseout of Contract requirements including, but not limited to, data sharing in connection with continuity of care for Members, Encounter Data reconciliation, Network Provider Data Reporting, and payment reconciliation. These phaseout transactions will require the transfer of data between Contractor and DHCS, including Protected Health Information (PHI) and other potentially sensitive data. To facilitate the safe and secure transfer of data, all requirements of this Contract pertaining to the transfer of data, including but not limited to Exhibit G (*Business Associate Addendum)*, will survive the termination or expiration of this Contract for as long as any PHI or other sensitive data remains in the possession of Contractor. This Subsection is intended to supplement and not replace the requirements of Exhibit G (*Business Associate Addendum*) regarding data sharing.

Exhibit F – Contractor's Release

Contractor's Release

Instructions to Contractor:

With final invoice(s), submit one (1) original and one (1) copy. The original must bear the original signature of a person authorized to bind Contractor. The additional copy may bear photocopied signatures.

Submission of Final Invoice

Pursuant to **contract number** ___ entered into between the Department of Health Care Services (DHCS) and Contractor (identified below), Contractor does acknowledge that final payment has been requested via **invoice number(s)** ___, in the **amount(s) of $** and **dated** ___. If necessary, enter "See Attached" in the appropriate blocks and attach a list of invoice numbers, dollar amounts and invoice dates.

Release of all Obligations

By signing this form, and upon receipt of the amount specified in the invoice number(s) referenced above, Contractor does hereby release and discharge the State, its officers, agents and employees of and from any and all liabilities, obligations, claims, and demands whatsoever arising from the above referenced contract.

Repayments Due to Audit Exceptions / Record Retention

By signing this form, Contractor acknowledges that expenses authorized for reimbursement do not guarantee final allowability of said expenses. Contractor agrees that the amount of any sustained audit exceptions resulting from any subsequent audit made after final payment will be refunded to the State.

All expense and accounting records related to the above referenced contract must be maintained for audit purposes for no less than three years beyond the date of final payment, unless a longer term is stated in said contract.

Recycled Product Use Certification

By signing this form, Contractor certifies under penalty of perjury that a minimum of 0% unless otherwise specified in writing of postconsumer material, as defined in the Public Contract Code Section 12200, in products, materials, goods, or supplies offered or sold to the State regardless of whether it meets the requirements of Public Contract Code Section 12209. Contractor specifies that printer or duplication cartridges offered or sold to the State comply with the requirements of Public Contract Code Section 12156(e).

Reminder to Return State Equipment/Property (If Applicable)

(Applies only if equipment was provided by DHCS or purchased with or reimbursed by contract funds)

Unless DHCS has approved the continued use and possession of State equipment (as defined in the above referenced contract) for use in connection with another DHCS agreement, Contractor agrees to promptly initiate arrangements to account for and return said equipment to DHCS, at DHCS' expense, if said equipment has not passed its useful life expectancy as defined in the above referenced contract.

Patents / Other Issues

By signing this form, Contractor further agrees, in connection with patent matters and with any claims that are not specifically released as set forth above, that it will comply with all of the provisions contained in the above referenced contract, including, but not limited to, those provisions relating to notification to the State and related to the defense or prosecution of litigation.

ONLY SIGN AND DATE THIS DOCUMENT WHEN ATTACHING IT TO THE FINAL INVOICE

Contractor's Legal Name (as on contract):
Signature of Contractor or Official Designee:
Date:

Printed Name/Title of Person Signing:
Distribution: Accounting (Original) Program

Exhibit G – Business Associate Addendum

1. This Agreement has been determined to constitute a business associate relationship under the Health Insurance Portability and Accountability Act (HIPAA) and its implementing privacy and security regulations at 45 Code of Federal Regulations parts 160 and 164 (collectively, and as used in this Agreement)

2. The term “Agreement” as used in this document refers to and includes both this Business Associate Addendum and the contract to which this Business Associate Agreement is attached as an exhibit, if any.

3. For purposes of this Agreement, the term “Business Associate” shall have the same meaning as set forth in 45 CFR section 160.103.

4. The Department of Health Care Services (DHCS) intends that Business Associate may create, receive, maintain, transmit or aggregate certain information pursuant to the terms of this Agreement, some of which information may constitute Protected Health Information (PHI) and/or confidential information protected by federal and/or State laws.

4.1 As used in this Agreement and unless otherwise stated, the term “PHI” refers to and includes both “PHI” as defined at 45 CFR section 160.103 and Personal Information (PI) as defined in the Information Practices Act (IPA) at California Civil Code section 1798.3(a). PHI includes information in any form, including paper, oral, and electronic.

4.2 As used in this Agreement, the term “confidential information” refers to information not otherwise defined as PHI in Section 4.1 of this Agreement, but to which State and/or federal privacy and/or security protections apply.

5. Contractor (however named elsewhere in this Agreement) is the Business Associate of DHCS acting on DHCS’ behalf and provides services or arranges, performs or assists in the performance of functions or activities on behalf of DHCS, and may create, receive, maintain, transmit, aggregate, use or disclose PHI (collectively, “use or disclose PHI”) in order to fulfill Business Associate’s obligations under this Agreement. DHCS and Business Associate are each a party to this Agreement and are collectively referred to as the "parties.”

6. The terms used in this Agreement, but not otherwise defined, shall have the same meanings as those terms in HIPAA and/or the IPA. Any reference to statutory or regulatory language shall be to such language as in effect or as amended.

7. **Permitted Uses and Disclosures of PHI by Business Associate**. Except as otherwise indicated in this Agreement, Business Associate may use or disclose PHI,

inclusive of de-identified data derived from such PHI, only to perform functions, activities or services specified in this Agreement on behalf of DHCS, provided that such use or disclosure would not violate HIPAA or other applicable laws if done by DHCS.

7.1 Specific Use and Disclosure Provisions. Except as otherwise indicated in this Agreement, Business Associate may use and disclose PHI if necessary for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate. Business Associate may disclose PHI for this purpose if the disclosure is required by law, or the Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will be held confidentially and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person. The person notify the Business Associate of any instances of which the person is aware that the confidentiality of the information has been breached, unless such person is a treatment provider not acting as a business associate of Business Associate.

8. Compliance with Other Applicable Law

To the extent that other State and/or federal laws provide additional, stricter and/or more protective (collectively, more protective) privacy and/or security protections to PHI or other confidential information covered under this Agreement beyond those provided through HIPAA, Business Associate agrees:

8.1.1 To comply with the more protective of the privacy and security standards set forth in applicable State or federal laws to the extent such standards provide a greater degree of protection and security than HIPAA or are otherwise more favorable to the individuals whose information is concerned; and

8.1.2 To treat any violation of such additional and/or more protective standards as a breach or security incident, as appropriate, pursuant to Section 18. of this Agreement.

8.2 Examples of laws that provide additional and/or stricter privacy protections to certain types of PHI and/or confidential information, as defined in Section 4. of this Agreement, include, but are not limited to the Information Practices Act, California Civil Code sections 1798-1798.78, Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR part 2, W&I section 5328, and Health and Safety Code section 11845.5.

8.3 If Business Associate is a Qualified Service Organization (QSO) as defined in 42 CFR section 2.11, Business Associate agrees to be bound by and comply with subdivisions (2)(i) and (2)(ii) under the definition of QSO in 42 CFR section 2.11.

9. Additional Responsibilities of Business Associate

Nondisclosure. Business Associate not use or disclose PHI or other confidential information other than as permitted or required by this Agreement or as required by law.

9.1 Safeguards and Security.

9.1.1 Business Associate use safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of PHI and other confidential data and comply, where applicable, with subpart C of 45 CFR part 164 with respect to electronic protected health information, to prevent use or disclosure of the information other than as provided for by this Agreement. Such safeguards be based on applicable Federal Information Processing Standards (FIPS) Publication 199 protection levels.

9.1.2 Business Associate, at a minimum, utilize a National Institute of Standards and Technology Special Publication (NIST SP) 800-53 compliant security framework when selecting and implementing its security controls and maintain continuous compliance with NIST SP 800-53 as it may be updated from time to time. The current version of NIST SP 800-53, Revision 5 is available online; updates will be available online at the NIST Computer Security Resource Centerhttps://csrc.nist.gov/publications/sp800.

9.1.3 Business Associate employ FIPS 140-2 validated encryption of PHI at rest and in motion unless Business Associate determines it is not reasonable and appropriate to do so based upon a risk assessment, and equivalent alternative measures are in place and documented as such. FIPS 140-2 validation can be determined online at the NIST Cryptographic Module Validation Program page, with information about the Cryptographic Module Validation Program under FIPS 140-2 available online. In addition, Business Associate maintain, at a minimum, the most current industry standards for transmission and storage of PHI and other confidential information.

9.1.4 Business Associate apply security patches and upgrades, and keep virus software up-to-date, on all systems on which PHI and other confidential information may be used.

9.1.5 Business Associate ensure that all members of its workforce with access to PHI and/or other confidential information sign a confidentiality statement prior to access to such data. The statement be renewed annually.

9.1.6 Business Associate identify the security official who is responsible for the development and implementation of the policies and procedures required by 45 CFR part 164, subpart C.

9.2 Business Associate's Agent. Business Associate ensure that any agents, subcontractors, subawardees, vendors or others (collectively, "agents") that use or disclose PHI and/or confidential information on behalf of Business Associate agree to the same restrictions and conditions that apply to Business Associate with respect to such PHI and/or confidential information.

10. **Mitigation of Harmful Effects**. Business Associate mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI and other confidential information in violation of the requirements of this Agreement.

11. **Access to PHI.** Business Associate make PHI available in accordance with 45 CFR section 164.524.

12. **Amendment of PHI.** Business Associate make PHI available for amendment and incorporate any amendments to protected health information in accordance with 45 CFR section 164.526.

13. **Accounting for Disclosures.** Business Associate make available the information required to provide an accounting of disclosures in accordance with 45 CFR section 164.528.

14. **Compliance with DHCS Obligations.** To the extent Business Associate is to carry out an obligation of DHCS under 45 CFR part 164, subpart E, comply with the requirements of the subpart that apply to DHCS in the performance of such obligation.

15. **Access to Practices, Books and Records.** Business Associate make its internal practices, books, and records relating to the use and disclosure of PHI on behalf of DHCS available to DHCS upon reasonable request, and to the federal Secretary of Health and Human Services for purposes of determining DHCS' compliance with 45 CFR part 164, subpart E.

16. **Return or Destroy PHI on Termination; Survival.** At termination of this Agreement, if feasible, Business Associate return or destroy all PHI and other confidential information received from, or created or received by Business Associate on behalf of, DHCS that Business Associate still maintains in any form and retain no copies of such information. If return or destruction is not feasible, Business Associate notify DHCS of the conditions that make the return or destruction infeasible, and DHCS and Business

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Associate determine the terms and conditions under which Business Associate may retain the PHI. If such return or destruction is not feasible, Business Associate extend the protections of this Agreement to the information and limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

17. **Special Provision for SSA Data.** If Business Associate receives data from or on behalf of DHCS that was verified by or provided by the Social Security Administration (SSA data) and is subject to an agreement between DHCS and SSA, Business Associate provide, upon request by DHCS, a list of all employees and agents and employees who have access to such data, including employees and agents of its agents, to DHCS.

18. **Breaches and Security Incidents.** Business Associate implement reasonable systems for the discovery and prompt reporting of any breach or security incident, and take the following steps:

18.1 Notice to DHCS.

18.1.1 Business Associate notify DHCS **immediately** upon the discovery of a suspected breach or security incident that involves SSA data. This notification will be provided by email upon discovery of the breach. If Business Associate is unable to provide notification by email, then Business Associate provide notice by telephone to DHCS.

18.1.2 Business Associate notify DHCS **within 24 hours by email** (or by telephone if Business Associate is unable to email DHCS) of the discovery of the following, unless attributable to a treatment provider that is not acting as a business associate of Business Associate:

18.1.2.1 Unsecured PHI if the PHI is reasonably believed to have been accessed or acquired by an unauthorized person;

18.1.2.2 Any suspected security incident which risks unauthorized access to PHI and/or other confidential information;

18.1.2.3 Any intrusion or unauthorized access, use or disclosure of PHI in violation of this Agreement; or

18.1.2.4 Potential loss of confidential information affecting this Agreement.

18.1.3 Notice be provided to the DHCS Program Contract Manager (as applicable), the DHCS Privacy Office, and the DHCS Information Security Office (collectively, “DHCS Contacts”) using the DHCS Contact Information at Section 18.6. below.

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Notice be made using the current DHCS "Privacy Incident Reporting Form" ("PIR Form"; the initial notice of a security incident or breach that is submitted is referred to as an "Initial PIR Form") and include all information known at the time the incident is reported. The Privacy Incident Reporting Form is available online.

Upon discovery of a breach or suspected security incident, intrusion or unauthorized access, use or disclosure of PHI, Business Associate take:

18.1.3.1 Prompt action to mitigate any risks or damages involved with the security incident or breach; and

18.1.3.2 Any action pertaining to such unauthorized disclosure required by applicable federal and State law.

18.2 Investigation. Business Associate immediately investigate such security incident or breach.

18.3 Complete Report. To provide a complete report of the investigation to the DHCS contacts within ten (10) working days of the discovery of the security incident or breach. This "Final PIR" include any applicable additional information not included in the Initial Form. The Final PIR Form include an assessment of all known factors relevant to a determination of whether a breach occurred under HIPAA and other applicable federal and State laws. The report also include a full, detailed corrective action plan, including its implementation date and information on mitigation measures taken to halt and/or contain the improper use or disclosure. If DHCS requests information in addition to that requested through the PIR form, Business Associate make reasonable efforts to provide DHCS with such information. A "Supplemental PIR" may be used to submit revised or additional information after the Final PIR is submitted. DHCS will review and approve or disapprove Business Associate's determination of whether a breach occurred, whether the security incident or breach is reportable to the appropriate entities, if individual notifications are required, and Business Associate's corrective action plan.

18.3.1 If Business Associate does not complete a Final PIR within the ten (10) working day timeframe, Business Associate request approval from DHCS within the ten (10) working day timeframe of a new submission timeframe for the Final PIR.

18.4 Notification of Individuals. If the cause of a breach is attributable to Business Associate or its agents, other than when attributable to a treatment provider that is not acting as a business associate of Business Associate, Business Associate notify individuals accordingly and pay all costs of such notifications, as well as all costs associated with the breach. The notifications comply with

applicable federal and State law. DHCS approve the time, manner and content of any such notifications and their review and approval be obtained before the notifications are made.

18.5 Responsibility for Reporting of Breaches to Entities Other than DHCS. If the cause of a breach of PHI is attributable to Business Associate or its agents, other than when attributable to a treatment provider that is not acting as a business associate of Business Associate, Business Associate is responsible for all required reporting of the breach as required by applicable federal and State law.

18.6 DHCS Contact Information. To direct communications to the above referenced DHCS staff, the Contractor initiate contact as indicated here. DHCS reserves the right to make changes to the contact information below by giving written notice to Business Associate. These changes shall not require an amendment to this Agreement.

DHCS Program Contract Manager	**DHCS Privacy Office**	**DHCS Information Security Office**
See the Scope of Work exhibit for Program Contract Manager information. If this Business Associate Agreement is not attached as an exhibit to a contract, contact the DHCS signatory to this Agreement.	Privacy Office c/o: Office of HIPAA Compliance Department of Health Care Services P.O. Box 997413, MS 4722 Sacramento, CA 95899-7413 Email: incidents@dhcs.ca.gov Telephone: (916) 445-4646	Information Security Office DHCS Information Security Office P.O. Box 997413, MS 6400 Sacramento, CA 95899-7413 Email: incidents@dhcs.ca.gov

19. Responsibility of DHCS. DHCS agrees to not request the Business Associate to use or disclose PHI in any manner that would not be permissible under HIPAA and/or other applicable federal and/or State law.

20. Audits, Inspection and Enforcement

20.1 From time to time, DHCS may inspect the facilities, systems, books and records of Business Associate to monitor compliance with this Agreement. Business

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Associate promptly remedy any violation of this Agreement and certify the same to the DHCS Privacy Officer in writing. Whether or how DHCS exercises this provision shall not in any respect relieve Business Associate of its responsibility to comply with this Agreement.

20.2 If Business Associate is the subject of an audit, compliance review, investigation or any proceeding that is related to the performance of its obligations pursuant to this Agreement, or is the subject of any judicial or administrative proceeding alleging a violation of HIPAA, Business Associate promptly notify DHCS unless it is legally prohibited from doing so.

21. Termination

21.1 **Termination for Cause**. Upon DHCS' knowledge of a violation of this Agreement by Business Associate, DHCS may in its discretion:

21.1.1 Provide an opportunity for Business Associate to cure the violation and terminate this Agreement if Business Associate does not do so within the time specified by DHCS; or

21.1.2 Terminate this Agreement if Business Associate has violated a material term of this Agreement.

21.2 **Judicial or Administrative Proceedings.** DHCS may terminate this Agreement if Business Associate is found to have violated HIPAA, or stipulates or consents to any such conclusion, in any judicial or administrative proceeding.

22. Miscellaneous Provisions

22.1 **Disclaimer**. DHCS makes no warranty or representation that compliance by Business Associate with this Agreement will satisfy Business Associate's business needs or compliance obligations. Business Associate is solely responsible for all decisions made by Business Associate regarding the safeguarding of PHI and other confidential information.

22.2. **Amendment**.

22.2.1 Any provision of this Agreement which is in conflict with current or future applicable federal or State laws is hereby amended to conform to the provisions of those laws. Such amendment of this Agreement shall be effective on the effective date of the laws necessitating it, and shall be binding on the parties even though such amendment may not have been reduced to writing and formally agreed upon and executed by the parties.

22.2.2 Failure by Business Associate to take necessary actions required by amendments to this Agreement under Section 22.2.1 shall constitute a material violation of this Agreement.

22.3 Assistance in Litigation or Administrative Proceedings. Business Associate make itself and its employees and agents available to DHCS at no cost to DHCS to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against DHCS, its directors, officers and/or employees based upon claimed violation of HIPAA, which involve inactions or actions by the Business Associate.

22.4 No Third-Party Beneficiaries. Nothing in this Agreement is intended to or shall confer, upon any third person any rights or remedies whatsoever.

22.5 Interpretation. The terms and conditions in this Agreement shall be interpreted as broadly as necessary to implement and comply with HIPAA and other applicable laws.

22.6 No Waiver of Obligations. No change, waiver or discharge of any liability or obligation hereunder on any one or more occasions shall be deemed a waiver of performance of any continuing or other obligation, or shall prohibit enforcement of any obligation, on any other occasion.

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Exhibit H – Conflict of Interest Avoidance Requirements

1.0 The Department of Health Care Services (DHCS) requires Contractor to avoid conflicts of interest or the appearance of conflicts of interest. DHCS reserves the right to determine, in DHCS' sole discretion, whether any information received from any source indicates the existence of a potential, suspected, and/or actual conflict of interest.

Exhibit H

1.0 Conflict of Interest Avoidance Requirements

1.1.1 Introduction
1.1.2 Identification of Ownership, Contractual, and Financial Interests
1.1.3 Conflicts of Interest
1.1.4 DHCS Approval of Conflict Avoidance Plan
1.1.5 Third-Party Monitor Oversight
1.1.6 DHCS' Right of Termination
1.1.7 Notice of Conflict of Interest to DHCS

1.0 Conflict of Interest Avoidance Requirements

1.1.1 Introduction

Contractor must ensure that it complies with the conflict of interest avoidance requirements set forth in this Exhibit H and must also ensure the compliance of its employees, officers, and directors throughout the entire term of the Contract, and any extensions thereto. Contractor must also ensure that its Subcontractors and Downstream Subcontractors (as those terms are defined in the Contract), and the employees, officers and directors of Subcontractors and Downstream Subcontractors, comply with the requirements set forth in this Exhibit H throughout the entire term of the Contract, and any extension thereto.

1.1.2 Identification of Ownership, Contractual, and Financial Interests

Contractor will disclose the following to DHCS, in a form and manner directed by DHCS through All Plan Letter (APL) or other similar instructions:

A. Any form of ownership interest, affiliation, financial interest, contractual relationship, and/or control Contractor has in any corporation or other entity that operates as a Medi-Cal managed care health plan, Prepaid Inpatient Health Plan (PIHP), Prepaid Ambulatory Health Plan (PAHP), Primary Care Case Management (PCCM), pharmaceutical company or any other health care provider, fiscal intermediary, billing agent, or any other controlling agent for Medi-Cal services (“Medi-Cal Program Participant”); and

B. Any form of ownership interest, affiliation, financial interest, contractual relationship, and/or control Contractor has in any corporation, partnership, limited partnership, limited liability company, sole proprietorship, or any other legal entity that is not a Medi-Cal Program Participant.

To the extent any interest identified by Contractor in Section 1.2 results in a potential, suspected, and/or actual conflict of interest, Contractor will be subject to all requirements of this Exhibit H.

1.1.3 Conflicts of Interest

If Contractor has a potential, suspected, and/or actual conflict of interest, Contractor must provide a description of the relationship and a conflict avoidance plan to ensure that such a relationship will not adversely affect DHCS, other Medi-Cal managed care plans, and/or Medi-Cal Members. In the conflict avoidance plan, Contractor must also establish procedures to avoid, neutralize, and/or mitigate a potential, suspected, and/or actual conflict of interest.

Any of the following instances would be considered a potential, suspected, and/or actual conflict of interest, including but not limited to any of these instances in the past, present, or future:

A. An instance where Contractor or any of its Subcontractors and Downstream Subcontractors, or any employee, officer, or director of Contractor or any of its Subcontractors and Downstream Subcontractors, has an interest, financial or otherwise, whereby the use or disclosure of information obtained while performing services under the Contract would allow for private or personal benefit or for any purpose that is inconsistent with the goals and objectives of the Contract;

B. An instance where Contractor or any of its Subcontractors and Downstream Subcontractors, or any employee, officer, or director of Contractor or any of its Subcontractors and Downstream Subcontractors, improperly uses their positions for purposes that are, or give the appearance of being, for private gain for themselves or others, such as those with whom they have family, business, or other ties that are determined by DHCS to be a conflict of interest;

C. An instance where Contractor or any of its Subcontractors and Downstream Subcontractors, or any employee, officer, or director of Contractor or any of its Subcontractors and Downstream Subcontractors, gains an unfair competitive advantage due to its unequal access to information, such as where non-public information gained on one contract by Contractor may be leveraged in bidding for another government contract;

   1) Where pursuant to the Political Reform Act (Govt. Code (GC) §§ 87100–87500), a DHCS official has an economic Interest in Contractor and the official makes, participates in the making of, or uses his or her official position to influence the making of a decision involving Contractor where it is reasonably foreseeable that the decision could materially affect the official's economic interest;

   2) Where pursuant to GC section 1090 *et seq*., a DHCS official participates in the making of a Contract with Contractor and the official is financially interested in the Contract;

   3) Where in contravention of Welfare and Institutions Code (W&I) section 14479, a DHCS officer or employee is employed in a management or consultant position by Contractor, Subcontractor,

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or Downstream Subcontractor one year after the DHCS officer or employee terminates their State employment; and

4) For Two-Plan managed care models, an instance where Contractor will be contracted, affiliated, or otherwise entered into a partnership arrangement to serve as a Local Initiative in the same Two-Plan county where Contractor is operating as the commercial plan, or has indicated an intent to do so.

D. Conflict Avoidance Plan Framework

The requirements of a conflict avoidance plan will vary depending on the nature of the conflict, but must include, at a minimum, the following elements:

1) Clear definitions;

2) Statement of organizational commitment to develop and follow the conflict avoidance plan;

3) Description of the type of conflict of interest (*e.g.*, unequal access to information, impaired objectivity, and/or biased ground rules implicated by a contract);

4) Description of the factors that may or do place Contractor in a potential, suspected, and/or actual conflict of interest situation;

5) If applicable, identification of Subcontractors and Downstream Subcontractors with potential, suspected, and/or actual conflict of interest;

6) Detailed plans for avoiding, neutralizing, and/or mitigating conflicts of interest, or, if not feasible, an explanation and justification for accepting conflicts of interest;

7) Administrative, technical, physical, and management controls, as required in the context of the specific conflict of interest;

8) Provision for third-party monitoring and a requirement that the third-party monitor certify Contractor's compliance with the conflict avoidance plan, if required by DHCS;

9) Contractor's certification of compliance with the conflict avoidance plan; and

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10) Provisions requiring periodic review and amendment by Contractor of the conflict avoidance plan to address material changes impacting the conflict of interest.

1.1.4 DHCS Approval of Conflict Avoidance Plan

DHCS, in its sole discretion, will determine whether the specific provisions of the conflict avoidance plan satisfactorily address the actual, suspected, or potential conflicts of interest. DHCS, in its sole discretion, may impose additional requirements or require modification to the conflict avoidance plan, which may include, but are not limited to, the following:

A. Termination of contractual obligations that in DHCS' determination create actual or potential conflicts of interest;

B. Removal of Contractor's management or staff who DHCS determines were involved in the relationship creating the conflict of interest; and/or

C. Creation of an "ethical firewall," with measures to ensure that no information passes between individuals/entities within Contractor's organization that were involved in the conflict and those individuals/entities not involved in the conflict.

These requirements will vary, depending on the nature of the potential, suspected, and/or actual conflicts of interest, the manner in which those potential, suspected, and/or actual conflicts of interest impact the Contract, and DHCS' determination of the best method for addressing those conflicts of interest.

1.1.5 Third-Party Monitor Oversight

DHCS may, in its sole discretion, appoint a third-party monitor to assist in overseeing Contractor's compliance with the conflict avoidance plan. The third-party monitor's responsibilities will include monitoring, reporting, consulting, and, where necessary, investigation of compliance concerns. Appropriate provisions regarding the third-party monitor's duties and Contractor's obligations in connection with the third-party monitor will be included in the conflict avoidance plan.

1.1.6 DHCS' Right of Termination

If DHCS is aware or becomes aware of a potential, suspected, and/or actual conflict of interest, Contractor will be given an opportunity to submit additional information to resolve the conflict of interest. If Contractor has a potential,

suspected, and/or actual conflict of interest, Contractor will have five Working Days from the date of notification by DHCS of the potential, suspected, and/or actual conflict of interest to provide complete information regarding the conflict of interest. If DHCS determines that an actual conflict of interest exists and the conflict cannot be resolved or mitigated to the satisfaction of DHCS, the conflict of interest will be grounds for termination of the Contract by DHCS for cause.

1.1.7 Notice of Conflict of Interest to DHCS

Contractor, and each of its Subcontractors and Downstream Subcontractors, must notify their DHCS Contract Manager within ten Working Days of when they become aware of any potential, suspected, or actual conflict of interest, or when any change occurs to the information provided to DHCS previously, whether provided previously through the Request for Procurement or previous notice given during the term of the Contract. This notice will be in a form and manner as directed by DHCS through APL or other similar instructions.

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Exhibit I – Contractor's Parent Guaranty Requirements

1.0 Contractor's Parent Guaranty Requirements

If Contractor is a subsidiary of a corporation or other legal entity, the full and prompt performance of all covenants, provisions, and agreements resulting from this Contract for the life of the Contract must be guaranteed by that entity in Contractor's chain of ownership, which is publicly traded (the "Guaranty"). This entity will be known as Contractor's "parent corporation" for purposes of the Contract (the "Guarantor").

1.1 Contractor's Parent Guaranty Requirements

1.1.1 Minimum Requirements
1.1.2 Provisions
1.1.3 Terms

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1.0 Contractor's Parent Guaranty Requirements

1.1.1 Minimum Requirements

The Guaranty must, at a minimum, meet the following requirements. It must:

A. Be made to DHCS, in writing, by the Contract effective date;

B. Be signed by an official authorized to bind the Guarantor organization;

C. Accept unconditional responsibility for all performance and financial requirements and obligations of the Contract including, but not limited to, maintenance of Tangible Net Equity (TNE) and payment of liquidated damages;

D. Recite that "for good and valuable consideration, receipt of which is hereby acknowledged," Guarantor is making the Guaranty;

E. State that Guarantor stipulates that if the Contract is ultimately awarded to the subsidiary, that DHCS will so award in reliance upon the Guaranty;

F. State that the undersigned corporate officer warrants that they have personally reviewed all pertinent corporate documents, including but not limited to, articles of incorporation, bylaws, and agreements between the parent and subsidiary; and

G. State that the undersigned corporate officer warrants that nothing in these documents in any way limits the capacity of the parent to enter into this Guaranty

1.1.2 Provisions

The Guaranty must include the following provisions:

A. DHCS need not take any action against Contractor, any other guarantor, or any other person, firm or corporation, or resort to any security held by Contractor at any time before proceeding against Guarantor;

B. Guarantor hereby waives any and all notices and demands which may be required to be given by any other statute or rule of law and agrees that its liability hereunder will be in no way affected, diminished, or released by any extension of time, forbearance, or waiver, which may be granted to Contractor, its successor or assignee;

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C. This Guaranty will extend to and include all future amendments, modifications, and extensions of the Contract and all future supplemental and other agreements with respect to matters covered by the Contract that DHCS and Contractor may enter into, with or without notice to or knowledge of Guarantor, but Guarantor will have the benefit of any such extension, forbearance, waiver, amendment, modification, or supplemental or other agreement. It is the purpose and intent of the parties hereto that the obligations of Guarantor hereunder will be co-extensive with, but not in excess of, the obligations of Contractor, its successor or assignee, under the Contract; and

D. Guarantor agrees that the Guaranty will continue in full force and effect despite any change in the legal or corporate status of the subsidiary, including, but not limited to, its sale, reorganization, dissolution or bankruptcy.

1.1.3 Terms

The Guaranty must be presented in terms, which DHCS in its sole discretion, determines, as a whole, adequately establish Contractor's financial responsibility.

Exhibit J: Delegation Reporting and Compliance Plan

This Exhibit contains instructions and templates for Contractor to make submissions to DHCS per the requirements set forth in Exhibit A, Attachment III, Subsection 3.1.3 *(Contractor's Duty to Disclose All Delegated Relationships and to Submit Delegation Reporting and Compliance Plan)*. As with all Exhibits to the Contract, Exhibit J is a part of this Contract and the reporting requirements in this Exhibit J and the use of the prescribed template are binding and enforceable contractual obligations under this Contract. Contractor must complete Exhibit J for each county in which they operate.

Template A: Delegation Function Matrix

Instructions: Complete *Table A1: Delegation Function Matrix – For Subcontractor* for all functions that are delegated through applicable Subcontractor Agreements. Contractor may not delegate contractual duties and obligations where delegation is legally or contractually prohibited. Use additional pages of Table A1 as needed – additional pages will not be counted in the total page count for the Delegation Justification and Plan.

Contractor Name:

Applicable County:

Compliance Officer:

Compliance Contact Information:

1. **Subcontractor Name:** Name of the Subcontractor with whom Contractor has a Subcontractor Agreement
2. **Type of Subcontractor:** Fully Delegated Subcontractor, Partially Delegated Subcontractor, Administrative Subcontractor

3. **Delegated Function(s):** The function(s) Contractor is delegating to Subcontractor. In the case of a Fully Delegated Subcontractor, this may be “all delegable functions.”

4. **Address:** The address for location of the performance of Subcontractor’s functions

5. **Contact Info:** Name and contact information for each of Subcontractor’s key personnel who is responsible for ensuring compliance.

6. **Medi-Cal Managed Care Member:** Percentage of the total Medi-Cal Members assigned to the Subcontractor if applicable.

7. **Proportion of Capitated Rates At Risk:** Proportion of total capitated rates for which the Subcontractor is at risk, if applicable.

Table A1: Delegation Function Matrix—For Subcontractors

Sub-contractor Name (1)	Type of Sub-contractor (2)	Delegated Function(s) (3)	Address (4)	Contact Info (5)	Percentage of Total Members (6)	Proportion of Total Capitated Rate (7)

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Instructions: Complete *Table A2 Delegation Function Matrix—Downstream Subcontractors* for all functions that are delegated through applicable Downstream Subcontractor Agreements. Use additional pages of Table A2 as needed. Subcontractor or Downstream Subcontractor may not delegate contractual duties and obligations where delegation is legally or contractually prohibited. Complete one for each Subcontractor that delegates functions downstream and, as applicable, for each Downstream Subcontractor, if they further delegate functions downstream. Use additional pages of Table A2 as needed – additional pages will not be counted in the total page count for the Delegation Justification and Plan.

Subcontractor or Downstream Subcontractors Name:
Applicable County(ies):
Compliance Officer:
Compliance Contact Information:

1. **Downstream Subcontractor Name:** Name of the Downstream Subcontractor with whom the Subcontractor has a Downstream Subcontractor Agreement; or the name of the Downstream Subcontractor with whom the Subcontractor's Downstream Subcontractor further delegates functions downstream
2. **Type of Downstream Subcontractor:** Downstream Fully Delegated Subcontractor, Downstream Partially Delegated Subcontractor, Downstream Administrative Subcontractor
3. **Delegated Function(s):** The function(s) Subcontractor is delegating to Downstream Subcontractor; in the case of a Downstream Fully Delegated Subcontractor, this may be "all delegable functions."
4. **Address:** The address of the location of the performance of the Downstream Subcontractor's functions.
5. **Contact Info:** Name and contact information for each of the Downstream Subcontractor's key personnel who is responsible for ensuring compliance.
6. **Medi-Cal Managed Care Member:** Percentage of the total Medi-Cal Members assigned to the Downstream Subcontractor, if applicable.
7. **Proportion of Capitated Rates At Risk:** Proportion of total capitated rates for which the Downstream Subcontractor, is at risk, if applicable.

Table A2: Delegation Function Matrix—For Downstream Subcontractors

Downstream Subcontractor Name (1)	Type (2)	Delegated Function(s) (3)	Address (4)	Contact Info (5)	Percentage of Total Members (6)	Proportion of Total Capitated Rate (7)

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Template B: Delegation Justification and Plan

Instructions: Complete this template for each Subcontractor or Downstream Subcontractor. Contractor may not delegate for those contractual duties and obligations where delegation is legally or contractually prohibited. Responses must be limited to no more than ten pages.

Subcontractor or Downstream Subcontractor Name:

Applicable County(ies):

Subcontractor or Downstream Key Personnel:

Subcontractor Key Personnel Contact Information:

Type of Subcontractor or Downstream Subcontractor: Fully delegated, Partially delegated, Administrative, Downstream Fully delegated, Downstream Partially delegated, Downstream Administrative:

a) **Justification of Subcontractor Agreement or Downstream Subcontractor Agreement:** Describe the purpose and the justification of the Subcontractor Agreement or Downstream Subcontractor Agreement.

b) **Pre-Existing Relationships:** Describe any pre-existing relationship, including any affiliation, parent entity, or prior existing contract between Contractor and Subcontractor, or Subcontractor and Downstream Subcontractor including the duration of such pre-existing relationship.

c) **Sub-Delegation**: Indicate if Subcontractor or Downstream Subcontractor is permitted to sub-delegate any functions. If so, describe how Contractor will maintain oversight over delegated functions to Subcontractors and Downstream Subcontractors. Provide citations to provisions in the Subcontractor Agreement and Downstream Subcontractor Agreement to support Contractor's assertions.

d) **Impact on Contractor:** Describe the impact and benefit, if any, the Subcontractor Agreement or Downstream Subcontractor Agreement will have on Contractor's operations, administrative capacity, and financial viability.

e) **Contractor's Administrative Capacity to Oversee and Monitor Subcontractor and Downstream Subcontractor:** Describe Contractor's administrative capacity to oversee and monitor Subcontractor and Downstream Subcontractor as applicable

f) **Subcontractor's and Downstream Subcontractor's Administrative Capacity:** Describe Subcontractor's and Downstream Subcontractor's administrative capacity to perform each delegated function, including but not limited to Subcontractor's and Downstream Subcontractor's capacity to perform quality monitoring and community engagement, if applicable.

g) **Subcontractor's and Downstream Subcontractors' Compliance with Applicable Contractual Provisions:** Detail how the Subcontractor Agreement and Downstream Subcontractor Agreement complies with, and ensures compliance, with all provisions of the Contract applicable to the delegated functions, including appropriate citations to the provisions in the Subcontractor Agreement and Downstream Subcontractor Agreement. Please complete Template C (Contract Requirements Grid) in Exhibit J to indicate which provisions are included in the Subcontractor Agreements and Downstream Subcontractor Agreements, as applicable for each Agreement.

h) **Contractor's Oversight Policy and Procedures:** Describe how Contractor will inform Subcontractor and Downstream Subcontractors of Contractor's oversight policies and procedures.

i) **Financial Arrangement:** Contractor must include description of any financial arrangements it has with Subcontractor and Downstream Subcontractor.

j) **Other Information:** Include any other information that would assist DHCS in its review of Contractor's delegated structure.

k) **Previously Approved Documents: (Applicable to annual submissions only)** If Contractor has previously submitted documentation to DHCS in connection with the Subcontractor Agreement or Downstream Subcontractor Agreement, either through the Request for Proposal (RFP) process or during the term of this Contract, Contractor must provide any such documentation.

Template C: Contract Requirements Grid

Instructions: If you delegate any functions, complete this template for those contractual duties. One Template C should be submitted showing all delegated functions to accompany Templates A and B.

Contractors must complete this table to indicate all the contract requirements that are applicable to their Subcontractors or Downstream Subcontractor, depending on the functions that are delegated to the respective entities.

This table also references obligations of Contractor where delegation must be contractually prohibited. While Contractor must not delegate contractual duties and obligations where delegation is contractually prohibited, Contractor or Subcontractor or Downstream Subcontractor may include related contractual requirements in their Agreements. For example, while Contractor may not delegate the functions of a Compliance Program, they may require Subcontractor and Downstream Subcontractors to maintain their own compliance programs. Regardless of Contractor's system of delegation, Contractor remains obligated to ensure performance of all duties and obligations under the Contract.

Fully Delegated Subcontractors must comply with all contractual requirements. Partially Delegated Subcontractors and Downstream Partially Delegated Subcontractors, and Administrative Subcontractors and Downstream Administrative Subcontractors must at minimum comply with requirements outlined in Exhibit A, Attachment III, Subsection 3.1.5.B *(Subcontractor and Downstream Subcontractor Agreement Requirements)*.

Additional requirements may apply depending on the nature of the function or functions delegated. For example, if a Subcontractor delegates claims processing to an Administrative Downstream Subcontractor for this function, the Administrative Downstream Subcontractor must comply with Exhibit A, Attachment III, Subsection 3.3.5 *(Claims Processing)* for all requirements related to timely processing of claims.

Delegating functions or including contractual provisions in Subcontractor Agreements or Downstream Subcontractor Agreements does not absolve Contractor of ensuring compliance of the Subcontractors or Downstream Subcontractors.

Note:

(1) Must not be delegated: These rows reference contractual requirements associated with functions for which delegation is contractually prohibited. While Contractor must not delegate contractual duties and obligations where delegation is legally or contractually prohibited, Contractor may include related contractual requirements in the Subcontractor Agreements. For example, while Contractor may not delegate the functions of a Compliance Program, they may require Subcontractor and Downstream Subcontractors to maintain their own compliance programs.

Contractor Name:

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
1.0 Organization	
1.1 Plan Organization and Administration	
1.1.1 Legal Capacity	☐
1.1.2 Key Personnel Disclosure Form	☐
1.1.3 Conflict of Interest – Current and Former State Employees	☐
1.1.4 Contract Performance	☐
1.1.5 Medical Decisions	☐
1.1.6 Medical Director	☐
1.1.7 Chief Health Equity Officer	*(1) Must not be delegated*
1.1.8 Key Personnel Changes	☐
1.1.9 Administrative Duties/Responsibilities	☐
1.1.10 Member Representation	☐
1.1.11 Diversity, Equity, and Inclusion Training	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
1.2 Financial Information	
1.2.1 Financial Viability and Standards Compliance	☐
1.2.2 Contractor's Financial Reporting Obligations	☐
1.2.3 Independent Financial Audit Reports	☐
1.2.4 Cooperation with DHCS' Financial Audits	☐
1.2.5 Medical Loss Ratio	*(1) Must not be delegated*
1.2.6 Contractor's Obligations	☐
1.2.7 Community Reinvestment Plan and Report	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
1.3 Program Integrity and Compliance Program	
1.3.1 Compliance Program	*(1) Must not be delegated*
1.3.2 Fraud Prevention Program	☐
1.3.3 Provider Screening, Enrolling, and Credentialing/Recredentialing	☐
1.3.4 Contractor's Obligations Regarding Suspended, Excluded, and Ineligible Providers	☐
1.3.5 Disclosures	☐
1.3.6 Treatment of Overpayment Recoveries	☐
1.3.7 Federal False Claims Act Compliance and Support	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
2.0 Systems and Processes	
2.1 Management Information System	
2.1.1 Management Information System Capability	☐
2.1.2 Encounter Data Reporting	☐
2.1.3 Participation in the State Drug Rebate Program	☐
2.1.4 Network Provider Data Reporting	☐
2.1.5 Program Data Reporting	☐
2.1.6 Template Data Reporting	☐
2.1.7 Management Information System/Data Audits	☐
2.1.8 Management Information System/Data Correspondence	☐
2.1.9. Tracking and Submitting Alternative Format Selections	☐
2.1.10 Interoperability Application Programming Information System Requirements	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
2.2 Quality Improvement and Health Equity Transformation Program	
2.2.1 Quality Improvement and Health Equity Transformation Program Overview	☐
2.2.2 Governing Board	☐
2.2.3 Quality Improvement and Health Equity Committee	☐
2.2.4 Provider Participation	☐
2.2.5 Subcontractor and Downstream Subcontractor Quality Improvement Activities	☐
2.2.6 Quality Improvement and Health Equity Transformation Program Policies and Procedures	☐
2.2.7 Quality Improvement and Health Equity Annual Plan	☐
2.2.8 National Committee for Quality Assurance Accreditation	*(1) Must not be delegated*
2.2.9 External Quality Review Requirements	☐
2.2.10 Quality Care for Children	☐
2.2.11 Skilled Nursing Facilities—Long-Term Care	☐
2.2.12 Disease Surveillance	☐
2.2.13 Credentialing and Recredentialing	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
2.3 Utilization Management Program	
2.3.1 Prior Authorizations and Review Procedures	☐
2.3.2 Timeframes for Medical Authorization	☐
2.3.3 Review of Utilization Data	☐
2.3.4 Delegating Utilization Management Activities	☐

Contractual Requirements		Delegated to Subcontractor
Exhibit A, Attachment III		
3.0	**Provider, Network Providers, Subcontractors, and Downstream Subcontractors**	
3.1	**Network Provider Agreements, Subcontractor Agreements, Downstream Subcontractor Agreements, and Contractor's Oversight Duties**	
3.1.1	Overview of Contractor's Duties and Obligations	☐
3.1.2	DHCS Approval of Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements	☐
3.1.3	Contractor's Duty to Disclose All Delegated Relationships and to Submit Delegation Reporting and Compliance Plan	☐
3.1.4	Contractor's Duty to Ensure Subcontractor, Downstream Subcontractor, and Network Provider Compliance	*(1) Must not be delegated*
3.1.5	Requirements for Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements	☐
3.1.6	Financial Viability of Subcontractors, Downstream Subcontractors, and Network Providers	☐
3.1.7	Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements with Federally Qualified Health Centers and Rural Health Clinics	☐
3.1.8	Network Provider Agreements with Safety-Net Providers	☐
3.1.9	Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements with Local Health Departments	☐
3.1.10	Nondiscrimination in Provider Contracts	☐
3.1.11	Public Records	☐
3.1.12	Requirement to Post	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
3.2 Provider Relations	
3.2.1 Exclusivity	☐
3.2.2 Provider Dispute Resolution Mechanism	☐
3.2.3 Out-of-Network Provider Relations	☐
3.2.4 Contractor's Provider Manual	☐
3.2.5 Network Provider Training	☐
3.2.6 Emergency Department Protocols	☐
3.2.7 Prohibited Punitive Action Against the Provider	☐
3.2.8 Submittal of Inpatient Days Information	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
3.3 Provider Compensation Arrangements	
3.3.1 Compensation and Value Based Arrangements	☐
3.3.2 Capitation Arrangements	☐
3.3.3 Provider Financial Incentive Program Payments	☐
3.3.4 Identification of Responsible Payor	☐
3.3.5 Claims Processing	☐
3.3.6 Prohibited Claims	☐
3.3.7 Federally Qualified Health Center, Rural Health Center, and Indian Health Care Provider	☐
3.3.8 Non-Contracting Certified Nurse Midwife, Nurse Practitioner, and Licensed Midwife Providers	☐
3.3.9 Non-Contracting Family Planning Providers	☐
3.3.10 Sexually Transmitted Disease	☐
3.3.11 Human Immunodeficiency Virus Testing and Counseling	☐
3.3.12 Immunizations	☐
3.3.13 Community Based Adult Services	☐
3.3.14 Organ and Bone Marrow Transplants	☐
3.3.15 Long-Term Care Services	☐
3.3.16 Emergency Services and Post-Stabilization Care Services	☐
3.3.17 Provider-Preventable Conditions	☐
3.3.18 Prohibition Against Payment to Excluded Providers	☐
3.3.19 Compliance with Directed Payment Initiatives and Related Reimbursement Requirements	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
4.0 Member	
4.1 Marketing	
4.1.1 Training and Certification of Marketing Representatives	☐
4.1.2 Marketing Plan	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
4.2 Enrollments and Disenrollments	
4.2.1 Enrollment	☐
4.2.2 Disenrollment	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
4.3 Population Health Management and Coordination of Care	
4.3.1 Population Health Management Program Requirements	☐
4.3.2 Population Needs Assessment	☐
4.3.3 Data Integration and Exchange	☐
4.3.4 Medi-Cal Connect (DHCS' PHM Service) **Population Health Management Service**	☐
4.3.5 Population Risk Stratification and Segmentation, and Risk Tiering	☐
4.3.6 Screening and Assessments	☐
4.3.7 Care Management Programs	☐
4.3.8 Basic Population Health Management	☐
4.3.9 Other Population Health Requirements for Children	☐
4.3.10 Transitional Care Services	☐
4.3.11 Targeted Case Management Services	☐
4.3.12 Mental Health Services	☐
4.3.13 Alcohol and Substance Use Disorder Treatment Services	☐
4.3.14 California Children's Services	☐
4.3.15 Services for Persons with Developmental Disabilities	☐
4.3.16 School-Based Services	☐
4.3.17 Dental	☐
4.3.18 Direct Observed Therapy for Treatment of Tuberculosis	☐
4.3.19 Women, Infants, and Children Supplemental Nutrition Program	☐
4.3.20 Home and Community-Based Services Programs	☐
4.3.21 In-Home Supportive Services	☐
4.3.22 Indian Health Care Providers	☐

Contractual Requirements	Delegated to Subcontractor
4.3.23 Justice Involved Reentry Coordination	☐
4.3.24 Managed Care Liaisons	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
4.4 Enhanced Care Management	
4.4.1 Contractor's Responsibilities for Administration of Enhanced Care Management	☐
4.4.2 Populations of Focus for Enhanced Care Management	☐
4.4.3 Enhanced Care Management Providers	☐
4.4.4 Enhanced Care Management Provider Capacity	☐
4.4.5 Enhanced Care Management Model of Care	☐
4.4.6 Member Identification for Enhanced Care Management	☐
4.4.7 Authorizing Members for Enhanced Care Management	☐
4.4.8 Assignment to an Enhanced Care Management Provider	☐
4.4.9 Initiating Delivery of Enhanced Care Management	☐
4.4.10 Discontinuation of Enhanced Care Management	☐
4.4.11 Core Service Components of Enhanced Care Management	☐
4.4.12 Data System Requirements and Data Sharing to Support Enhanced Care Management	☐
4.4.13 Oversight of Enhanced Care Management Providers	☐
4.4.14 Payment of Enhanced Care Management Providers	☐
4.4.15 Enhanced Care Management Reporting Requirements	☐
4.4.16 Enhanced Care Management Quality and Performance Incentive Program	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
4.5 Community Supports	
4.5.1 Contractor's Responsibility for Administration of Community Supports	☐
4.5.2 DHCS Pre-Approved Community Supports	☐
4.5.3 Community Supports Providers	☐
4.5.4 Community Supports Provider Capacity	☐
4.5.5 Community Supports Model of Care	☐
4.5.6 Identifying Members for Community Supports	☐
4.5.7 Authorizing Members for Community Supports and Communication of Authorization Status	☐
4.5.8 Referring Members to Community Supports Providers for Community Supports	☐
4.5.9 Data System Requirements and Data Sharing to Support Community Supports	☐
4.5.10 Contractor's Oversight of Community Supports Providers	☐
4.5.11 Delegation of Community Supports Administration to Network Providers, Subcontractors, or Downstream Subcontractors	☐
4.5.12 Payment of Community Supports Providers	☐
4.5.13 Community Supports Reporting Requirements	☐
4.5.14 Community Supports Quality and Performance Incentive Program	☐

Contractual Requirements		Delegated to Subcontractor
Exhibit A, Attachment III		
4.6	**Member Grievance and Appeal System**	
4.6.1	Grievance and Appeal Program Requirements	☐
4.6.2	Grievance Process	☐
4.6.3	Discrimination Grievances	☐
4.6.4	Notice of Action	☐
4.6.5	Appeal Process	☐
4.6.6	Responsibilities in Expedited Appeals	☐
4.6.7	State Hearings and Independent Medical Reviews	☐
4.6.8	Continuation of Services Until Appeal and State Hearing Rights Are Exhausted	☐
4.6.9	Grievance and Appeal Reporting and Data	☐

Contractual Requirements		Delegated to Subcontractor
Exhibit A, Attachment III		
5.0	**Services – Scope and Delivery**	
5.1	**Member Services**	
5.1.1	Members Rights and Responsibilities	☐
5.1.2	Member Services Staff	☐
5.1.3	Member Information	☐
5.1.4	Primary Care Provider Selection	☐
5.1.5	Notices of Action for Denial, Deferral, or Modification of Prior Authorization Requests	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
5.2 Network and Access to Care	
5.2.1 Access to Network Providers and Covered Services	☐
5.2.2 Network Capacity	☐
5.2.3 Network Composition	☐
5.2.4 Network Ratios	☐
5.2.5 Network Adequacy Standards	☐
5.2.6 Access to Emergency Service Providers and Emergency Services	☐
5.2.7 Out-of-Network Access	☐
5.2.8 Specific Requirements for Access to Programs and Covered Services	☐
5.2.9 Network and Access Changes to Covered Services	☐
5.2.10 Access Rights	☐
5.2.11 Cultural and Linguistic Programs and Committees	☐
5.2.12 Continuity of Care for Seniors and Persons with Disabilities	☐
5.2.13 Network Reports	☐
5.2.14 Site Review	☐
5.2.15 Street Medicine	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
5.3 Scope of Services	
5.3.1 Covered Services	☐
5.3.2 Medically Necessary Services	☐
5.3.3 Initial Health Appointment	☐
5.3.4 Services for Members Less Than 21 Years of Age	☐
5.3.5 Services for Adults	☐
5.3.6 Pregnant and Postpartum Members	☐
5.3.7 Services for All Members	☐
5.3.8 Investigational Services	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
5.4 Community Based Adult Services	
5.4.1 Covered Services	☐
5.4.2 Coordination of Care	☐
5.4.3 Required Reports for the Community Based Adult Services Program	☐
5.4.4 Community Participation	☐
5.4.5 Community Based Adult Services Program Integrity	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
5.5 Mental Health and Substance Use Disorder Benefits	
5.5.1 Mental Health Parity Requirements	☐
5.5.2 Non-Sspecialty Mental Health Services and Substance Use Disorder Services	☐
5.5.3 Non-Sspecialty Mental Health Services Providers	☐
5.5.4 Emergency Mental Health and Substance Use Disorder Services	☐
5.5.5 Mental Health and Substance Use Disorder Services Disputes	☐
5.5.6 No Wrong Door for Mental Health Services	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
5.6 MOUs with Local Government Agencies, County Programs, and Third Parties	
5.6.1 MOU Purpose	☐
5.6.2 MOU Requirements	☐
5.6.3 MOU Oversight and Compliance	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
6.0 Emergency Preparedness and Response	
6.**1.**1 General Guidance	☐
6.**1.**2 Business Continuity Emergency Plan	☐
6.**1.**3 Member Emergency Preparedness Plan	☐
6.**1.**4 California's Standardized Emergency Management System	☐
6.**1.**5 Reporting Requirements During an Emergency	☐
6.**1.**6 DHCS Emergency Directives	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
7.0 Operations Deliverables and Requirements	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit E	
1.0 Program Terms and Conditions	
1.1.1 Governing Law	☐
1.1.2 DHCS Guidance	☐
1.1.3 Contract Interpretation	☐
1.1.4 Assignments, Mergers, Acquisitions	☐
1.1.5 Independent Contractor	☐
1.1.6 Amendment and Change Order Process	☐
1.1.7 Delegation of Authority	*(1) Must not be delegated*
1.1.8 Authority of the State	☐
1.1.9 Fulfillment of Obligations	☐
1.1.10 Obtaining DHCS Approval	☐
1.1.11 Certifications	☐
1.1.12 Notices	☐
1.1.13 Term	☐
1.1.14 Service Area	☐
1.1.15 Contract Extension	☐
1.1.16 Termination	☐
1.1.17 Phaseout Requirements	☐
1.1.18 Indemnification	☐
1.1.19 Sanctions	☐
1.1.20 Liquidated Damages	☐
1.1.21 Contractor's Dispute Resolution Requirements	☐
1.1.22 Inspection and Audit of Records and Facilities	☐
1.1.23 Confidentiality of Information	☐

Contractual Requirements	Delegated to Subcontractor
1.1.24 Pilot Projects	☐
1.1.25 Cost Avoidance and Post-Payment Recovery (PPR) of Other Health Coverage (OHC)	☐
1.1.26 Third-Party Tort and Workers' Compensation Liability	☐
1.1.27 Litigation Support	☐
1.1.28 Equal Opportunity Employer	☐
1.1.29 Federal and State Nondiscrimination Requirements	☐
1.1.30 Discrimination Prohibitions	☐
1.1.31 Small Business Participation and Disabled Veteran Business Enterprises (DVBE) Reporting Requirements	☐
1.1.32 Conflict of Interest Avoidance Requirements	*(1) Must not be delegated*
1.1.33 Guaranty Provision	☐
1.1.34 Priority of Provisions	☐
1.1.35 Additional Incorporated Provisions – Proposals	☐
1.1.36 Miscellaneous Provisions	☐
1.1.37 Data Sharing	☐

Exhibit K – Excluded Provisions as to Contractors Not Licensed Pursuant to the Knox-Keene Health Care Service Plan Act of 1975

Unless otherwise specified in this Contract, the following provisions of the Knox-Keene Health Care Service Plan Act of 1975~~, (KKA),~~ and its implementing regulations (28 California Code of Regulations (CCR) section 1000, *et seq*.) **(KKA)** are excluded from this Contract if Contractor is not licensed to operate as a health care service plans pursuant to the KKA. This list is not exhaustive or exclusive since other provisions of the KKA may also be excluded from the Contract pursuant to Exhibit E, **Sub**section 1.1.**1.**D (*Applicability of the Knox-Keene Act*) or other provisions of the Contract:

1. Health and Safety Code (H&S) sections 1341 – 1341.14.
2. H&S sections 1342.4 – 1342.73.
3. H&S sections 1346 – 1347.5.
4. H&S sections 1348.9 – 1348.96.
5. H&S, Article 3 of Chapter 2.2 of Division 2.
6. H&S, Article 3.1 of Chapter 2.2 of Division 2.
7. H&S, Article 3.15 of Chapter 2.2 of Division 2.
8. H&S, Article 3.16 of Chapter 2.2 of Division 2.
9. H&S, Article 3.17 of Chapter 2.2 of Division 2.
10. H&S, Article 3.5 of Chapter 2.2 of Division 2.
11. H&S sections 1359 – 1361.1.
12. H&S section 1363.01.
13. H&S section 1363.03.
14. H&S section 1363.05.
15. H&S, Article 4.5 of Chapter 2.2 of Division 2.
16. H&S sections 1367.002 – 1367.009.
17. H&S section 1367.010 – 1367.012.
18. H&S section 1367.02.
19. H&S section 1367.035.
20. H&S section 1367.042.
21. H&S section 1367.07 – 1367.1
22. H&S sections 1367.45 – 1367.46.
23. H&S section 1367.15.
24. H&S section 1367.23.
25. H&S section 1367.30.
26. H&S section 1368.2
27. H&S sections 1368.04 – 1368.05.
28. H&S section 1372.
29. H&S section 1373.5.
30. H&S sections 1373.621 – 1373.622.
31. H&S section 1373.7 – 1373.8.
32. H&S section 1373.95.
33. H&S section 1373.10.

34. H&S section 1373.14.
35. H&S section 1373.18.
36. H&S section 1374.
37. H&S sections 1374.5 – 1374.58.
38. H&S sections 1374.9 – 1374.10.
39. H&S, Article 5.5 of Chapter 2.2 of Division 2.
40. H&S, Article 5.55 of Chapter 2.2 of Division 2.
41. H&S sections 1374.65 – 1374.721.
42. H&S sections 1374.723 – 1374.76.
43. H&S sections 1375.1 – 1375.3.
44. H&S section 1376.
45. H&S section 1377.
46. H&S sections 1379.5 – 1380.
47. H&S section 1381.
48. H&S section 1383.
49. H&S section 1385.
50. H&S, Article 6.1 of Chapter 2.2 of Division 2.
51. H&S, Article 6.2 of Chapter 2.2 of Division 2.
52. H&S, Article 7 of Chapter 2.2 of Division 2.
53. H&S sections 1389.1 – 1389.7.
54. H&S, Article 8 of Chapter 2.2 of Division 2.
55. H&S, Article 8.5 of Chapter 2.2 of Division 2.
56. H&S sections 1395.6.H&S sections 1399.5.
57. H&S section 1399.57.
58. H&S, Article 10 of Chapter 2.2 of Division 2.
59. H&S, Article 10.2 of Chapter 2.2 of Division 2.
60. H&S, Article 11 of Chapter 2.2 of Division 2.
61. H&S, Article 11.1 of Chapter 2.2 of Division 2.
62. H&S, Article 11.5 of Chapter 2.2 of Division 2.
63. H&S, Article 11.8 of Chapter 2.2 of Division 2.

Exhibit L
REQUIREMENTS SPECIFIC TO CONTRACTOR

1.0 Definitions

As used in this Exhibit L of this Contract, unless otherwise expressly provided or the context otherwise requires, the following definitions of terms governs the construction of this Exhibit L. To the extent that definitions in this Exhibit L conflict with definitions in Exhibit A, Attachment I, Article 1.0 (*Definitions*), the definitions used in this Exhibit L apply here:

Potential Member or Potential Enrollee aid codes:

Aid Group	Mandatory Aid Codes	Non-Mandatory Aid Codes
Adult & Family/Optional Targeted Low-Income Child	01, 02, 08, 0A, 0E, 2V, 30, 32, 33, 34, 35, 38, 39, 3A, 3C, 3E, 3F, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 3W, 47, 54, 59, 5C, 5D, 5V, 72, 7A, 7J, 7S, 7W, 81, 82, 86, 8E, 8P, 8R, 8U, E6, E7, E8, H1, H2, H3, H4, H5, K1, M3, M5, M7, M9, P5, P7, P9, R1, T1, T2, T3, T4, T5	03, 04, 06, 07, 2P, 2R, 2S, 2T, 2U, 40, 42, 43, 45, 46, 49, 4A, 4F, 4G, 4H, 4K, 4L, 4M, 4N, 4S, 4T, 4U, 4W, 5K, 5L, 76
Adult & Family/Optional Targeted Low-Income Child Dual Eligible	0A, 0E, 2V, 30, 32, 33, 34, 35, 38, 39, 3A, 3C, 3E, 3F, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 3W, 47, 54, 59, 5C, 5D, 5V, 72, 7A, 7J, 7S, 7W, 82, 8E, 8P, 8R, 8U, E6, E7, E8, H1, H2, H3, H4, H5, K1, M3, M5, M7, M9, P5, P7, P9, R1, T1, T2, T3, T4, T5	03, 04, 06, 07, 40, 42, 43, 45, 46, 49, 4A, 4F, 4G, 4H, 4K, 4L, 4M, 4N, 4S, 4T, 4U, 4W, 5K, 5L
SPD Dual	10, 14, 16,1E, 1H, 1X, 20, 24, 26, 2E, 2H, 36, 60, 64, 66, 6A, 6C, 6E, 6G, 6H, 6J, 6N, 6P, 6V, 6X, L6	
SPD	10, 14, 16, 1E, 1H, 20, 24, 26, 2E, 2H, 36, 60, 64, 66, 6A, 6C, 6E, 6G, 6H, 6J, 6N, 6P, 6V, L6	
Adult Expansion	L1, M1, 7U	
Breast and Cervical Cancer Treatment Program (BCCTP)	0M, 0N, 0P, 0R, 0T, 0U, 0W	
Long-Term Care	13, 23, 53, 63	
Long-Term Care Dual	13, 23, 53, 63	

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Specialized Durable Medical Equipment means Durable Medical Equipment (DME) that is uniquely constructed from raw materials or substantially modified from the base material solely for the full-time use of a specific Member, according to a Physician's description and orders; is made to order or adapted to meet the specific needs of the beneficiary; and is so uniquely constructed, adapted, or modified that it is unusable by another individual, and is so different from another item used for the same purpose that the two could not be grouped together for pricing purposes.

Exhibit L
REQUIREMENTS SPECIFIC TO CONTRACTOR

2.0 Capitation Payment Rates

As used in this Exhibit L of this Contract, unless otherwise expressly provided or the context otherwise requires, the following Capitation Payment rates govern the construction of this Exhibit L.

For the period January 1, 2024 – December 31, 2024	Orange
Aid Group	Rates
Adult/Family/OTLIC Under 21 - SIS	$199.26
Adult/Family/OTLIC Under 21 - UIS	$109.70
Adult/Family/OTLIC 21 & Over - SIS	$401.77
Adult/Family/OTLIC 21 & Over - UIS	$309.70
SPD - SIS	$1,241.72
SPD - UIS	$735.64
BCCTP - SIS	$1,241.72
BCCTP - UIS	$735.64
SPD Dual - SIS	$584.50
SPD Dual - UIS	$161.81
LTC - SIS	$1,241.72
LTC - UIS	$735.64
LTC Dual - SIS	$584.50
LTC Dual - UIS	$161.81
Adult Expansion - SIS	$449.68
Adult Expansion - UIS	$378.90
WCM - SIS	$2,252.84
WCM - UIS	$612.50

For the period January 1, 2024 – December 31, 2024	Orange
Supplemental and Additional Payment Groups	Rates
Maternity - SIS	$8,811.73
Maternity - UIS	$8,811.73
Adult Expansion Maternity - SIS	$8,811.73
Adult Expansion Maternity - UIS	$8,811.73

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For the period January 1, 2025 – December 31, 2025	Orange
Aid Group	Rates
Adult/Family/OTLIC Under 21 - SIS	$246.69
Adult/Family/OTLIC Under 21 - UIS	$111.90
Adult/Family/OTLIC 21 & Over - SIS	$456.13
Adult/Family/OTLIC 21 & Over - UIS	$250.92
SPD - SIS	$1,386.57
SPD - UIS	$494.05
BCCTP - SIS	$1,386.57
BCCTP - UIS	$494.05
SPD Dual - SIS	$679.21
SPD Dual - UIS	$210.22
LTC - SIS	$1,386.57
LTC - UIS	$494.05
LTC Dual - SIS	$679.21
LTC Dual - UIS	$210.22
Adult Expansion - SIS	$447.71
Adult Expansion - UIS	$306.12
WCM - SIS	$2,170.52
WCM - UIS	$544.79

For the period January 1, 2025 – December 31, 2025	Orange
Supplemental and Additional Payment Groups	Rates
Maternity - SIS	$6,869.95
Maternity - UIS	$6,869.95
Adult Expansion Maternity - SIS	$6,869.95
Adult Expansion Maternity - UIS	$6,869.95

Exhibit L
REQUIREMENTS SPECIFIC TO CONTRACTOR

32.0 EXHIBIT L OPERATIONAL READINESS DELIVERABLES AND REQUIREMENTS

	Operational Readiness Requirement
Exhibit L 1	Submit a written transition plan detailing the transfer of case management, Care Coordination, Provider referral, and service authorization administrative functions of the California Children's Services (CCS) program to Contractor to be prepared by the designated county agency and Contractor. The transition plan must include the following: 1) Details regarding the transfer of case management, Care Coordination, Provider referrals, and service authorization, including administrative functions, of the CCS Program to Contractor to be prepared by the designated county agency and Contractor. 2) Details regarding communications with Members regarding, but not limited to, authorizations, Network, case management, and ensuring continuity of care and services for Members who are in the process of aging out of CCS. 3) Details regarding the process for ensuring all WCM Members have access to a primary point of care who has knowledge or adequate training on the CCS Program and who is responsible for Care Coordination. 4) Details regarding the process for completing all required pediatric risk assessments within 45 calendar days of the transition to determine Members' risk level, including telephonic or in-person communications. 5) A detailed process for completing all Individual Care Plans (ICPs) for WCM Members determined to be high risk within one year of the transition. 6) A detailed process for verifying the compliance of Fully Delegated Subcontractors, Partially Delegated Subcontractors, Downstream Fully Delegated Subcontractors, and Downstream Partially Delegated Subcontractors.

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	7) A detailed dispute resolutions policy setting out how disagreements between Contractor and the county CCS Program regarding CCS medical eligibility determinations must be resolved by the county CCS Program in consultation with DHCS, in compliance with the dispute resolution requirements in APL 23-034. 8) Confirmation that Contractor will collaborate with the county CCS Program to provide input on the development of the transition plan.
Exhibit L 2	Submit the executed WCM Memorandum of Understanding (MOU) or evidence indicating a reasonable effort to finalize the MOU with the county CCS program. Additionally, the MOU must address Contractor and county CCS Program coordination with regards to Medical Therapy Unit services.
Exhibit L 3	Submit a network that includes an appropriate number of CCS Providers adequate to serve the needs of WCM Members in the Service Area.
Exhibit L 4	Submit an updated Provider network via the Provider Network Readiness template. Contractor must complete and submit the provided template as well as include any additional contracted CCS-paneled Providers, allied and medical supportive personnel, Durable Medical Equipment (DME) Providers, and approved Provider facilities, including: Specialists, Tertiary and Pediatric Community Hospitals, and Special Care Centers. Contractor must also include required outreach conducted to all out-of-Network Providers and facilities.
Exhibit L 5	Submit updated policies and procedures that outline Continuity of Care (COC) for CCS-Medically Necessary services as set out in APL 23-034. These policies and procedures must describe in detail a process which allows Members to request and receive continuity of care with both existing CCS Provider(s) and Specialized DME Provider(s) for up to 12 months. The policies and procedures must outline how Contractor will ensure the WCM Members receive expert case management, Care Coordination, service authorization, and Provider referral services. The policies and procedures must outline Contractor's compliance with the continuity of care requirements identified in APL 23-022 and APL 23-034.

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Exhibit L 6	Submit network analysis to demonstrate the availability of an appropriate Provider network to serve the needs of WCM Members, including Primary Care Providers (PCP), pediatric Specialists and sub-Specialists, professional, allied, and medical supportive personnel, licensed acute care hospitals, special care centers, and DME Providers. This Network analysis must include an assessment of capacity, the existing Network and capabilities, the Providers available for contracting, a gap analysis, and a plan for closing those gaps. Contractor must, at a minimum, provide the following information in the analysis: 1) Number of Members that Contractor expects to receive; 2) Number of paneled / approved CCS Providers and facilities; 3) Number of paneled / approved CCS Providers and facilities targeted for contracting; and 4) The existing CCS/WCM Provider Network and its capacity to serve the expected Members.
Exhibit L 7	Submit an attestation that Contractor and its Subcontractors and Downstream Subcontractors will work to execute contracts with all Providers included on the updated Provider Network Readiness template submission.

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Exhibit L 8	Submit updated policies and procedures for ensuring Subcontractors and Downstream Subcontractors fully comply with all the terms and conditions of this Contract relating to WCM network certification requirements including: 1) Policies and procedures for ensuring Subcontractors and Downstream Subcontractors meet WCM operational requirements included in this Contract, as well as APL 23-034. 2) Process for ensuring a Subcontractor and Downstream Subcontractor meets WCM network certification requirements. 3) Oversight and readiness activities for Subcontractors and Downstream Subcontractors for Phase 2 to demonstrate requirements are met for implementation including: a) Subcontractor and Downstream Subcontractor Correspondence/Bulletins; b) Agendas and Meeting Notes regarding WCM; and c) Policies and Procedures setting out the compliance review process for Subcontractors and Downstream Subcontractor.
Exhibit L 9	Submit updated policies and procedures to ensure that credentialing and re-credentialing includes and speaks to CCS Providers.
Exhibit L 10	Submit an attestation that no WCM Members will be enrolled or assigned to a Subcontractor and Downstream Subcontractor that is excluded from participating in WCM, and that Contractor will allow Members access to Providers within all of Contractor's network for CCS services. Provide process for how Contractor will ensure that that no WCM Members will be enrolled or assigned to a Subcontractor or Downstream Subcontractor that is excluded from participating in WCM.

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Exhibit L 11	Submit updated policies and procedures to explain the approach and development of ICPs for WCM Members based on the results of the pediatric health risk assessment process. Contractor must complete ICPs with a particular focus on CCS specialty care, must consider behavioral health needs, and must coordinate those services. The policies and procedures must state that if the Member or the Member's parents, custodial parents, legal guardians, or other Authorized Representatives decline the development of an ICP, Contactor must notate the denial in the medical record as evidence of Contractor compliance. The policies and procedures must state that the ICP must incorporate, at a minimum, the Member's goals and preferences, and provide measurable objectives and timetables to meet the needs for the services listed in APL 23-034. The policies and procedures must state that the ICP must be developed by the case management team, in collaboration with the Member, the Member's parents, custodial parents, legal guardians, other Authorized Representatives, caregivers, or other authorized support persons, and must indicate the level of care the Member requires. The policies and procedures must also require that the ICP include all of the information listed in APL 23-034, as applicable. The policies and procedures must state that Contractor must reassess a Member's risk level and needs annually at the CCS eligibility redetermination or upon the report of a significant change to a Member's condition.
Exhibit L 12	Provide summary of details regarding local stakeholder process with the meaningful engagement of a diverse group of families that represent a range of conditions, disabilities, demographics, and local Providers, including, but not limited to, the parent centers, such as family resource centers, family empowerment centers as well as parent training and information centers that support families in the particular county. Additionally, Contractor's summary must provide details on the meeting frequency of the CCS family advisory committee and CCS clinical advisory committee, which must meet at least quarterly in compliance with APL 23-034. Refer to the advisory committee requirements in APL 23-034 for direction on required deliverable updates.

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Exhibit L 13	Submit updated policies and procedures as to the CCS maintenance and transportation benefit, in compliance with the transportation requirements as outlined in APL 23-034. If no updates to policies and procedures are needed, Contractor must submit an attestation stating that it reviewed the policies and procedures and no changes are necessary.
Exhibit L 14	Submit updated policies and procedures including details regarding person-centered planning provided to WCM Members including details on CCS age-out planning responsibilities. Contractor must establish and maintain a process for preparing Members approaching CCS Program age limitations, including identification of Primary Care Providers (PCP) and specialty care Providers appropriate to the Members' CCS-Eligible Condition(s). Refer to requirements relating to age-out planning responsibilities in APL 23-034 for direction on required deliverable updates.
Exhibit L 15	Submit updated policies and procedures that include the mechanism by which WCM Members can request from Contractor a Specialist or clinic to serve as their Primary Care Provider.
Exhibit L 16	Submit updated policies and procedures describing the CCS clinical advisory committee and CCS family advisory committee, in compliance with W&I section 14094.17 and APL 23-034.
Exhibit L 17	Submit updated policies and procedures on how Contractor will inform WCM Members of how to access local family resource centers and family empowerment centers.

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Exhibit L 18	Submit updated policies and procedures to ensure Contractor covers all Medically Necessary blood, tissue, and solid organ transplants, as defined by APL 21-015, for WCM Members, as outlined in the Medi-Cal Provider Manual. Contractor must refer WCM Members to a CCS-approved Special Care Center (SCC) for evaluation within 72 hours of the PCP or Specialist identifying the WCM Members' potential candidature for a blood, tissue, or solid organ transplant and receiving all of the necessary information to make a referral or authorization. Contractor must authorize the request for the blood, tissue, or solid organ transplant after the SCC confirms the Member is a suitable candidate for the blood, tissue, or solid organ transplant, in compliance with Health and Safety Code section 1367.01 and APL 21-015. If no updates are needed, Contractor must submit an attestation stating that its policies and procedures have been reviewed and no changes are necessary.
Exhibit L 19	Submit all WCM policies and procedures updates required by APL 23-034 that were not captured in the above deliverables.
Exhibit L 20	Submit updated policies and procedures that outline enhanced continuity of care policies applying to Members transitioning under the WCM expansion, as set out in APL 23-034.

Exhibit L
REQUIREMENTS SPECIFIC TO CONTRACTOR

43.0 Whole Child Model Program

43.1 Whole Child Model Scope of Services
43.2 Required Reports for the Whole Child Model Program
43.3 Data Sharing Links
43.4 Whole Child Model Payments

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Exhibit L
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43.1 Whole Child Model Scope of Services

43.1.1 Whole Child Model Program Compliance

In Orange County, Contractor must implement the Whole Child Model (WCM) program, as directed by DHCS and in accordance with all WCM program requirements, including Senate Bill (SB) 586 (Hernandez, Chapter 625, Statutes of 2016), Assembly Bill (AB) 2724 (Arambula, Chapter 73, Statutes of 2022), AB 118 (Committee on Budget, Chapter 42, Statutes of 2023), and All Plan Letter (APL) 23-034, in order to cover benefits that were previously covered by the California Children's Services (CCS) Program. Contractor's implementation of and participation in the WCM Program renders this Contract's requirements, as stated in Exhibit A, Attachment III, Subsection 4.3.14 (*California Children's Services*), inapplicable to Contractor.

A. Contractor must provide all Medically Necessary services previously covered by the CCS program as Covered Services for Members who are eligible for the CCS program at the time of the transition of benefits to Contractor, and for Members who are determined eligible for WCM after the transition of benefits.

B. To ensure consistency in the provision of CCS Covered Services, Contractor must use all current and applicable CCS program guidelines, including CCS program statutes, regulations, CCS program information notices, and numbered letters in developing criteria for use by Contractor's Medical Director or the equivalent, and other care management staff. When applicable CCS clinical guidelines do not exist, Contractor must use evidence-based guidelines or treatment protocols that are medically appropriate given the Member's CCS-eligible condition.

   The CCS numbered letters are posted by DHCS at the following web address for guidance on providing CCS Covered Services to WCM Members:

   http://www.dhcs.ca.gov/services/ccs/Pages/CCSNL.aspx

C. Contractor must provide all available Medically Necessary Medi-Cal Covered Services. Any Medically Necessary CCS services not available as a Medi-Cal Covered Service must remain the responsibility of the State and the county.

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D. Contractor must provide DHCS with documentation confirming that Contractor has established a local stakeholder process in accordance with Welfare and Institutions Code (W&I) section 14094.7(d)(3). Such documentation may include meeting minutes, a meeting schedule, or other forms of confirmation approved by DHCS.

E. Contractor must execute a MOU with the county CCS program as stipulated in Exhibit A, Attachment III, Subsection 5.6.3 (*MOU Oversight and Compliance*), and APL 23-034, for the coordination of CCS services to Members. This MOU must include the following:

1) At a minimum, all of the provisions required in the WCM MOU template posted on the CCS WCM page of the DHCS website pursuant to W&I section 14094.9. If the Contractor or County CCS Program modifies any of the provisions of the WCM MOU Template, the Contractor must submit a redlined version of the MOU to DHCS for review and approval, prior to execution.

2) A provision requiring policies and procedures for referral to and coordination with the local CCS Medical Therapy Unit (MTU) to ensure appropriate access to MTU services, and other non-MTU services provided under this Contract.

3) A provision requiring Contractor to allow a WCM Member, or the Member's parents, custodial parents, legal guardians, or other Authorized Representatives, to request to continue case management and Care Coordination from their public health nurse within 90 days of their transition to the WCM Program, in accordance with W&I section 14094.13(e) and Subsection **4**~~3~~.1.9 (*Care Management and Coordination of Care*) of this Exhibit L.

4) Contractor must designate CCS Liaison(s) to be the primary point(s) of contact for the MOU and coordination of services between Contractor and county CCS Program. The CCS Liaisons must meet no less than quarterly to discuss activities related to the MOU and any other related matters. Contractor must submit to DHCS its designated CCS Liaison's contact information.

5) A provision requiring Contractor, at a minimum, to review its MOUs annually for any needed modifications or renewal of responsibilities and obligations outlined within. Contractor must submit to DHCS'

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Contract Manager evidence of the annual review of MOUs as well as copies of any MOUs modified or renewed as a result.

F. To the extent Contractor does not execute an MOU with the county CCS Program by the timeframe required by DHCS, Contractor must submit quarterly reports to DHCS documenting its continuing good faith efforts to execute the MOU, until such time as the MOU is executed. Documentation of good faith efforts must include a description of Contractor's attempts to execute an MOU and an explanation of why the MOU has not been executed.

43.1.2 Annual Medical Eligibility Redeterminations

A. Contractor must provide all necessary documentation, dated within the last six months but no later than 12 months prior to the Member's CCS program eligibility end date to allow for an annual medical eligibility redetermination by the county CCS program in accordance with 22 California Code of Regulations (CCR) section 41515.1 and APL 23-034. This includes but is not limited to:

1) The Member's current medical records that document the Member's medical history;

2) Results of physical examinations by a physician's assistant, or nurse practitioner acting within the scope of their licensing authority;

3) Laboratory test results;

4) Radiologic findings; or

5) Other tests and examinations that support the diagnosis of the CCS-eligible condition(s), including any medical therapy unit diagnosis or high-risk infant follow-up reports.

B. Contractor must provide the documentation, including efforts made to receive required documentation when it is not available to the independent County CCS Program, no later than 60 calendar days before the Member's program eligibility end date, unless the independent County CCS Program verifies that all needed medical information is already available to them. If documentation is received after the 60-day timeframe, Contractor must notify and engage in a collaborative process with the

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County CCS Programs to remedy any issues or challenges related to the timeliness or completeness of records provided by the Contractor that are needed for the annual medical redetermination.

C. If the county CCS program requires additional documentation, Contractor must, upon notification from the county CCS program, coordinate with the Member's Provider(s) to obtain any needed documentation, within the agreed upon timeframe, to support the county CCS program's medical redetermination efforts.

D. Contractor must proactively engage in a collaborative process with the county CCS program to remedy any issues or challenges related to timeliness or completeness of records for the medical eligibility redetermination process.

E. For disputes between Contractor and the county CCS program regarding CCS medical eligibility determinations where a resolution cannot be reached, Contractor may refer the dispute directly to DHCS for review and a final determination.

4~~3~~.1.3 WCM Advisory Committees

A. In accordance with W&I section 14094.17(a) and APL 23-034, Contractor must create and maintain a WCM clinical advisory committee, separate and distinct from its Quality Improvement and Health Equity Committee described in Exhibit A, Attachment III, Section 2.2 (*Quality Improvement and Health Equity Committee*). The WCM clinical advisory committee must be composed of Contractor's Chief Medical Officer or the equivalent, the county CCS medical director, and at least four CCS-paneled Providers.

1) The WCM clinical advisory committee must advise on clinical issues relating to CCS conditions, including treatment authorization guidelines, and to serve as clinical advisers on other clinical issues relating to CCS conditions.

2) The WCM clinical advisory committee must meet at least quarterly, or more frequently if determined necessary.

B. In accordance with W&I section 14094.17(b) and APL 23-034, Contractor must establish a WCM family advisory group that is separate and distinct from its Community Advisory Committee described in Exhibit A,

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Attachment III, Subsection 5.2.11.E (*Cultural and Linguistic Programs and Committees*), and is specifically for WCM families.

1) The WCM family advisory group must be comprised of WCM Members' parents, custodial parents, legal guardians, or other Authorized Representatives. Family representatives who serve may receive a reasonable per diem payment to enable in-person participation in the WCM family advisory group.

2) Contractor must conduct WCM family advisory group meetings at least quarterly and may utilize teleconference or other similar electronic means to facilitate participation.

3) A representative of the WCM family advisory group must be invited to serve on the DHCS statewide stakeholder advisory group for CCS.

4~~3~~.1.4 CCS Provider Network

A. Contractor must include in their Network an adequate number of CCS Providers able to serve the needs of Members with CCS-eligible conditions and receive timely access. Contractor must utilize only paneled CCS Providers to treat CCS-eligible conditions when a WCM Member's condition requires treatment from the Provider types described in this Exhibit L. DHCS remains responsible for paneling CCS Providers. Contractor may use an out-of-state Provider, in accordance with APL 19-004, if an in-state CCS Provider does not possess the clinical expertise to appropriately treat the Member's CCS-eligible condition.

B. In addition to the Network requirements found in Exhibit A, Attachment III, Subsection 5.2.3 (*Network Composition*), Contractor must also include the following:

1) An adequate number of hospitals and/or facilities that include neonatal intensive care units, CCS-approved pediatric intensive care units, and CCS-approved inpatient facilities.

2) Licensed acute care hospitals and special care centers approved by the CCS program to treat a CCS-eligible condition.

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3) That among the pediatric Network Providers are an adequate number of CCS-paneled Providers who are board-certified in both pediatrics and the appropriate pediatric subspecialty.

C. In addition to the requirements in Exhibit A, Attachment III, Subsection 2.2.13 (*Credentialing and Recredentialing*), Contractor must credential CCS Providers in accordance with APL 23-034.

D. CCS Providers must be able to utilize Contractor's Provider Dispute Resolution Mechanism, as described in Exhibit A, Attachment III, Section 3.2.2 (*Provider Dispute Resolution Mechanism*).

43.1.5 Provider Compensation

In addition to the requirements found in Exhibit A, Attachment III, Section 3.3 (*Provider Compensation Arrangements*), Contractor must also reimburse Physicians and surgeons providing CCS to eligible Members at rates that are equal to or exceed the applicable CCS Fee-For-Service (FFS) rates, unless the Physician and surgeon enters into an agreement on an alternative payment methodology mutually agreed to by the Physician or surgeon and Contractor.

43.1.6 Covered Services

In addition to the requirements found in Exhibit A, Attachment III, Section 5.3 (*Scope of Services*), Contractor must cover CCS for Members determined to be eligible in accordance with 22 CCR section 51013. Upon diagnostic evidence that a Member under 21 years of age may have a CCS-eligible condition, Contractor must refer the Member to the county CCS program office for eligibility determination.

A. Contractor must ensure assessment and Care Coordination for the transition of Members who are eligible for CCS and receiving services through the CCS program at the time of the transition, as required below in Exhibit L, Subsection 43.1.9 (*Care Management and Coordination of Care*).

B. For the identification of a Member eligible for CCS, Contractor must ensure the following:

1) Network Providers must perform appropriate baseline health assessments and diagnostic evaluations that provide sufficient

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clinical detail to establish, or raise a reasonable likelihood, that a Member has a CCS-eligible condition.

2) Initial referrals of Member's with potential CCS-eligible conditions must be made to the county CCS program by telephone, same day mail, or fax or other secure electronic system, if available. The initial referral must be followed by submission of supporting medical documentation sufficient to allow for eligibility determination by the county CCS program.

3) Contractor must provide all Medically Necessary CCS Covered Services for the Member's CCS-eligible condition(s).

4) If the county CCS program does not approve eligibility, Contractor remains responsible for the provision of all Medically Necessary Covered Services to the Member, including Early Periodic Screening, Diagnosis and Testing (EPSDT) as required in Exhibit A, Attachment III, Subsection 5.3.4.E (*Services for Members Less Than 21 Years of Age*).

4~~3~~.1.7 Continuity of Care

Contractor must provide continuity of care to WCM Members transitioning to the WCM program in accordance with W&I sections 14094.13, Health and Safety Code section 1373.96, APL 23-034, and as follows:

A. In accordance with W&I section 14094.13(a)-(d), Contractor must establish and maintain a process for continuity of care for up to 12 months after the transition between WCM Members and CCS Providers, and Specialized Durable Medical Equipment (DME) Providers, with whom the WCM Member has an existing relationship. If Contractor and the Provider are unable to reach an agreement, Contractor must offer the Member an alternative Network Provider.

B. For out-of-Network CCS Providers and Specialized DME Providers, Contractor must provide continuity of care under the following conditions, as applicable:

1) The Member has seen the out-of-Network CCS Provider for a non-emergency visit at least once during the 12 months immediately preceding their transition to the WCM program.

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2) The Member has previously received Specialized DME from the Specialized DME Provider.

3) The CCS Provider or Specialized DME Provider accepts Contractor's rate for the service, or the applicable Medi-Cal or CCS FFS rate, whichever is higher, unless the CCS Provider or Specialized DME Provider enters into an agreement on an alternative payment methodology mutually agreed upon by Contractor and the CCS Provider or Specialized DME Provider.

4) Contractor confirms that the CCS Provider meets applicable CCS standards and has no disqualifying quality of care issues.

5) The CCS Provider makes treatment information available to Contractor, to the extent authorized by the State and federal patient privacy provisions.

6) The Specialized DME Provider makes information available as requested by Contractor, to the extent authorized by the State and federal patient privacy provisions.

7) At its discretion, Contractor may extend the continuity of care period beyond the 12 months, as specified in Paragraph B.1) above.

C. Ensure that the continuity of care requirements for Pharmaceutical Services and Provision of Prescription Drugs described in Exhibit A, Attachment III, Subsection 5.3.7.H (*Services for All Members*), are applied to Members who are eligible for the CCS program at the time of the transition to the WCM program. Before the previously prescribed Prescription Drug is discontinued, Contractor and the Member's prescribing CCS Provider must complete the necessary evaluation and treatments and must both agree that the previously prescribed Prescription Drug is no longer Medically Necessary, or that it is no longer prescribed by the Member's prescribing CCS Provider.

D. For CCS neonatal intensive care units, Contractor must pay the Provider either the equivalent of Medi-Cal FFS rates, such as the All Patient Refined Diagnosis Related Group (APR-DRG) rates or other established rates, or Contractor's negotiated rate, whichever is higher, for up to 12 months after the transition.

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Exhibit L
REQUIREMENTS SPECIFIC TO CONTRACTOR

43.1.8 EPSDT Services

For WCM Members, Contractor must provide all Medically Necessary Covered Services, including EPSDT services, as described in Exhibit A, Attachment III, Subsection 5.3.4.E (*Services for Members Less Than 21 Years of Age*), when the scope of an EPSDT benefit is more generous than the scope of a CCS benefit. In such cases, Contractor must apply the EPSDT standard of what is Medically Necessary to correct or ameliorate the Member's condition.

43.1.9 Care Management and Coordination of Care

In addition to the requirements in Exhibit A, Attachment III, Section 2.3 (*Utilization Management Program*), and Exhibit A, Attachment III, Section 4.3 (*Population Health Management and Coordination of Care*), Contractor must provide service authorization, case management, and Care Coordination for CCS through a CCS Case Manager, assigned as the primary point of contact for the Member, with knowledge or adequate training on the CCS program, and clinical experience with either the CCS population or pediatric patients with complex medical conditions. Once a Member's eligibility for the CCS program is established, Contractor must complete the following for risk stratification and assessment, and coordination of care in accordance with APL 23-034:

A. Contractor must designate at least one individual to serve as the CCS Case Manager. The CCS Case Manager will serve as the primary point of contact responsible for the provision of case management services and facilitation of Care Coordination for a Member receiving services through the WCM Program. The CCS Case Manager must have knowledge of or adequate training on the CCS Program and clinical experience with either the CCS population or pediatric patients with complex medical conditions. When WCM Members are eligible for and choose to receive Enhanced Care Management (ECM) services, Contractor may assign some or all CCS Case Manager functions to be delivered by ECM Providers as outlined DHCS' ECM Policy Guide. The CCS Case Manager should also be a point of contact for other care managers and service providers that serve WCM Members, including ECM Providers and Community Supports Providers.

B. For the transition of Members who are eligible for CCS and receiving services through the CCS program at the time of the transition, Contractor must conduct a RSS in accordance with the requirements of this Contract.

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REQUIREMENTS SPECIFIC TO CONTRACTOR

C. Contractor must assess Member eligibility for Complex Care Management (CCM) and Enhanced Care Management (ECM), as set out in Exhibit A, Attachment III, Subsection 4.3.7 (*Care Management Programs*), and coordinate enrollment into the most appropriate care management program to meet Member needs. A Member may not be enrolled in CCM and ECM at the same time.

A Member receiving CCS may also receive either CCM or ECM. When Members receive both CCS case management services and either CCM or ECM, Contractor must ensure coordination and non-duplication of CCS case management and CCM or ECM.

For Members receiving CCS case management and either CCM or ECM, the Contractor must provide coordination of care across all settings, including, but not limited to, between the Members' Primary Care Provider (PCP), CCS specialty services, and, if applicable, Non-Specialty Mental Health Services and Regional Center services.

D. Contractor must also arrange referral to Specialty Mental Health Services and Drug Medi-Cal services as appropriate through the county Substance Use Disorder (SUD) program if determined necessary through Contractor's RSS. To arrange services with a Regional Center, Contractor must:

1) Coordinate with WCM Members and their parents, custodial parents, legal guardians, or other Authorized Representatives, in understanding and accessing services; and

2) Operate as a central point of contact for questions regarding access, care, and problem resolution.

E. Contractor must create an Individual Care Plan (ICP) for WCM Members who have been determined high risk through the RSS process, incorporate the required elements stated in W&I section 14094.11 and APL 23-034, be specific to individual Member needs, and update the ICP at least annually.

F. Contractor must provide Person-Centered Planning, as described in Exhibit A, Attachment III, Subsection 5.2.12 (*Continuity of Care for Seniors and Persons with Disabilities*), to WCM Members and in collaboration with the Member's parents, custodial parents, legal guardians, or other Authorized Representatives.

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REQUIREMENTS SPECIFIC TO CONTRACTOR

G. Contractor must provide information to WCM Members on how to access local family resource centers or family empowerment centers.

H. Contractor must provide continuing services with a county CCS Program Public Health Nurse:

1) Contractor must allow a WCM Member, or the Member's parents, custodial parents, legal guardians, or other Authorized Representatives, to request continuing case management and Care Coordination from their public health nurse within 90 calendar days of transitioning to the WCM program, in accordance with W&I section 14094.13(e).

2) Contractor must begin to process non-urgent requests for continuing public health nurse services within five Working Days of receipt of the request and complete the request within 30 calendar days of receipt. If the Member's medical condition requires more immediate attention, such as upcoming appointments or other pressing care needs, Contractor must complete the request within 15 calendar days of receipt. If there is an identified imminent and serious threat to the health of the Member, Contractor must complete the request as soon as possible, but no longer than three calendar days of receipt.

3) Contractor must make good faith efforts to reach a mutually agreeable financial arrangement for reimbursing the county CCS Program for continuing public health nurse services. If Contractor is unable to enter into such an arrangement, it must submit a waiver request to DHCS on the basis that reimbursement at the county CCS Program's proposed rate would result in substantially increased program costs. The waiver request will be subject to DHCS review and approval.

4) If the requested county public health nurse is no longer available to provide case management and Care Coordination, Contractor must transition those services to one of its CCS Case Managers who has received adequate training on the CCS Program and has clinical experience with the CCS population or pediatric patients with complex medical conditions.

I. For WCM Members, Contractor must conduct Risk Stratification and Segmentation (RSS), in accordance with the requirements in Exhibit A,

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REQUIREMENTS SPECIFIC TO CONTRACTOR

Attachment III, Subsection 4.3.5 (*Population Risk Stratification and Segmentation, and Risk Tiering*), which is approved by DHCS for use with WCM Members. Based on the results of the RSS, Contractor must, as appropriate, further assess WCM Members' risk levels and needs with an in-person or telephone communication, or an additional risk assessment approved by DHCS.

J. If Contractor expands its CCS coverage area to other counties, Contractor must comply with CCS program standards including, but not limited to, referral standards as stated in W&I section 14093.06(a).

43.1.10 Rights for WCM Members

A. Contractor must provide a mechanism for a WCM Member, or the Member's parents, custodial parents, legal guardians, or other authorized representatives, to request a Specialist or clinic as a Primary Care Provider.

B. For Members receiving continuity of care as stated in Subsection 43.1.7 (*Continuity of Care)* of this Exhibit L, Contractor must send a written notice 60 calendar days prior to the end of the authorized continuity of care period. The notice must explain that the Member may petition Contractor for an extension of the continuity of care period, the criteria used to evaluate the petition, and the Appeals process if Contractor denies the petition.

C. In addition to the Member's right to file a Grievance or request an Appeal, State Hearing, or an Independent Medical Review if applicable, as stated in Exhibit A, Attachment III, Section 4.6 (*Member Grievance and Appeal System*), Contractor must also ensure that WCM Members, or the Member's parents, custodial parents, legal guardians, or other Authorized Representatives, may Appeal the continuity of care limitations, or the extension of a continuity of care period, as stated in this Exhibit L, Subsection 43.1.6 (*Covered Services*), to the DHCS Director in accordance with W&I section 14094.13(i)(1).

D. Contractor must also ensure that WCM Members retain the right to request an Appeal and State Hearing for CCS eligibility and CCS service authorization denials.

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Exhibit L
REQUIREMENTS SPECIFIC TO CONTRACTOR

43.2 Required Reports for the Whole Child Model Program

In addition to the reporting requirements for Exhibit A, Attachment III, Section 4.6 (*Member Grievance and Appeal System*) stated in Exhibit A, Attachment III, Article 7.0.(*Operations Deliverables and Requirements*), Contractor must also identify which Grievances and requests for Appeal were submitted by WCM Members.

43.3 Data Sharing Links

Contractor must establish and maintain communication links to allow interfaces with Children's Medical Services (CMS) Net and outside entities designated by DHCS.

43.3.1 Contractor must establish and maintain an agreement with the Office of Technology Services (OTech) within the California Department of Technology for an appropriate link between Contractor and OTech for the purpose of computer access for records contained in CMS Net and other Medi-Cal eligibility files that may be made available to Contractor. Upon connectivity with the authorized external entities, Contractor must retrieve information in a format to be determined by DHCS.

43.3.2 Contractor must comply with all data sharing requirements in Exhibit G of this Contract.

43.4 Whole Child Model Payments

Contractor must be paid a supplemental WCM monthly payment for each WCM Member. Payments for WCM Members cannot exceed the rate as stated in Exhibit B, Section 1.3 (*Capitation Payment Rates*) and will be adjusted if DHCS has sent a separate rate payment for the WCM Member for the same month of service. The payment period for the supplemental WCM payment must commence on the effective date of this Contract, January 1, 2024.

43.4.1 Contractor must receive the supplemental WCM payment in accordance with the conditions listed below.

A. The supplemental WCM payment must be in lieu of any other compensation for a WCM Member in any month.

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REQUIREMENTS SPECIFIC TO CONTRACTOR

B. Contractor must be eligible to receive a supplemental WCM payment in the month in which a WCM Member's eligibility is determined by the county CCS program.

43~~3~~.4.2 If DHCS determines that a Member for whom Contractor received a supplemental WCM payment was not determined eligible for CCS in the month(s) for which supplemental WCM payment was made, DHCS may recover any amount improperly paid, by an offset to Contractor's capitation payment, in accordance with Exhibit B, Subsection 1.1.9 (*Recovery of Amounts Paid to Contractor*). DHCS must give Contractor at least 30 calendar days prior written notice of any such offset.

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EXHIBIT A
SCOPE OF WORK

1. Service Overview

This is a companion to Contractor's Medi-Cal Managed Care ~~Health~~ Plan Contract 23-30235, hereafter referred to as the "Primary Contract", to cover specific Medi-Cal State-Supported Services to Contractor's Members enrolled under Contractor's Primary Contract.

A. All Covered Services as defined in Contractor's Primary Contract will be provided to Unsatisfactory Immigration Status (UIS) Members in the same manner and subject to the same requirements as described in the Primary Contract, except as described in this Contract.

B. Private Services described in Exhibit A, S~~ubse~~ction 1.2~~.A~~ (*All State-Supported Services to be Performed*), must be provided in the same manner as described in the Primary Contract under Exhibit A, Attachment **III**~~3~~, Section 5.2 (*Network and Access to Care*).

C. Contractor must provide services and interact with UIS Members on an equal basis as with Members covered under the Primary Contract. Contractor, including but not limited to Contractor's Network Providers and Subcontractors are required to cover and provide services to UIS Members in a manner that is indistinguishable from the rest of Contractor's Members covered under the Primary Contract.

2. Service Location

The Service Area covered under this Contract between Department of Health Care Services (DHCS) and Contractor is the same as specified in the Primary Contract.

3. Project Representatives

A. The Contract representatives during the term of this Contract will be:

Department of Health Care Services	**Orange County Health Authority, A Public Agency**
Managed Care Operations Division Attention: Chief, Procurement and Contract Development Branch Telephone: (916) 449-5000 Fax: (916) 449-5090	**dba CalOptima Health** Attention: Michael Wood, Manager, Regulatory Affairs & Compliance Telephone: (714) 246-8415 Fax: (714) 246-6418

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EXHIBIT A
SCOPE OF WORK

B. Direct all inquiries to:

Department of Health Care Services	**Orange County Health Authority, A Public Agency**
Managed Care Operations Division Attention: Contracting Officer 1501 Capitol Avenue, Suite 71.4001 Mail Stop 4401 P.O. Box 997413 Sacramento, CA 95899-7413 Telephone: (916) 449-5000 Fax: (916) 449-5090	**dba CalOptima Health** Attention: Michael Wood, Manager, Regulatory Affairs & Compliance 505 City Parkway West Orange, CA 92868 Telephone: (714) 246-8415 Fax: (714) 246-6418

C. Either party may make changes to the information above by giving written notice to the other party. Said changes ~~shall~~**will** not require an amendment to this Contract.

4. Americans with Disabilities Act

Contractor agrees to ensure that deliverables developed and produced, pursuant to this Agreement ~~shall~~ comply with the accessibility requirements of the Rehabilitation Act and the Americans with Disabilities Act of 1973 (The Act) section 508 as amended in 29 USC section 794(d), and regulations implementing The Act as set forth in Title 36 of the Federal Code of Regulations Part 1194. In 1998, Congress amended The Act to require federal agencies to make their electronic and information technology accessible to people with disabilities. California Government Code section 11135 codifies The Act section 508, requiring accessibility of electronic and information technology.

The provision of the State Supported Services is subject to the Provisions set forth in the Exhibits and Attachments appended hereto.

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EXHIBIT A
SCOPE OF WORK

1.0 State-Supported Services

1.1 Definitions
1.2 All State-Supported Services to be Performed
1.3 Primary Contract Covered Services Excluded from This Contract

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EXHIBIT A
SCOPE OF WORK

1.0 State-Supported Services

1.1. Definitions

As used in this Contract, unless otherwise expressly provided or the context otherwise requires, the definitions of terms in the Primary Contract will govern the construction of this Contract.

Primary Contract means Contract Number 23-30235, including all applicable amendments, Exhibits, and/or Attachments to that Contract as of and subsequent to the effective date of this Contract. Termination of the Primary Contract ~~shall~~**will** be deemed a termination of this Contract.

Private Services (PS) means Current Procedural Terminology Codes 59840 through 59857 and CMS Common Procedure Coding System Codes X1516, X1518, X7724, X7726, and Z0336.

State-Supported Services means Private Services as defined and described in this Contract, and Covered Services, as identified in the Primary Contract, for UIS Members with the exception of pregnancy-related services for UIS Members and emergency services as they are described in the Primary Contract.

Unsatisfactory Immigration Status (UIS) Member means a Member enrolled under the Primary Contract for whom, by virtue of their immigration status, federal financial participation is available only for emergency services and qualifying pregnancy-related services as they are described in the Primary Contract, and are included in any of the following groups:

A. "Qualified" ~~N~~**n**on-~~C~~**c**itizen ~~(QNC)~~**(also known as "alien")**, subject to, and have not met, the five-year bar **as defined in Section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 and Public Law 104-193**;

B. **Trafficking and Crime Victim Assistance Program;**

C. Expansion population. For the purpose of this Contract, expansion population refers to Medi-Cal Members eligible for full scope Medi-Cal coverage regardless of immigration status based on California's legislative expansions including:

1) "Permanently ~~R~~**r**esiding ~~U~~**u**nder ~~C~~**c**olor of ~~L~~**l**aw**"** ~~(PRUCOL)~~ **as defined in 20 Code of Federal Regulations section 416.1618(b) and Welfare and Institutions Code (W&I) section 14007.5**;

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EXHIBIT A
SCOPE OF WORK

~~C.~~ **2) Less than 19 years of age as defined in W&I section 14007.8 and** ~~Senate~~ Bill 75 (**Smallwood-Cuevas,** Chapter 18, Statutes of 2015)~~, under the age of 19~~;

~~D.~~ **3) 19 through 25 years of age (**Young Adult Expansion**) as defined in W&I section 14007.8** ~~(YAE), under the age of 26~~;

~~E. Trafficking and Crime Victim Assistance Program (TCVAP).; and~~

~~F.~~ **4) Ages 26 through 49 (Adult Expansion) as defined in W&I section 14007.8; and**

5) Ages 50 and over (Older Adult Expansion**) as defined in W&I section 14007.8)** ~~(OAE), 50 years of age or older~~.

1.2 All State-Supported Services to be Performed

1.2.1 Contractor agrees to provide, or arrange to provide, to eligible Members enrolled under either this Contract or the Primary Contract, the following Private Services:

A. Current Procedural Terminology Codes*: 59840 through 59857**; and**

B. CMS Common Procedure Coding System Codes*: X1516, X1518, X7724, X7726, Z0336**.**

1.2.2 The codes identified above in Exhibit A, Section 1.2~~.A~~ (*All State-Supported Services to be Performed*), are subject to change upon the Department of Health Care Services**'** (DHCS) implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) electronic transaction and code sets provisions. Such changes ~~shall~~ **will** not require an amendment to this Contract.

1.2.3 Contractor agrees to provide, or arrange to provide, to UIS Members enrolled under this Contract all Covered Services specified in the Primary Contract, except as set forth in Exhibit A, Section 1.3 ***(Primary Contract Covered Services Excluded from This Contract)*** of this Contract.

1.3 Primary Contract Covered Services Excluded from This Contract

The following services are covered, and will remain covered, in the Primary Contract and are therefore excluded from this Contract:

1.3.1 The provision of pregnancy-related services for UIS Members as described in Exhibit A, Attachment **III**~~3~~, Subsection 5.3.6 (*Pregnant and Postpartum Members*), of the Primary Contract.

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EXHIBIT A
SCOPE OF WORK

1.3.2 The provision of Emergency Services for UIS Members as described in Exhibit A, Attachment **III**~~3~~, Subsection 3.3.16 (*Emergency Services and Post-Stabilization Care Services*), and defined in Exhibit A, Attachment **I**~~1~~, Section 1.0 (*Definitions*), of the Primary Contract.

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EXHIBIT B
BUDGET DETAIL AND PAYMENT PROVISIONS

1.0 Budget Detail and Payment Provisions

1.1 Overview
1.2 Capitation Rates

EXHIBIT B
BUDGET DETAIL AND PAYMENT PROVISIONS

1.1 Overview

Unless otherwise provided for herein, Contractor and DHCS agree to be bound by all applicable terms and conditions of Exhibit B **(*Budget Detail and Payment Provisions*)** of the Primary Contract between Contractor and DHCS, in accordance with Exhibit E, ~~Section~~ **Article** 1**.0 *(Program Terms and Conditions)***, of this Contract.

1.2 Capitation Rates

1.2.1 DHCS ~~shall~~ **will** remit to Contractor a Capitation Payment for each month that a Member appears on the approved list of Members supplied to Contractor by DHCS. Subject to Exhibit B, Subsection 1.2.3 (*Capitation Rates*) of this Contract, Capitation Payments must be made in accordance with the schedule of Capitation Payment rates set forth below. Contractor and DHCS agree to update the table below upon the establishment of Capitation Payment rates in accordance with this Exhibit B, Subsection 1.2.3 (*Capitation Rates*) of this Contract.

For the period 01/01/2024 – 12/31/2024	**Orange**
Aid Group	**Rates**
Adult & Family/OTLIC (21 & ~~Older~~**Over**) - PS	$0.25
Adult Expansion - PS	$0.25
Adult & Family/OTLIC (Under 21) - PS	$0.25
Adult/Family/OTLIC Under 21 - UIS	$72.81
Adult/Family/OTLIC 21 & Over - UIS	$200.11
SPD - UIS	$653.45
BCCTP - UIS	$653.45
SPD Dual - UIS	$373.37
LTC - UIS	$653.45
LTC Dual - UIS	$373.37
Adult Expansion - UIS	$269.56
WCM - UIS	$1,199.51

1.2.2 Aid Codes within each Aid Group for this time-period are set forth in the Primary Contract for Members enrolled under the Primary Contract. For the purposes of this Contract, UIS Members are defined in Exhibit A, Section 1.1 (*Definitions*) of this Contract.

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EXHIBIT B
BUDGET DETAIL AND PAYMENT PROVISIONS

1.2.3 UIS Member Capitation Payments and Private Services (PS) payments will be made monthly, in alignment with Capitation Payments in the Primary Contract.

1.2.4 The amount ~~shall~~**will** be calculated based on the enrollment of Members identified in the approved list for the month of eligibility of each month at the rate specified for each Service Area included under this Contract.

1.2.5 DHCS ~~shall~~**will** establish Capitation Payment rates on an actuarial basis, and that basis ~~shall~~**will** be set forth in the DHCS rate certification(s), including any amendment(s) or revision(s), for the applicable Rating Period. Upon completion, said rate certification(s) are hereby incorporated by reference and made a part of this Contract by this reference as if attached hereto in full.

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EXHIBIT E
ADDITIONAL PROVISIONS

1.0 Program Terms and Conditions

1.1 Additional Incorporated Exhibits
1.2 Governing Law
1.3 Entire Agreement
1.4 Amendment Process
1.5 Notices
1.6 Term
1.7 Non-Cancellation
1.8 Termination for Cause and Other Terminations
1.9 Administrative Duties/Responsibilities

EXHIBIT E
ADDITIONAL PROVISIONS

1.1 Additional Incorporated Exhibits

1.1.1 Unless otherwise provided for herein, Contractor and DHCS agree to be bound by all applicable terms and conditions of the Primary Contract between Contractor and DHCS, including all applicable amendments to the Primary Contract as of the effective date of this Contract, all applicable subsequent amendments to the Primary Contract, and all applicable Exhibits and Attachments to the Primary Contract, all of which are hereby incorporated by reference as if fully set forth herein, except for the following Exhibits and Provisions from the Primary Contract, which ~~shall~~**will** be excluded from this Contract:

A. Exhibit B, S**ubs**ection **1.**1.3 (*Capitation Payment Rates*);

B. Exhibit B, Subsection **1.**1.9.B (*Recovery of Amounts Paid to Contractor*), regarding disallowance of Federal Financial Participation (FFP);

C. Exhibit B, S**ubs**ection **1.**1.7 (*Supplemental Payments*);

D. Exhibit B, S**ubs**ection **1.**1.16 (*State Program~~s~~ Receiving Federal Financial Participation*);

E. Exhibit D(F);

F. Exhibit E, S**ubs**ection **1.**1.6 (*Amendment and Change Order Process*);

G. Any Primary Contract provision deemed not applicable by DHCS to the performance of this Contract; and

H. Any Primary Contract provision otherwise provided for in this Contract.

1.1.2 In the event of a conflict between the provisions of this Contract and the Primary Contract, the provisions of this Contract ~~shall~~**will** prevail.

1.2 Governing Law

In addition to Exhibit E, S**ubs**ection **1.**1.1 (*Governing Law*) of the Primary Contract, Contractor also agrees to the following:

1.2.1 If it is necessary to interpret this Contract, all applicable laws may be used as aids in interpreting the Contract. However, the parties agree that any such applicable laws ~~shall~~**will** not be interpreted to create contractual obligations upon DHCS or Contractor, unless such applicable laws are expressly incorporated into

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this Contract in some section other than this provision, Governing Law. ~~-~~Except for Exhibit E, S**ubs**ection **1.**1.19 (*Sanctions*) of the Primary Contract, the parties agree that any remedies for DHCS or Contractor's non-compliance with laws not expressly incorporated into this Contract, or any covenants judicially implied to be part of this Contract, ~~shall~~**will** not include money damages, but may include equitable remedies such as injunctive relief or specific performance. This Contract is the product of mutual negotiation, and if any ambiguities should arise in the interpretation of this Contract, both parties ~~shall~~**will** be deemed authors of this Contract.

1.2.2 Any provision of this Contract that is in conflict with current or future applicable federal or State laws or regulations is hereby amended to conform to the provisions of those laws and regulations. Such amendment of the Contract ~~shall~~ **will** be effective on the effective date of the statutes or regulations necessitating it~~,~~ and ~~shall~~**will** be binding on the parties even though such amendment may not have been reduced to writing and formally agreed upon and executed by the parties.

1.2.3 Such amendment ~~shall~~**will** constitute grounds for termination of this Contract in accordance with the procedures and provisions of Exhibit B, Subsection **1.**1.5.B.4 (*Determination and Redetermination of Capitation Payment Rates*) in the Primary Contract. The parties ~~shall~~**will** be bound by the terms of the amendment until the effective date of the termination.

1.3 Entire Agreement

This written Contract, and any amendments thereto, **and the Primary Contract, and any amendments thereto,** will constitute the entire agreement between the parties. No oral representations will be binding on either party unless such representations are put in writing and made an amendment to this Contract.

1.4 Amendment Process

1.4.1 Proposal of Contract Changes

Except for required amendments pursuant to **Exhibit E,** Section 1.2 (*Governing Law*) above, and Exhibit E, S**ubs**ection **1.**1.3.A (~~*Conflict with Law*~~ ***Contract Interpretation***) of the Primary Contract, should either party, during the life of this Contract, desire a change in this Contract, that change must be proposed in writing to the other party. The other party must acknowledge receipt of the proposal within ten calendar days of receipt of the proposal. The party proposing any such change will have the right to withdraw the proposal any time prior to acceptance or rejection by the other party. Any proposal must set forth an

explanation of the reason and basis for the proposed change and the text of the desired amendment to this Contract.

A. Regardless of the party desiring the change, DHCS will be responsible for drafting the proposed amendment and providing it to Contractor for review and comment.

B. DHCS will determine Contractor's Capitation Payment rates for each Rating Period and, as necessary, subsequent revised rates for the same Rating Period, as stated in Exhibit B, Section 1.2 (*Capitation Rates*) of this Contract.

1.4.2 Implementation of Contract ~~Changes~~ **Capitation Payments**

DHCS may, at any time within the general scope of this Contract and by written notice, implement **Capitation Payment rates through** amendments ~~or issue change orders~~ to the Contract~~, as follows:~~ **where**

~~A. Capitation Payment rates may be implemented through a change order if the rates are the only changes proposed by DHCS for a Rating Period.~~

~~B~~ Capitation Payment rates ~~that~~ are ~~also~~ tied to proposed changes to the terms or requirements of the Contract effective within the Rating Period will be included in an amendment to the Contract.

1.5 Notices

All notices to be given under this Contract must be in writing and are deemed given when sent certified mail or electronic mail (email) to DHCS or Contractor. DHCS and Contractor will designate email addresses for notices sent via email. Notices sent certified mail must be addressed to the following DHCS and Contractor addresses:

California Department of Health Care Services

Managed Care Operations Division
Attn: DHCS Contract Manager
MS 4401
P.O. Box 997413
Sacramento, CA 95899-7413

Orange County Health Authority,
A Public Agency
Attn: Michael Wood, Manager,
Regulatory Affairs & Compliance
505 City Parkway West
Orange, CA 92868

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EXHIBIT E
ADDITIONAL PROVISIONS

1.6 Term

The Contract will become effective January 1, 2024, and will continue in full force and effect through the term of the Primary Contract, subject to the provisions of Exhibit B, S**ubs**ection **1.**1.1 (*Budget Contingency Clause*), of the Primary Contract.

1.7 Non-Cancellation

Except as set forth in Exhibit E, Section 1.8 ***(Termination for Cause and Other Terminations)*** below, this Contract will ~~thereafter~~ continue in full force and effect through the end date specified in the Primary Contract, subject to Exhibit B, S**ubs**ection **1.**1.1 (*Budget Contingency Clause*), of the Primary Contract.

1.8 Termination for Cause and Other Terminations

Contractor agrees to the termination provisions in the Primary Contract, which are incorporated into this Contract.

1.9 Administrative Duties/Responsibilities

Contractor ~~shall~~**will** maintain the organizational and administrative capabilities to carry out its duties and responsibilities under this Contract in the same manner as required by the Primary Contract.

CY 2025 – A Contract Amendment Detail

Attachment to the November 6, 2025 Board of Directors Meeting – Agenda Item 8

Category	Requirement	Regulatory and Sub-Regulatory Guidance
Community Reinvestment Plan and Report (pp. 101 – 102, 529 – 530)	• Removal of Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors from the requirement. • If the Subcontractor meets Community Reinvestment requirements, MCPs must annually request and incorporate the Subcontractor's Community Reinvestment Plan in the DHCS submission.	APL 25-004: Community Reinvestment Requirements
Fraud Prevention Program (p. 109)	• MCPs must notify their local county office in lieu of DHCS when information is received about changes in member's circumstances that may impact their eligibility.	
Treatment of Overpayment Recoveries (pp. 115 – 116, 520)	• Incorporates requirements regarding retention, reporting, and payment of recoveries.	APL 23-011: Treatment of Recoveries Made by the Managed Care Health Plan of Overpayments to Providers
Quality Care for Children – School-Based Services (p. 150)	• MCPs must collaborate and negotiate a MOU with the California Department of Corrections and Rehabilitation, County Jails, and Youth Correctional Facilities by January 1, 2026, or a later date determined by DHCS, and Local Education Agencies (LEAs) by January 1, 2027.	APL 23-029 (Revised): Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans and Third-Party Entities
Provider Compensation Arrangements - Claims Processing (pp. 191 – 192)	• Updated federal and state regulatory citations.	APL 23-020 (Revised): Requirements for Timely Payment of Claims
Mental Health Services (p. 243)	• Create and annually update a member and PCP Non – Specialty Mental Health Services (NSMHS) Outreach and Education Plan. • MCPs must publicly post the approved outreach and education plan and utilization assessment annually.	APL 24-012: Non-Specialty Mental Health Services: Member Outreach, Education, and Experience Requirements

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Category	Requirement	Regulatory and Sub-Regulatory Guidance
Member Identification for Enhanced Care Management (pp. 268 – 269)	• MCPs must update ECM referral forms and tools to reflect requirements in the DHCS Referral Standards and Form Templates. • MCPs must not require nor request supplemental information beyond the information provided in the ECM Referral Standards to confirm eligibility and authorize ECM.	Enhanced Care Management (ECM) Policy Guide ECM Referral Standards and Form Templates
Authorizing Members for Enhanced Care Management (pp. 270 – 272)	• MCPs must develop policies and procedures to implement ECM Streamlined Authorization in alignment with the ECM Policy Guide. • Implement ECM Streamlined Authorization arrangements that enable ECM Providers to initiate and be reimbursed for ECM services for a 30-calendar day timeframe.	ECM Policy Guide ECM Referral Standards and Form Templates
Minor Consent Services (p. 375)	• Updated minor consent requirements.	APL 24-019: Minor Consent to Outpatient Mental Health Treatment or Counseling
Recovery of Amounts Paid to Contractor (pp. 519 – 520)	• DHCS will work with MCPs to either recover the entire amount of an overpayment by imposing an offset to Contract Revenues or require a check from the MCP when an overpayment has been identified through audit, investigation or otherwise that were not previously identified to DHCS.	APL 23-011: Treatment of Recoveries Made by the Managed Care Health Plan of Overpayments to Providers
Special Contract Provisions Related to Payment (p. 527)	• Removal of the CalAIM Incentive Payment and Student Behavioral Health Incentive Program (SBHIP) from current incentive arrangements.	APL 23-035: Student Behavioral Health Incentive Program APL 23-003: California Advancing and Innovating Medi-Cal Incentive Payment Program

Category	Requirement	Regulatory and Sub-Regulatory Guidance
Risk Corridor (pp. 531 - 532)	• MCPs must comply with the terms of any Risk Sharing Mechanisms in a form specified by DHCS through APLs or other technical guidance. • Removal of the Unsatisfactory Immigration Status Risk Corridor.	
Miscellaneous Updates	• Updated terms and acronyms used in the agreement. • Updated regulatory and APL citations. • Clarified and corrected language as necessary. • Updated Exhibit A, Attachment III – 7.0: Operations Deliverables and Requirements • Aid codes and capitation payment rates were moved to Exhibit L of the Primary Agreement.	

CalOptima Health Board Action Agenda Referral

Action To Be Taken November 6, 2025
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

9. Authorize Amendments to the CalOptima Health Contracts with Edifecs Inc. for Covered California Related Services and Enterprise Data Management Software and the Consolidation of the Contracts

Contacts

Kathleen Linder, Chief Information Officer, (714) 475-9291
Donna Laverdiere, Executive Director, Strategic Development, (714) 986-6981

Recommended Actions

Authorize the Chief Executive Officer, or designee, to execute amendments to the CalOptima Health contracts with Edifecs Inc. (Edifecs) to take the following contract actions:

1. Add the Covered California line of business and applicable Department of Managed Health Care regulatory requirements and add to the scope of work the Encounter Management Affordable Care Act Module;
2. Consolidate separate Edifecs software agreements into a single combined contract, effective upon execution but no later than March 9, 2026;
3. Extend the duration of the combined Edifecs contract for five years from the execution date, with five one-year renewal extension options, each exercisable at CalOptima Health's sole discretion; and
4. Update payment terms for additional services and contract extension.

Background

Edifecs provides a suite of software products that allow data exchange between providers, payors, and government oversight agencies. To adhere to frequently updated guidelines from the Department of Health and Human Services (HHS), the Centers for Medicare & Medicaid Services (CMS), and the Department of Health Care Services (DHCS), CalOptima Health (CalOptima) has been working with Edifecs since 2011 to collect and provide accurate data and to comply with reporting requirements.

On March 9, 2011, CalOptima issued a Request for Proposals (RFP 11-0487) for various data management tools. CalOptima selected Edifecs to provide tools that would allow it to define and publish healthcare data specifications and to consolidate transaction streams across multiple information systems. As new regulations emerged, technology progressed, and CalOptima's needs evolved, CalOptima acquired additional Edifecs products.

- In March 2021, CalOptima executed a contract with Edifecs for its Healthcare Interoperability Solution.
- In December 2022, CalOptima executed another contract with Edifecs for Encounter Data Management Review Services.
- In September 2025, CalOptima amended the Encounter Data Management Review Services contract to add the Edifecs Smart Trading Platform that validates inbound claims and encounter data prior to adjudicating and submitting claims to DHCS and CMS.

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CalOptima is currently engaged in a multi-phased filing process with the Department of Managed Health Care (DMHC) to expand the scope of its current Knox Keene Act license to operate a Covered California product. This process must be completed by early 2026 to offer the product for benefit plan year 2027. The process requires the submission of fully executed Administrative Service Agreements (ASAs) for vendors that will perform services for the Covered California line of business. The Edifecs contracts are administrative services contracts, and if related to the proposed Covered California line of business, they must be approved by DMHC as part of the licensure review process to ensure their durations and scopes include the activities for the Covered California line of business and applicable regulatory requirements.

Discussion

Staff proposes combining all existing Edifecs contracts and adding the Covered California line of business, including the addition of the related Encounter Management Affordable Care Act (ACA) Module, and associated Covered California and DMHC-regulatory requirements to the new combined contract to ensure the services are available for the start of the Covered California 2027 benefit plan year.

The current suite of Edifecs contracts provide tools that allow CalOptima to validate and submit encounter data to DHCS and CMS, correct rejections and resubmit the data, and monitor submission outcomes. To provide service continuity, streamline administrative work, simplify contract management, and prepare for entering the Covered California market, using the existing vendor that has become an important part of CalOptima's infrastructure would be the most cost-effective and practical approach.

The proposed combined contract will become effective upon execution, but no later than March 9, 2026, and special provisions related to Covered California will be included. To support ongoing operations and compliance, staff recommends the combined contract have a five-year term from the contract execution date, with five one-year renewal extension options. The combined contract would replace the varying contract terms and termination dates with a single contract term and termination date as specified below. The new contract with Edifecs will also allow CalOptima to terminate with 90 days' notice.

Edifecs Service	**Current Contract Termination Date**	**Proposed Contract Termination Date**
Encounter Data Management Review Services	12/22/26	Five years after execution date but no later than 3/8/31 plus five one-year extension options, each exercisable at CalOptima's sole discretion
Healthcare Interoperability	3/28/26	
SpecBuilder EDI Translation	3/8/26	
Smart Trading Platform	9/11/28 plus two one-year extension options	
Encounter Data Management ACA Module	N/A	

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Fiscal Impact

Recommended action #1: The estimated cost for year 1, including costs associated with implementation, is approximately $550,000. Funding for this service along with internal resource needs will be included in future Covered California budgets or requested through separate Board actions.

Recommended actions #2 and #3: The estimated annual cost for the existing Edifecs contracts is approximately $8.0 million and is budgeted in the Fiscal Year 2025-26 Operating Budget approved by the Board on June 5, 2025. Staff will include operating expenses for the period beginning July 1, 2026, and after in future operating budgets.

Rationale for Recommendation

The above recommended actions will allow filing of all ASAs with DMHC in a timely fashion, ensure continuity of services during implementation of the new Covered California product, comply with data reporting requirements for Covered California, and simplify contract management for administrative efficiency.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Entities Covered by this Recommended Action

/s/ Michael Hunn *10/31/2025*
Authorized Signature **Date**

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Attachment to the November 6, 2025, Board of Directors Meeting – Agenda Item 9

CONTRACTED/ IMPACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Edifecs, Inc.	1756 114th Avenue SE	Bellevue	WA	98004

CalOptima Health Board Action Agenda Referral

Action To Be Taken November 6, 2025
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

10. Approve New CalOptima Health Policy CC.1502: Coverage for Rape and Sexual Assault Treatment Services

Contacts

Richard Pitts, D.O., Ph.D., Chief Medical Officer, (714) 246-8491
Kelly Giardina, MSG, CCM, Executive Director Clinical Operations, (657) 900-1013

Recommended Actions

Approve new CalOptima Health Policy CC.1502: Coverage for Rape and Sexual Assault Treatment Services effective January 1, 2026.

Background/Discussion

This policy outlines CalOptima Health's commitment to ensuring comprehensive coverage for emergency department medical care and follow-up health care treatment for Covered California members who have experienced rape or sexual assault. It supports compliance with federal and state laws, program regulations, and contractual obligations.

CalOptima Health and its delegated Health Networks shall provide coverage without cost sharing for emergency department medical care and follow-up health care treatment for a period of nine (9) months following the initiation of treatment by a member who has experienced rape or sexual assault, as defined in California Penal Code §§ 261, 261.6, 263, 263.1, 286, 287, and 288.7.

Implementation guidelines for CalOptima Health Policy CC.1502: Coverage for Rape and Sexual Assault Treatment Services:

- Upon notification that a member has received emergency services related to rape or sexual assault, the Health Network or primary care practitioner must coordinate appropriate follow-up care.
- Health Networks are required to establish written procedures to ensure timely and appropriate follow-up treatment.
- CalOptima Health will monitor the coordination of services through internal oversight and Policy GG.1619: Delegation Oversight.
- This coverage is considered a sensitive service under Civil Code §§ 56.05 and 56.107 and is subject to confidentiality protections per CalOptima Health Policy HH.3024: Confidentiality of Medical Information Act Compliance.

CalOptima Health and its Health Networks will utilize case management, claims data, and other systems to support and monitor care coordination throughout the nine-month follow-up period.

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Fiscal Impact
The recommended action is operational in nature. Any anticipated costs will be included in future Covered California operating budgets.

Rationale for Recommendation
To ensure CalOptima Health's continuing commitment to conducting its operations in compliance with all applicable state and federal laws and regulations, staff recommends that the CalOptima Health Board of Directors approve and adopt CalOptima Health Policy CC.1502: Coverage for Rape and Sexual Assault Treatment Services.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. CalOptima Health Policy CalOptima Health Policy CC.1502: Coverage for Rape and Sexual Assault Treatment Services

/s/ Michael Hunn *10/30/2025*
Authorized Signature **Date**

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Policy:	CC.1502
Title:	**Coverage for Rape and Sexual Assault Treatment Services**
Department:	Medical Management
Section:	Utilization Management
CEO Approval:	*/s/*
Effective Date:	01/01/2027
Revised Date:	Not Applicable
Applicable to:	☐ Administrative ☒ Covered California [Effective 2027] ☐ Medi-Cal ☐ OneCare ☐ PACE

For 20251106 BOD Review Only

I. PURPOSE

This policy describes CalOptima Health's procedures for Covered California to ensure coverage is provided for emergency department medical care and Follow-up Health Care Treatment for a Member following a rape or sexual assault.

II. POLICY

A. CalOptima Health and its Health Networks shall provide coverage without Cost Sharing for emergency department medical care and Follow-up Health Care Treatment for nine (9) months after the Member initiates treatment following a rape or sexual assault, as defined in Penal Code §§ 261, 261.6, 263, 263.1, 286, 287, and 288.7.

B. The Health Network or primary care Practitioner (PCP) is required to arrange for appropriate Follow-up Health Care Treatment upon notification that a Member received services in an emergency department.

C. Health Networks shall establish written policies and procedures to ensure the provision of Follow-up Health Care Treatment for Members seen in an emergency department.

D. CalOptima Health monitors coordination of services, including follow-up with Members who accessed emergency room medical care services, as part of the ongoing monitoring of direct network Providers through internal procedures and Health Network oversight process in accordance with CalOptima Health Policies GG.1619: Delegation Oversight.

1. CalOptima Health and its Health Networks shall utilize case management resources, claims data, and other appropriate technologies and systems to monitor and support the coordination of care for a duration of nine (9) months following the initiation of treatment by a Member who has experienced rape or sexual assault.

E. Coverage for emergency department medical care and Follow-up Health Care Treatment following a rape or sexual assault is considered coverage of sensitive services provided to a protected individual as defined in Civil Code §§ 56.05 and 56.107 and in accordance with CalOptima Health Policy HH.3024: Confidentiality of Medical Information Act Compliance

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III. PROCEDURE

A. CalOptima Health or its Health Networks shall not require, as a condition of providing coverage for emergency department medical care and Follow-up Health Care Treatment, any of the following:

1. A Member to file a police report on the rape or sexual assault.

2. Charges to be brought against an assailant.

3. An assailant to be convicted of an offense listed in Health & Safety Code § 1367.37(a).

B. CalOptima Health and its Health Networks are not required to authorize Follow-up Health Care Treatment if the Member receives these services from a Non-Contracted Provider unless any of the following applies:

1. CalOptima Health or a Health Network shall arrange for the provision of Follow-up Health Care Treatment to a Member through an Out-of-Network Provider if those services are unavailable within the network to ensure timely access to Covered Services in accordance with CalOptima Health Policy CC.1700: Standards of Accessibility and Timely Access.

   a. CalOptima Health or a Health Network shall arrange for a Letter of Agreement (LOA) with an identified Out-of-Network Provider.

2. CalOptima Health and its Health Networks shall cover Follow-up Health Care Treatment if those services are for Emergency Services and Care.

C. Claims Submission Requirements

1. The Member's treating Provider must submit all requests for claims payments to CalOptima Health or its Health Networks using accurate diagnosis codes specific to rape or sexual assault in order to apply the waiver of Cost Sharing, and in accordance with CalOptima Health Policy CC.1001: Claims Processing for Covered Services for which CalOptima Health is Financially Responsible.

D. If a CalOptima Health contract meets the definition of a "high-deductible health plan" as set forth in Section 223(c)(2) of Title 26 of the United States Code, this policy shall only apply once a Member's deductible has been satisfied for the year.

E. CalOptima Health and its Health Networks shall inform Providers about the provisions in this policy including the meaning of Follow-up Health Care Treatment and definitions of rape and sexual assault by sending provider notifications through Provider Alerts/Notices and in the Provider Manual, available on the CalOptima Health website at www.caloptima.org.

IV. ATTACHMENT(S)

A. Provider Notice Template
B. Non-Contracted Provider Notice Template

V. REFERENCE(S)

A. CalOptima Health Policy CC.1001: Claims Processing for Covered Services for which CalOptima Health is Financially Responsible
B. CalOptima Health Policy CC.1700: Standards of Accessibility and Timely Access
C. CalOptima Health Policy GG.1619: Delegation Oversight

For 2025 1106 BOD Review Only

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D. CalOptima Health Policy HH.3024: Confidentiality of Medical Information Act Compliance
E. Department of Managed Health Care (DMHC) All Plan Letter (APL) 24-023: Newly Enacted Statutes Impacting Health Plans (2024 Legislative Session)
F. Civil Code, §§ 56.05 and 56.107
G. Health and Safety Code, §§ 1317.1 and 1367.37
H. Penal Code, §§ 261, 261.6, 263, 263.1, 286, 287, and 288.7

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
11/06/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2027	CC.1502	Coverage for Rape and Sexual Assault Treatment Services	Covered California

For 20251106 BOD Review Only

IX. GLOSSARY

Term	Definition
Authorization	A formal process requiring a Provider to obtain approval for the amount, duration, and scope of non-emergent Covered Services. Authorization can occur prior to, concurrent with, or retrospective to the Covered Services, as specified in this policy.
Cost Sharing	Any copayment, coinsurance, or deductible, or any other form of cost sharing paid by the enrollee other than premium or share of premium.
Covered Services	Health care services that are covered benefits under CalOptima Health's contract with Covered California as further described in the Evidence of Coverage and supporting documents.
Emergency Medical Condition	A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following: 1. Placing the patient's health in serious jeopardy. 2. Serious impairment to bodily functions. 3. Serious dysfunction of any bodily organ or part. (Health & Safety Code §1317.1(b))
Emergency Services and Care	Inpatient and outpatient Covered Services that are furnished by a qualified Provider and needed to evaluate or stabilize an Emergency Medical Condition as defined in Health & Safety Code § 1317.1(a)(1) and § 1317.1(a)(2).
Follow-up Health Care Treatment	Medical or surgical services for the diagnosis, prevention, or treatment of medical conditions arising from an instance of rape or sexual assault.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a health maintenance organization (HMO), subcontractor, or first tier entity, that contracts with CalOptima Health to provide Covered Services to Members.
Medically Necessary or Medical Necessity	Health care and related services and supplies provided to a Member for the purpose of evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms and that are: (i) in accordance with generally accepted standards of medical practice; (ii) appropriate for the symptoms, diagnosis, or treatment of the Member's condition, disease, illness or injury; (iii) not primarily for the convenience of the Member or health care Provider; and (iv) not more costly than an alternative service, or suite of services, and at least as likely to produce equivalent results. For treatment of a mental health or substance use disorder, Medical Necessity shall include: A service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of an illness, injury, condition, or its symptoms, in a manner that is all of the following: (i) in accordance with the generally accepted standards of mental health and substance use disorder care; (ii) clinically appropriate in terms of type, frequency, extent, site, and duration; (iii) not primarily for the economic benefit of the disability insurer and insureds or for the convenience of the patient, treating physician, or other health care Provider, as required by HSC §1374.72 (a)(3)(A).
Member	An individual enrolled in a CalOptima Health program.
Non-Contracted Provider	A Provider who is not contracted with CalOptima Health to provide services under the Member's CalOptima Health plan contract.

For 2025 1106 BOD Review Only

Term	Definition
Out-of-Network	Health Network: Outside of the selected Health Network's participating provider network within the CalOptima Health's service area. CalOptima Health: A Provider that does not participate in CalOptima Health's Network.
Practitioner	A licensed independent practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.
Provider	A licensed health care facility or as stipulated by local or international jurisdictions, a program, agency or health care professional that delivers Covered Services.

For 20251106 BOD Review Only

PROVIDER ALERT

[Insert Date]
To: CalOptima Health Providers

Re: Notice to Providers Regarding AB 2843: New Law Expands Coverage for Survivors of Rape and Sexual Assault Without Cost Sharing for Covered California.

Dear CalOptima Health Providers:

Effective July 1, 2025, Assembly Bill 2843 (AB 2843) requires coverage for emergency room medical care and follow-up health care treatment without cost sharing for nine (9) months after the member initiates treatment following a rape or sexual assault. “Follow-up health care treatment” includes any medical or surgical services for the diagnosis, prevention, or treatment of medical conditions arising from an instance of rape or sexual assault.

For members who are enrolled in a high-deductible health plan, these requirements will apply only once the deductible has been met.

AB 2843 prohibits plans from requiring any of the following as a condition of coverage:

- A member to file a police report on the rape or sexual assault.
- Charges to be brought against an assailant.
- An assailant to be convicted of rape or sexual assault.

To facilitate the waiver of cost sharing, treating providers must submit all claims using accurate diagnosis codes specific to rape or sexual assault. Please refer to Penal Code §§ 261, 261.6, 263, 263.1, 286, 287, and 288.7 for definitions of “rape” and “sexual assault” which may be accessed at the California Legislative Information website.

For more information regarding AB 2843, visit AB-2843 Health care coverage: rape and sexual assault.

Providers with questions regarding this Provider Alert can call CalOptima’s Provider Relations department at **714-246-8600** or email Providerservicesinbox@caloptima.org.

PAXXXXXX

PROVIDER ALERT

[Insert Date]
To: CalOptima Health Covered California Non-Contracted Providers

Re: Notice to Non-Contracted Providers Regarding AB 2843: New Law Expands Coverage for Survivors of Rape and Sexual Assault Without Cost Sharing for Covered California.

Dear CalOptima Health Covered California Provider:

Effective July 1, 2025, Assembly Bill 2843 (AB 2843) requires coverage for emergency room medical care and follow-up health care treatment without cost sharing for nine (9) months after the member initiates treatment following a rape or sexual assault. “Follow-up health care treatment” includes any medical or surgical services for the diagnosis, prevention, or treatment of medical conditions arising from an instance of rape or sexual assault.

CalOptima Health is not required to cover follow-up health care treatment provided by a non-contracted provider, except when the member is seeking emergency or urgent care. CalOptima Health must cover out-of-network services if medically necessary care is not available within the member’s network to ensure timely access.

AB 2843 prohibits plans from requiring any of the following as a condition of coverage:

- A member to file a police report on the rape or sexual assault.
- Charges to be brought against an assailant.
- An assailant to be convicted of rape or sexual assault.

To facilitate the waiver of cost sharing, treating providers must submit all claims using accurate diagnosis codes specific to rape or sexual assault. Please refer to Penal Code §§ 261, 261.6, 263, 263.1, 286, 287, and 288.7 for definitions of “rape” and “sexual assault” which may be accessed at the California Legislative Information website.

For more information regarding AB 2843, visit AB-2843 Health care coverage: rape and sexual assault.

Providers with questions regarding this Provider Alert can call CalOptima’s Provider Relations department at **714-246-8600** or email Providerservicesinbox@caloptima.org.

CalOptima Health Board Action Agenda Referral

Action To Be Taken November 6, 2025
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

11. Approve Actions Related to Covered California Administrative Services Agreement for Transportation

Contacts

Donna Laverdiere, Executive Director, Strategic Development, (714) 986-6981
Ladan Khamseh, Executive Director, Operations, (714) 246-8866

Recommended Actions

To support the Department of Managed Health Care licensure filing process, authorize the Chief Executive Officer, or designee, to negotiate and execute a contract amendment with Modivcare Solutions, LLC, to update contract terms as necessary to expand services to the Covered California line of business and to add payment terms and regulatory requirements.

Background

On June 5, 2025, the Board of Directors (Board) authorized the Chief Executive Officer to initiate, submit, and complete a filing with the Department of Managed Health Care (DMHC) to expand CalOptima Health's current Knox-Keene Act license to operate a Covered California health plan. On June 16, 2025, CalOptima Health submitted the initial filing to DMHC.

The DMHC filing is a multi-phased process that CalOptima Health must complete by mid-2026 to offer the Covered California product for benefit plan year 2027. The process requires the submission of many supporting exhibits that demonstrate compliance with the requirements of the Knox-Keene Act. Requirements include filing fully executed administrative service agreements for vendors that will perform services for CalOptima Health's Covered California line of business. CalOptima Health plans to file several administrative service agreements in February 2026.

Discussion

As part of CalOptima Health's delivery of services in the Covered California line of business, CalOptima Health proposes using current vendors who provide administrative services to create continuity in service and streamline administrative operations. CalOptima Health must amend several administrative services contracts before submitting them to DMHC to ensure their duration includes the launch of the Covered California product in 2027 and that the scope includes the performance of activities for the Covered California line of business and the appliable Covered California and DMHC regulatory requirements.

Adding Covered California to the Modivcare Scope of Work

CalOptima Health needs to add the Covered California line of business and its associated DMHC regulatory requirements into the scope of work for the current contract with Modivcare to ensure that members can access required non-emergency medical transportation services covered under the Covered California essential health benefits. The current Modivcare contract extends beyond the start of

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CalOptima Health's Covered California program launching in January 2027 and does not require extension if the existing term extension options are exercised by CalOptima Health.

Vendor	Administrative Service	Current Contract Term Date & Extensions Dates	Proposed Amendment
Modivcare Solutions, LLC	Non-emergency medical transportation services.	12/31/2026 plus 2 one-year extension	Add Covered California line of business for non-emergency ambulance and psychiatric transport services.

CalOptima Health is also pursuing a contingency plan for contracting with another vendor as a backup if a situation arises where the current vendor is unable to provide the required services. The contingency plan will allow for a ninety (90) day transition to a new vendor.

In the event the contract with Modivcare is terminated prior to the effectuation of the provisions related to the addition of the Covered California line of business, staff will provide an update to the Board that will include a contingency plan to meet required services.

Fiscal Impact
The recommended action has no additional impact on the current fiscal year. Funding for the contract amendment will be included in future Covered California operating budgets or through separate Board actions.

Rationale for Recommendation
The above recommended actions will support CalOptima Health's requirement to file all administrative services agreements with the DMHC in a timely fashion and ensure continuity of services during implementation of the new Covered California product.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Entities Covered by this Recommended Action

/s/ Michael Hunn *10/31/2025*
Authorized Signature **Date**

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Attachment to the November 6, 2025, Board of Directors Meeting – Agenda Item 11

CONTRACTED/ IMPACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Modivcare	6900 Layton Ave. Suite 1200	Denver	CO	80237

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Financial Summary
September 30, 2025

Board of Directors Meeting

November 6, 2025

Nancy Huang, Chief Financial Officer

Our Mission

To serve member health with excellence and dignity, respecting the value and needs of each person.

Our Vision

Provide all members with access to care and supports to achieve optimal health and well-being through an equitable and high-quality health care system.

Financial Highlights Notes: September 2025

- Notable events/items in September 2025
  - $212.1 million of Hospital Directed Payments (DP) were received and paid out in September 2025 for Calendar Year (CY) 2023
  - $9.1 million of Quality Incentive Pool Program (QIP) received and paid out in September 2025 for CY 2024

CalOptima Health

Financial Highlights
September 2025

September 2025					July - September 205			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
885,314	898,765	(13,451)	(1.5%)	Member Months	2,681,404	2,708,085	(26,681)	(1.0%)
631,490,594	395,456,178	236,034,416	59.7%	Revenues	1,420,510,565	1,192,100,988	228,409,577	19.2%
581,778,696	363,134,399	(218,644,297)	(60.2%)	Medical Expenses	1,299,525,490	1,103,665,172	(195,860,318)	(17.7%)
22,219,615	25,294,095	3,074,480	12.2%	Administrative Expenses	63,850,891	75,571,593	11,720,702	15.5%
27,492,283	**7,027,684**	**20,464,599**	**291.2%**	**Operating Margin**	**57,134,184**	**12,864,223**	**44,269,961**	**344.1%**
				Non-Operating Income (Loss)				
14,217,389	8,333,340	5,884,049	70.6%	Net Investment Income/Expense	46,524,912	25,000,020	21,524,892	86.1%
(457,546)	-	(457,546)	(100.0%)	Grant Expense	(457,546)	-	(457,546)	(100.0%)
(5,274,430)	-	(5,274,430)	(100.0%)	Community Reinvestment	(15,724,510)	-	(15,724,510)	(100.0%)
(176,029)	(138,610)	(37,419)	(27.0%)	Other Income/Expense	(338,377)	(415,830)	77,453	18.6%
8,309,384	**8,194,730**	**114,654**	**1.4%**	**Total Non-Operating Income (Loss)**	**30,004,478**	**24,584,190**	**5,420,288**	**22.0%**
35,801,667	**15,222,414**	**20,579,253**	**135.2%**	**Change in Net Assets**	**87,138,662**	**37,448,413**	**49,690,249**	**132.7%**
92.1%	*91.8%*	*0.3%*		*Medical Loss Ratio*	*91.5%*	*92.6%*	*(1.1%)*	
3.5%	*6.4%*	*2.9%*		*Administrative Loss Ratio*	*4.5%*	*6.3%*	*1.8%*	
4.4%	*1.8%*	*2.6%*		*Operating Margin Ratio*	*4.0%*	*1.1%*	*2.9%*	
100.0%	*100.0%*			*Total Operating*	*100.0%*	*100.0%*		
83.6%	*87.4%*	*(3.8%)*		**Adjusted MLR*	*85.5%*	*88.2%*	*(2.7%)*	
5.4%	*6.4%*	*1.0%*		**Adjusted ALR*	*5.3%*	*6.3%*	*1.0%*	

*Adjusted MLR/ALR excludes estimated Board-approved Provider Rate increases and Directed Payments, but includes costs associated with CalOptima Health's Digital Transformation Strategy (DTS) budget

CalOptima Health

FY 2025-26: Management Summary

- Change in Net Assets Surplus or (Deficit)
  - Month To Date (MTD) September 2025: $35.8 million, favorable to budget $20.6 million or 135.2% driven by Net Investment Income and member mix
  - Year To Date (YTD) July – September 2025: $87.1 million, favorable to budget $49.7 million or 132.7% driven by Net Investment Income, member mix, and lower than forecasted claims expenses

CalOptima Health

FY 2025-26: Management Summary (cont.)

- Enrollment
  - MTD: 885,314 members, unfavorable to budget 13,451 or 1.5% due to higher than anticipated disenrollment
  - YTD: 2,681,404 member months, unfavorable to budget 26,681 or 1.0%

FY 2025-26: Management Summary (cont.)

- Revenue
  - MTD: $631.5 million, favorable to budget $236.0 million or 59.7% driven by Medi-Cal (MC) Line of Business (LOB) due to CY 2023 Hospital DP, CY 2024 QIP, favorable member mix and prior year revenue
  - YTD: $1,420.5 million, favorable to budget $228.4 million or 19.2% due primarily to:
    - MC LOB due to CY 2023 Hospital DP, CY 2024 QIP and favorable member mix
    - Offset by OneCare (OC) LOB lower than anticipated Risk Adjustment Factor (RAF)

CalOptima Health

FY 2025-26: Management Summary (cont.)

- Medical Expenses
  - MTD: $581.8 million, unfavorable to budget $218.6 million or 60.2% driven by:
    - $221.5 million in MC Other Medical Expenses primarily due to CY 2023 Hospital DP, CY 2024 QIP
    - $7.3 million in Facilities Claims due to transplant-related claims
    - $1.4 million in Incentive Payments expense
    - Offset by $11.8 million favorable variance in all other medical expense categories

FY 2025-26: Management Summary (cont.)

- Medical Expenses
  - YTD: $1,299.5 million, unfavorable to budget $195.9 million or 17.7% due to:
    - $221.3 million in MC Other Medical Expenses primarily due to CY 2023 Hospital DP and CY 2024 QIP
    - Offset by $20.5 million of Managed Long-Term Services and Supports (MLTSS) favorable variance to budget

FY 2025-26: Management Summary (cont.)

- Administrative Expenses
  - MTD: $22.2 million, favorable to budget $3.1 million or 12.2% due to the timing of administrative expense activities
  - YTD: $63.9 million, favorable to budget $11.7 million or 15.5% due to the timing of administrative expense activities

FY 2025-26: Management Summary (cont.)

- Non-Operating Income (Loss)
  - MTD: $8.3 million, favorable to budget $0.1 million or 1.4% due primarily to $5.9 million favorable Net Investment Income, offset by Community Reinvestment contractual obligation accrual of $5.3 million
  - YTD: $30.0 million, favorable to budget $5.4 million or 22.0% due primarily to $21.5 million favorable Net Investment Income, offset by Community Reinvestment contractual obligation accrual of $15.7 million

CalOptima Health

FY 2025-26: Key Financial Ratios

- Medical Loss Ratio (MLR)

		Actual	Budget	Variance (%)
MTD	MLR	92.1%	91.8%	0.3%
	Adjusted MLR*	83.6%	87.4%	(3.8%)
YTD	MLR	91.5%	92.6%	(1.1%)
	Adjusted MLR*	85.5%	88.2%	(2.7%)

- Administrative Loss Ratio (ALR)

		Actual	Budget	Variance (%)
MTD	ALR	3.5%	6.4%	2.9%
	Adjusted ALR*	5.4%	6.4%	1.0%
YTD	ALR	4.5%	6.3%	1.8%
	Adjusted ALR*	5.3%	6.3%	1.0%

* Adjusted MLR/ALR excludes estimated Board-approved Provider Rate Increases and Directed Payments, but include costs associated with DTS.

CalOptima Health

FY 2025-26: Key Financials Ratios (cont.)

- Balance Sheet Ratios
  - Current ratio*: 1.9
  - Board Designated Reserve level: 3.71
  - Statutory Designated Reserve level: 1.02
  - Net-position: $2.9 billion, including required TNE of $131.8 million

*Current ratio compares current assets to current liabilities. It measures CalOptima Health's ability to pay short-term obligations.

Enrollment Summary: September 2025

September 2025					July - September 2025			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
152,063	147,660	4,403	3.0%	SPD	456,467	442,241	14,226	3.2%
252,438	258,905	(6,467)	(2.5%)	TANF Child	764,218	778,580	(14,362)	(1.8%)
125,087	129,020	(3,933)	(3.0%)	TANF Adult	380,333	389,206	(8,873)	(2.3%)
3,016	2,512	504	20.1%	LTC	8,380	7,537	843	11.2%
324,901	333,259	(8,358)	(2.5%)	MCE	989,167	1,008,393	(19,226)	(1.9%)
9,038	9,098	(60)	(0.7%)	WCM	27,167	27,325	(158)	(0.6%)
866,543	**880,454**	**(13,911)**	**(1.6%)**	**Medi-Cal Total**	**2,625,732**	**2,653,282**	**(27,550)**	**(1.0%)**
18,242	**17,774**	**468**	**2.6%**	**OneCare**	**54,086**	**53,204**	**882**	**1.7%**
529	**537**	**(8)**	**(1.5%)**	**PACE**	**1,586**	**1,599**	**(13)**	**(0.8%)**
556	**558**	**(2)**	**(0.4%)**	**MSSP***	**1,660**	**1,674**	**(14)**	**(0.8%)**
885,314	**898,765**	**(13,451)**	**(1.5%)**	**CalOptima Health Total**	**2,681,404**	**2,708,085**	**(26,681)**	**(1.0%)**

*MSSP enrollment is included in Medi-Cal total

Consolidated Revenue & Expenses: September 2025 MTD

	Medi-Cal	OneCare	PACE	MSSP	Covered CA	Consolidated
MEMBER MONTHS	866,543	18,242	529	556		885,314
REVENUES						
Capitation Revenue	$ 590,336,455	$ 36,050,141	$ 4,857,160	$ 246,838	$ -	$ 631,490,594
Total Operating Revenue	**590,336,455**	**36,050,141**	**4,857,160**	**246,838**	**-**	**631,490,594**
MEDICAL EXPENSES						
Provider Capitation	112,574,021	14,441,234				127,015,254
Professional, Facility & Ancillary Claims	141,930,599	7,426,106	2,307,318			151,664,023
Managed Long-Term Services & Supports (MLTSS)	46,223,456		67,691	29,451		46,320,598
Prescription Drugs		9,308,310	600,631			9,908,941
Case Management & Other Medical	243,233,824	1,976,077	1,451,363	208,615		246,869,879
Total Medical Expenses	**543,961,900**	**33,151,727**	**4,427,003**	**238,066**	**-**	**581,778,696**
Medical Loss Ratio	*92.1%*	*92.0%*	*91.1%*	*96.4%*	*0.0%*	*92.1%*
GROSS MARGIN	**46,374,556**	**2,898,414**	**430,157**	**8,771**	**-**	**49,711,898**
ADMINISTRATIVE EXPENSES						
Salaries & Benefits	11,624,032	1,052,696	183,669	91,049	70,435	13,021,882
Non-Salary Operating Expenses	3,598,986	603,944	175,827	1,470	579,875	4,960,102
Depreciation & Amortization	812,783		886			813,669
Other Operating Expenses	2,750,502	146,998	13,834	6,759		2,918,092
Indirect Cost Allocation, Occupancy	74,242	416,925	10,810	3,893		505,871
Total Administrative Expenses	**18,860,545**	**2,220,563**	**385,025**	**103,172**	**650,310**	**22,219,615**
Administrative Loss Ratio	*3.2%*	*6.2%*	*7.9%*	*41.8%*	*0.0%*	*3.5%*
Operating Income/(Loss)	**27,514,011**	**677,851**	**45,132**	**(94,400)**	**(650,310)**	**27,492,283**
Investments and Other Non-Operating	(5,273,035)					8,309,384
CHANGE IN NET ASSETS	**$ 22,240,975**	**$ 677,851**	**$ 45,132**	**$ (94,400)**	**$ (650,310)**	**$ 35,801,667**
BUDGETED CHANGE IN NET ASSETS	9,171,604	(1,496,157)	348,432	(118,290)	(877,905)	15,222,415
Variance to Budget - Fav/(Unfav)	$ 13,069,371	$ 2,174,008	$ (303,300)	$ 23,890	$ 227,595	$ 20,579,252

CalOptima Health

Consolidated Revenue & Expenses: September 2025 YTD

	Medi-Cal	OneCare	PACE	MSSP	Covered CA	Consolidated
MEMBER MONTHS	2,625,732	54,086	1,586	1,660		2,681,404
REVENUES						
Capitation Revenue	$ 1,298,045,656	$ 107,307,133	$ 14,422,370	$ 735,406	$ -	$ 1,420,510,565
Total Operating Revenue	**1,298,045,656**	**107,307,133**	**14,422,370**	**735,406**	**-**	**1,420,510,565**
MEDICAL EXPENSES						
Provider Capitation	337,888,326	43,517,288				381,405,614
Professional, Facility & Ancillary Claims	431,917,065	21,964,706	6,310,599			460,192,370
Managed Long-Term Services & Supports (MLTSS)	128,510,477		121,819	105,610		128,737,907
Prescription Drugs		29,808,854	1,757,554			31,566,409
Case Management & Other Medical	285,902,075	6,864,883	4,264,830	591,401		297,623,190
Total Medical Expenses	**1,184,217,944**	**102,155,731**	**12,454,803**	**697,012**	**-**	**1,299,525,490**
Medical Loss Ratio	*91.2%*	*95.2%*	*86.4%*	*94.8%*	*0.0%*	*91.5%*
GROSS MARGIN	**113,827,712**	**5,151,402**	**1,967,568**	**38,394**	**-**	**120,985,075**
ADMINISTRATIVE EXPENSES						
Salaries & Benefits	34,686,364	3,022,970	548,889	290,198	197,104	38,745,525
Non-Salary Operating Expenses	9,801,601	1,319,637	347,677	4,392	1,192,025	12,665,333
Depreciation & Amortization	2,415,258		2,658			2,417,916
Other Operating Expenses	8,370,024	292,522	32,650	18,896		8,714,092
Indirect Cost Allocation, Occupancy	(1,535,343)	2,780,165	44,149	19,053		1,308,025
Total Administrative Expenses	**53,737,904**	**7,415,294**	**976,024**	**332,540**	**1,389,129**	**63,850,891**
Administrative Loss Ratio	*4.1%*	*6.9%*	*6.8%*	*45.2%*	*0.0%*	*4.5%*
Operating Income/(Loss)	**60,089,808**	**(2,263,893)**	**991,544**	**(294,146)**	**(1,389,129)**	**57,134,184**
Investments and Other Non-Operating	(15,720,004)					30,004,478
CHANGE IN NET ASSETS	**$ 44,369,804**	**$ (2,263,893)**	**$ 991,544**	**$ (294,146)**	**$ (1,389,129)**	**$ 87,138,662**
BUDGETED CHANGE IN NET ASSETS	19,940,204	(5,182,591)	883,547	(356,450)	(2,420,487)	37,448,416
Variance to Budget - Fav/(Unfav)	$ 24,429,600	$ 2,918,698	$ 107,997	$ 62,304	$ 1,031,358	$ 49,690,246

CalOptima Health

Balance Sheet: As of September 2025

ASSETS		LIABILITIES & NET POSITION	
Current Assets		**Current Liabilities**	
Operating Cash	$529,228,976	Accounts Payable	$102,805,275
Short-term Investments	1,438,154,754	Medical Claims Liability	1,052,501,127
Capitation Receivable	455,576,184	Accrued Payroll Liabilities	27,598,083
Receivables - Other	86,563,533	Deferred Revenue	14,728,656
Prepaid Expenses	24,490,152	Other Current Liabilities	-
Total Current Assets	**2,534,013,599**	Capitation and Withholds	168,197,198
		Total Current Liabilities	**1,365,830,338**
Capital Assets		**Other Liabilities**	
Capital Assets	192,362,882	GASB 96 Subscription Liabilities	19,540,147
Less Accumulated Depreciation	(89,531,288)	Community Reinvestment	103,822,622
Capital Assets, Net of Depreciation	**102,831,594**	Capital Lease Payable	233,561
		Postemployment Health Care Plan	17,312,195
Other Assets		Net Pension Liabilities	5,840,992
Restricted Deposits	300,000	**Total Other Liabilities**	**146,749,516**
Board Designated Reserves	1,604,696,215		
Statutory Designated Reserves	134,144,257	**TOTAL LIABILITIES**	**1,512,579,855**
Total Other Assets	**1,739,140,472**		
TOTAL ASSETS	**4,375,985,665**	**Deferred Inflows**	**4,309,519**
Deferred Outflows	**28,626,072**	**Net Position**	
		Required TNE	131,812,377
		Funds in Excess of TNE	2,755,909,986
		TOTAL NET POSITION	**2,887,722,363**
TOTAL ASSETS & DEFERRED OUTFLOWS	**4,404,611,737**	**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION**	**4,404,611,737**

CalOptima Health

Board Designated Reserve and TNE Analysis: As of September 2025

Board Designated Reserves

Investment Account Name	Market Value	CalOptima Policy Compliance Level		Variance	
		Low	High	Mkt - Low	Mkt - High
Payden & Rygel Tier One	802,340,607				
MetLife Tier One	802,355,608				
Board Designated Reserves	1,604,696,215	1,082,540,573	1,732,064,917	522,155,642	(127,368,702)
Current Reserve Level (X months of average monthly revenue) [1]	*3.71*	*2.50*	*4.00*		

Statutory Designated Reserves

Investment Account Name	Market Value	CalOptima Policy Compliance Level		Variance	
		Low	High	Mkt - Low	Mkt - High
Payden & Rygel Tier Two	67,192,404				
MetLife Tier Two	66,951,852				
Statutory Designated Reserves	134,144,257	131,812,377	144,993,614	2,331,880	(10,849,358)
Current Reserve Level (X min. TNE) [1]	*1.02*	*1.00*	*1.10*		

[1] *See CalOptima Health Policy GA.3001: Statutory and Board-Designated Reserve Funds for more information.*

CalOptima Health

Spending Plan: As of September 2025

Item Description	Amount (millions)	Approved Initiative	Expense to Date	%
Total Net Position @ 9/30/2025	**$2,887.7**			**100.0%**
Resources Assigned				
Board Designated Reserve[1]	**$1,604.7**			**55.6%**
Statutory Designated Reserve[1]	**$134.1**			**4.6%**
Capital Assets, net of Depreciation	**$102.8**			**3.6%**
Resources Allocated[3]				
Homeless Health Initiative[2]	$19.1	$65.9	$46.8	0.7%
Housing and Homelessness Incentive Program[2]	24.9	87.4	62.5	0.9%
Intergovernmental Transfers (IGT)[4]	40.4	52.1	11.7	1.4%
Digital Transformation and Workplace Modernization[3]	25.9	100.0	74.1	0.9%
CalFresh Outreach Strategy	0.0	2.0	2.0	0.0%
CalFresh and Redetermination Outreach Strategy	1.7	6.0	4.3	0.1%
Coalition of Orange County Community Health Centers Grant	25.7	50.0	24.3	0.9%
Mind OC Grant (Irvine)	0.0	15.0	15.0	0.0%
General Awareness Campaign	0.3	4.7	4.4	0.0%
Member Health Needs Assessment	0.6	1.3	0.7	0.0%
Five-Year Hospital Quality Program Beginning MY 2023	117.8	153.5	35.7	4.1%
Skilled Nursing Facility Access Program	10.0	10.0	0.0	0.3%
In-Home Care Pilot Program with the UCI Family Health Center	2.0	2.0	0.0	0.1%
National Alliance for Mental Illness Orange County Peer Support Program Grant	3.0	5.0	2.0	0.1%
Stipend Program for Master of Social Work Students Grant	0.0	5.0	5.0	0.0%
Wellness & Prevention Program Grant	1.3	2.7	1.4	0.0%
CalOptima Health Provider Workforce Development Fund Grant	44.3	50.0	5.7	1.5%
Distribution Event - Naloxone Grant	2.2	15.0	12.8	0.1%
Garden Grove Bldg. Improvement	9.7	10.5	0.8	0.3%
CalOptima Health Community Reinvestment Program	38.0	38.0	0.0	1.3%
Dyadic Services Program Academy	1.0	1.9	0.9	0.0%
Outreach Strategy for newly eligible Adult Expansion members	2.1	7.6	5.5	0.1%
Quality Initiatives from unearned Pay for Value Program	18.6	23.3	4.7	0.6%
Expansion of CalOptima Health OC Outreach and Engagement Strategy	0.0	1.0	1.0	0.0%
Medi-Cal Provider Rate Increases	263.1	526.2	263.1	9.1%
Homeless Prevention and Stabilization Pilot Program	0.2	0.3	0.1	0.0%
OneCare Member Engagement and Education	0.3	0.3	0.0	0.0%
Medi-Cal Eligibility Outreach Strategy	0.8	0.8	0.0	0.0%
Subtotal:	**$653.0**	**$1,237.2**	**$584.2**	**22.6%**
Resources Available for New Initiatives				
Unallocated/Unassigned[1]	**$393.0**			**13.6%**

[1] Total Designated Reserves and unallocated reserve amount can support approximately 180 days of CalOptima Health's current operations.

[2] See HHI and HHIP summaries and Allocated Funds for list of Board Approved Initiatives. Amount reported includes only portion funded by reserves.

[3] On June 6, 2024, the Board of Directors approved an update to the Digital Transformation Strategy which will impact these figures beginning July 2024.

[4] On June 5, 2025, the Board of Directors approved the close out of Board-approved initiatives and transfer of remaining funds back to unallocated reserves.

CalOptima Health

Homeless Health Initiative and Allocated Funds: As of September 2025

Summary by Funding Source:	Total Funds	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funds Available for New Initiatives
HHI - IGT'S	64,131,301	64,131,301	46,765,350	17,365,951	-
HHI - Existing Reserves	1,800,000	1,800,000	-	1,800,000	-
HHIP	40,100,000	40,100,000	-	40,100,000	-
Total	**106,031,301**	**106,031,301**	**46,765,350**	**59,265,951**	**-**

Funds Allocation, approved initiatives:	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funding Source(s)
Enhanced Medi-Cal Services at the Be Well OC Regional Mental Health and Wellness Campus	11,400,000	11,400,000	-	IGT's
Recuperative Care	6,194,190	6,194,190	-	IGT's
Medical Respite	250,000	250,000	-	IGT's
Day Habilitation (County for HomeKey)	2,500,000	-	2,500,000	IGT's
Clinical Field Team Start-up & Federally Qualified Health Center (FQHC)	1,600,000	1,600,000	-	IGT's
CalOptima Health Homeless Response Team	1,681,734	1,681,734	-	IGT's
Homeless Coordination at Hospitals	10,000,000	9,956,478	43,522	IGT's
CalOptima Health Days, Homeless Clinical Access Program (HCAP) and FQHC Administrative Support	963,261	925,540	37,721	IGT's
FQHC (Community Health Center) Expansion	21,902	21,902	-	IGT's
HCAP and CalOptima Health Days	9,888,914	4,655,022	5,233,892	IGT's
Vaccination Intervention and Member Incentive Strategy[2]	54,649	54,649	-	IGT's
Street Medicine[1]	14,376,652	7,749,821	6,626,831	IGT's & Existing Reserves
Outreach and Engagement	7,000,000	2,276,015	4,723,985	IGT's
Housing and Homelessness Incentive Program (HHIP)[3]	40,100,000	-	40,100,000	IGT's & Existing Reserves
Subtotal of Approved Initiatives	**106,031,300**	**46,765,350**	**59,265,951**	
Transfer of funds to HHIP[3]	(40,100,000)	-	(40,100,000)	
Program Total	**65,931,300**	**46,765,350**	**19,165,951**	

[1]On August 7, 2025, CalOptima Health's Board of Directors approved $9.3 million to expand the Street Medicine Program - $3.2 million remaining from Street Medicine Initiative (from the Homeless Health Initiatives Reserve), $1.8 million from Existing Reserves, and $4.3 million from Intergovernmental Transfer balance resulting from a June 5, 2025, Board of of Director action, to fund 2-year grant agreements to Healthcare in Action (Anaheim), Celebrating Life Community Health Center (Costa Mesa), and AltaMed (Santa Ana).

[2]On June 5, 2025 the Board of Directors approved the close out of the Vaccination Intervention and Member Incentive Strategy program and transfer of the remaining funds of $68,699 to unallocated reserves for new initiatives.

[3]On September 1, 2022, CalOptima Health's Board of Directors approved reallocation of $40.1 million from HHI to HHIP.

CalOptima Health

Housing and Homelessness Incentive Program: As of September 2025

Summary by Funding Source:	Total Funds[1]	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funds Available for New Initiatives
DHCS HHIP Funds	72,931,189	54,930,994	32,970,535	21,960,459	$18,000,195
Existing Reserves & HHI Transfer	87,384,530	87,384,530	62,511,836	24,872,694	-
Total	**160,315,719**	**142,315,524**	**95,482,371**	**46,833,154**	**18,000,195**

Funds Allocation, approved initiatives:	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funding Source(s)
Office of Care Coordination	2,200,000	2,200,000	-	HHI
Pulse For Good	1,400,000	869,850	530,150	HHI
Equity Grants for Programs Serving Underrepresented Populations	4,621,311	3,696,311	925,000	HHI & DHCS
Infrastructure Projects	5,832,314	5,580,354	251,960	HHI
Capital Projects	108,247,369	74,146,735	34,100,634	HHI, DHCS & Existing Reserves
System Change Projects	10,184,530	8,323,680	1,860,850	DHCS
Non-Profit Healthcare Academy	700,000	655,391	44,609	DHCS
Total of Approved Initiatives	**$133,185,524[1]**	**$95,472,320**	**$37,713,204**	

[1]Total funding $160.3 million: $40.1 million Board-approved reallocation from HHI, $47.2 million from CalOptima Health existing reserves and $73.0 million from DHCS HHIP incentive payments.

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UNAUDITED FINANCIAL STATEMENTS

September 30, 2025

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CalOptima Health - Consolidated
Financial Highlights
For the Three Months Ending September 30, 2025

September 2025					July - September 2025			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
885,314	898,765	(13,451)	(1.5%)	Member Months	2,681,404	2,708,085	(26,681)	(1.0%)
631,490,594	395,456,178	236,034,416	59.7%	Revenues	1,420,510,565	1,192,100,988	228,409,577	19.2%
581,778,696	363,134,399	(218,644,297)	(60.2%)	Medical Expenses	1,299,525,490	1,103,665,172	(195,860,318)	(17.7%)
22,219,615	25,294,095	3,074,480	12.2%	Administrative Expenses	63,850,891	75,571,593	11,720,702	15.5%
27,492,283	**7,027,684**	**20,464,599**	**291.2%**	**Operating Margin**	**57,134,184**	**12,864,223**	**44,269,961**	**344.1%**
				Non-Operating Income (Loss)				
14,217,389	8,333,340	5,884,049	70.6%	Net Investment Income/Expense	46,524,912	25,000,020	21,524,892	86.1%
(457,546)	-	(457,546)	(100.0%)	Grant Expense	(457,546)	-	(457,546)	(100.0%)
(5,274,430)	-	(5,274,430)	(100.0%)	Community Reinvestment	(15,724,510)	-	(15,724,510)	(100.0%)
(176,029)	(138,610)	(37,419)	(27.0%)	Other Income/Expense	(338,377)	(415,830)	77,453	18.6%
8,309,384	**8,194,730**	**114,654**	**1.4%**	**Total Non-Operating Income (Loss)**	**30,004,478**	**24,584,190**	**5,420,288**	**22.0%**
35,801,667	**15,222,414**	**20,579,253**	**135.2%**	**Change in Net Assets**	**87,138,662**	**37,448,413**	**49,690,249**	**132.7%**
92.1%	*91.8%*	*0.3%*		*Medical Loss Ratio*	*91.5%*	*92.6%*	*(1.1%)*	
3.5%	*6.4%*	*2.9%*		*Administrative Loss Ratio*	*4.5%*	*6.3%*	*1.8%*	
4.4%	*1.8%*	*2.6%*		*Operating Margin Ratio*	*4.0%*	*1.1%*	*2.9%*	
100.0%	*100.0%*			*Total Operating*	*100.0%*	*100.0%*		
83.6%	*87.4%*	*(3.8%)*		**Adjusted MLR*	*85.5%*	*88.2%*	*(2.7%)*	
5.4%	*6.4%*	*1.0%*		**Adjusted ALR*	*5.3%*	*6.3%*	*1.0%*	

*Adjusted MLR /ALR excludes estimated Board-approved Provider Rate increases and Directed Payments, but includes costs associated with CalOptima Health's Digital Transformation Strategy (DTS) budget.

CalOptima Health - Consolidated
Full Time Equivalent (FTE) Data
For the Three Months Ending September 30, 2025

Total FTE's MTD			
	Actual	Budget	Fav/Unfav
Medi-Cal	1,325	1,406	81
OneCare	168	182	14
PACE	112	119	7
CCA	3	15	12
MSSP	22	24	2
Total	1,631	1,746	115

Total FTE's YTD			
	Actual	Budget	Fav/Unfav
Medi-Cal	3,978	4,216	238
OneCare	500	543	43
PACE	335	357	22
CCA	8	35	27
MSSP	66	71	5
Total	4,888	5,222	334

MM per FTE MTD			
	Actual	Budget	Fav/Unfav
Medi-Cal	654	626	(28)
OneCare	108	98	(10)
PACE	5	5	(0)
CCA	0	0	0
MSSP	0	23	23
Consolidated	543	515	(28)

MM per FTE YTD			
	Actual	Budget	Fav/Unfav
Medi-Cal	660	629	(31)
OneCare	108	98	(10)
PACE	5	4	(1)
CCA	0	0	0
MSSP	17	23	6
Consolidated	549	519	(30)

Open FTE			
	Total	Medical	Admin
Medi-Cal	89	29	60
OneCare	13	4	9
PACE	5	5	0
CCA	17	1	16
MSSP	0	0	0
Total	124	39	85

CalOptima Health - Consolidated - Month to Date
Statement of Revenues and Expenses
For the One Month Ending September 30, 2025

MEMBER MONTHS		885,314		898,765		(13,451)
	Actual		**Budget**		**Variance**	
REVENUE	**$**	**PMPM**	**$**	**PMPM**	**$**	**PMPM**
Medi-Cal	$590,336,455	$681.25	$353,258,583	$401.22	$237,077,872	$280.03
OneCare	36,050,141	1,976.22	37,137,027	2,089.40	(1,086,886)	(113.18)
PACE	4,857,160	9,181.78	4,811,514	8,959.99	45,646	221.79
MSSP	246,838	443.95	249,054	446.33	(2,216)	(2.38)
Total Operating Revenue	631,490,594	713.30	395,456,178	440.00	236,034,416	273.30
MEDICAL EXPENSES						
Medi-Cal	543,961,900	627.74	323,288,850	367.18	(220,673,050)	(260.56)
OneCare	33,151,727	1,817.33	35,429,054	1,993.31	2,277,327	175.98
PACE	4,427,003	8,368.63	4,144,419	7,717.73	(282,584)	(650.90)
MSSP	238,066	428.18	227,092	406.97	(10,974)	(21.21)
Covered CA		-	44,984	80.62	44,984	80.62
Total Medical Expenses	581,778,696	657.14	363,134,399	404.04	(218,644,297)	(253.10)
GROSS MARGIN	49,711,898	56.16	32,321,779	35.96	17,390,119	20.20
ADMINISTRATIVE EXPENSES						
Salaries and Benefits	13,021,882	14.71	14,007,985	15.59	986,103	0.88
Professional Fees	1,662,911	1.88	1,941,119	2.16	278,208	0.28
Purchased Services	2,713,836	3.07	2,807,953	3.12	94,117	0.05
Printing & Postage	583,355	0.66	620,975	0.69	37,620	0.03
Depreciation & Amortization	813,669	0.92	949,334	1.06	135,665	0.14
Other Expenses	2,918,092	3.30	4,484,861	4.99	1,566,769	1.69
Indirect Cost Allocation, Occupancy	505,871	0.57	481,868	0.54	(24,003)	(0.03)
Total Administrative Expenses	22,219,615	25.10	25,294,095	28.14	3,074,480	3.04
NET INCOME (LOSS) FROM OPERATIONS	27,492,283	31.05	7,027,684	7.82	20,464,599	23.23
INVESTMENT INCOME						
Interest Income	14,173,819	16.01	8,333,340	9.27	5,840,479	6.74
Realized Gain/(Loss) on Investments	1,049,892	1.19	-	-	1,049,892	1.19
Unrealized Gain/(Loss) on Investments	(1,006,322)	(1.14)	-	-	(1,006,322)	(1.14)
Total Investment Income	14,217,389	16.06	8,333,340	9.27	5,884,049	6.79
GRANT EXPENSE	(457,546)	(0.52)	-	-	(457,546)	(0.52)
COMMUNITY REINVESTMENT	(5,274,430)	(5.96)	-	-	(5,274,430)	(5.96)
OTHER INCOME/EXPENSE	(176,029)	(0.20)	(138,610)	(0.15)	(37,419)	(0.05)
CHANGE IN NET ASSETS	**35,801,667**	**40.44**	**15,222,414**	**16.94**	**20,579,253**	**23.50**
MEDICAL LOSS RATIO	**92.1%**		**91.8%**		**0.3%**	
ADMINISTRATIVE LOSS RATIO	**3.5%**		**6.4%**		**2.9%**	

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CalOptima Health- Consolidated - Year to Date
Statement of Revenues and Expenses
For the Three Months Ending September 30, 2025

MEMBER MONTHS		2,681,404		2,708,085		(26,681)
	Actual		**Budget**		**Variance**	
REVENUE	**$**	**PMPM**	**$**	**PMPM**	**$**	**PMPM**
Medi-Cal	$1,298,045,656	$494.36	$1,065,254,456	$401.49	$232,791,200	$92.87
OneCare	107,307,133	1,984.01	111,747,514	2,100.36	(4,440,381)	(116.35)
PACE	14,422,370	9,093.55	14,351,856	8,975.52	70,514	118.03
MSSP	735,406	443.02	747,162	446.33	(11,756)	(3.31)
Total Operating Revenue	1,420,510,565	529.76	1,192,100,988	440.2	228,409,577	89.56
MEDICAL EXPENSES						
Medi-Cal	1,184,217,944	451.00	982,957,069	370.47	(201,260,875)	(80.53)
OneCare	102,155,731	1,888.76	107,381,849	2,018.30	5,226,118	129.54
PACE	12,454,803	7,852.97	12,510,026	7,823.66	55,223	(29.31)
MSSP	697,012	419.89	681,276	406.97	(15,736)	(12.92)
Covered CA		0.00	134,952	80.62	134,952	80.62
Total Medical Expenses	1,299,525,490	484.64	1,103,665,172	407.54	(195,860,318)	(77.10)
GROSS MARGIN	120,985,075	45.12	88,435,816	32.66	32,549,259	12.46
ADMINISTRATIVE EXPENSES						
Salaries and Benefits	38,745,525	14.45	41,923,264	15.48	3,177,739	1.03
Professional Fees	4,511,156	1.68	5,743,340	2.12	1,232,183	0.44
Purchased Services	6,570,696	2.45	8,249,222	3.05	1,678,527	0.60
Printing & Postage	1,583,481	0.59	1,876,925	0.69	293,444	0.10
Depreciation & Amortization	2,417,916	0.90	2,848,002	1.05	430,086	0.15
Other Expenses	8,714,092	3.25	13,485,236	4.98	4,771,144	1.73
Indirect Cost Allocation, Occupancy	1,308,025	0.49	1,445,604	0.53	137,579	0.04
Total Administrative Expenses	63,850,891	23.81	75,571,593	27.91	11,720,702	4.10
NET INCOME (LOSS) FROM OPERATIONS	57,134,184	21.31	12,864,223	4.75	44,269,961	16.56
INVESTMENT INCOME						
Interest Income	41,733,624	15.56	25,000,020	9.23	16,733,604	6.33
Realized Gain/(Loss) on Investments	1,989,246	0.74	-	0.00	1,989,246	0.74
Unrealized Gain/(Loss) on Investments	2,802,041	1.04	-	0.00	2,802,041	1.04
Total Investment Income	46,524,912	17.35	25,000,020	9.23	21,524,892	8.12
GRANT EXPENSE	(457,546)	(0.17)	-	0.00	(457,546)	(0.17)
COMMUNITY REINVESTMENT	(15,724,510)	(5.86)	-	0.00	(15,724,510)	(5.86)
OTHER INCOME/EXPENSE	(338,377)	(0.13)	(415,830)	(0.15)	77,453	0.02
CHANGE IN NET ASSETS	**87,138,662**	**32.50**	**37,448,413**	**13.83**	**49,690,249**	**18.67**
MEDICAL LOSS RATIO	**91.5%**		**92.6%**		**(1.1%)**	
ADMINISTRATIVE LOSS RATIO	**4.5%**		**6.3%**		**1.8%**	

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CalOptima Health - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the One Month Ending September 30, 2025

	Medi-Cal	OneCare	PACE	MSSP	Covered CA	Consolidated
MEMBER MONTHS	866,543	18,242	529	556	-	885,314
REVENUES						
Capitation Revenue	$ 590,336,455	$ 36,050,141	$ 4,857,160	$ 246,838	$ -	$ 631,490,594
Total Operating Revenue	**590,336,455**	**36,050,141**	**4,857,160**	**246,838**	**-**	**631,490,594**
MEDICAL EXPENSES						
Provider Capitation	112,574,021	14,441,234				127,015,254
Professional, Facilty and Ancillary Claims	141,930,599	7,426,106	2,307,318			151,664,023
Managed Long-Term Services & Supports (MLTSS)	46,223,456		67,691	29,451		46,320,598
Prescription Drugs		9,308,310	600,631			9,908,941
Case Management & Other Medical	243,233,824	1,976,077	1,451,363	208,615		246,869,879
Total Medical Expenses	**543,961,900**	**33,151,727**	**4,427,003**	**238,066**	**-**	**581,778,696**
Medical Loss Ratio	*92.1%*	*92.0%*	*91.1%*	*96.4%*	*0.0%*	*92.1%*
GROSS MARGIN	**46,374,556**	**2,898,414**	**430,157**	**8,771**	**-**	**49,711,898**
ADMINISTRATIVE EXPENSES						
Salaries & Benefits	11,624,032	1,052,696	183,669	91,049	70,435	13,021,882
Non-Salary Operating Expenses	3,598,986	603,944	175,827	1,470	579,875	4,960,102
Depreciation & Amortization	812,783		886			813,669
Other Operating Expenses	2,750,502	146,998	13,834	6,759		2,918,092
Indirect Cost Allocation, Occupancy	74,242	416,925	10,810	3,893		505,871
Total Administrative Expenses	**18,860,545**	**2,220,563**	**385,025**	**103,172**	**650,310**	**22,219,615**
Administrative Loss Ratio	*3.2%*	*6.2%*	*7.9%*	*41.8%*	*0.0%*	*3.5%*
Operating Income/(Loss)	**27,514,011**	**677,851**	**45,132**	**(94,400)**	**(650,310)**	**27,492,283**
Investments and Other Non-Operating	(5,273,035)					8,309,384
CHANGE IN NET ASSETS	**$ 22,240,975**	**$ 677,851**	**$ 45,132**	**$ (94,400)**	**$ (650,310)**	**$ 35,801,667**
BUDGETED CHANGE IN NET ASSETS	9,171,604	(1,496,157)	348,432	(118,290)	(877,905)	15,222,415
Variance to Budget - Fav/(Unfav)	$ 13,069,371	$ 2,174,008	$ (303,300)	$ 23,890	$ 227,595	$ 20,579,252

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CalOptima Health - Consolidated - Year to Date
Statement of Revenues and Expenses by LOB
For the Three Months Ending September 30, 2025

	Medi-Cal	OneCare	PACE	MSSP	Covered CA	Consolidated
MEMBER MONTHS	2,625,732	54,086	1,586	1,660	-	2,681,404
REVENUES						
Capitation Revenue	$ 1,298,045,656	$ 107,307,133	$ 14,422,370	$ 735,406	$ -	$ 1,420,510,565
Total Operating Revenue	**1,298,045,656**	**107,307,133**	**14,422,370**	**735,406**	**-**	**1,420,510,565**
MEDICAL EXPENSES						
Provider Capitation	337,888,326	43,517,288				381,405,614
Professional, Facilty and Ancillary Claims	431,917,065	21,964,706	6,310,599			460,192,370
Managed Long-Term Services & Supports (MLTSS)	128,510,477		121,819	105,610		128,737,907
Prescription Drugs		29,808,854	1,757,554			31,566,409
Case Management & Other Medical	285,902,075	6,864,883	4,264,830	591,401		297,623,190
Total Medical Expenses	**1,184,217,944**	**102,155,731**	**12,454,803**	**697,012**	**-**	**1,299,525,490**
Medical Loss Ratio	*91.2%*	*95.2%*	*86.4%*	*94.8%*	*0.0%*	*91.5%*
GROSS MARGIN	**113,827,712**	**5,151,402**	**1,967,568**	**38,394**	**-**	**120,985,075**
ADMINISTRATIVE EXPENSES						
Salaries & Benefits	34,686,364	3,022,970	548,889	290,198	197,104	38,745,525
Non-Salary Operating Expenses	9,801,601	1,319,637	347,677	4,392	1,192,025	12,665,333
Depreciation & Amortization	2,415,258		2,658			2,417,916
Other Operating Expenses	8,370,024	292,522	32,650	18,896		8,714,092
Indirect Cost Allocation, Occupancy	(1,535,343)	2,780,165	44,149	19,053		1,308,025
Total Administrative Expenses	**53,737,904**	**7,415,294**	**976,024**	**332,540**	**1,389,129**	**63,850,891**
Administrative Loss Ratio	*4.1%*	*6.9%*	*6.8%*	*45.2%*	*0.0%*	*4.5%*
Operating Income/(Loss)	**60,089,808**	**(2,263,893)**	**991,544**	**(294,146)**	**(1,389,129)**	**57,134,184**
Investments and Other Non-Operating	(15,720,004)					30,004,478
CHANGE IN NET ASSETS	**$ 44,369,804**	**$ (2,263,893)**	**$ 991,544**	**$ (294,146)**	**$ (1,389,129)**	**$ 87,138,662**
BUDGETED CHANGE IN NET ASSETS	19,940,204	(5,182,591)	883,547	(356,450)	(2,420,487)	37,448,416
Variance to Budget - Fav/(Unfav)	$ 24,429,600	$ 2,918,698	$ 107,997	$ 62,304	$ 1,031,358	$ 49,690,246

CalOptima Health

Highlights – Consolidated, for Three Months Ending September 30, 2025

MONTH TO DATE RESULTS:

- Change in Net Assets is $35.8 million, favorable to budget $20.6 million
- Operating surplus is $27.5 million, with a surplus in non-operating income of $8.3 million

YEAR TO DATE RESULTS:

- Change in Net Assets is $87.1 million, favorable to budget $49.7 million
- Operating surplus is $57.1 million, with a surplus in non-operating income of $30.0 million

Change in Net Assets by Line of Business (LOB) ($ millions):

September 2025				July - September 2025		
Actual	**Budget**	**Variance**	**Operating Income (Loss)**	**Actual**	**Budget**	**Variance**
27.5	9.2	18.3	Medi-Cal	60.1	19.9	40.1
0.7	(1.5)	2.2	OneCare	(2.3)	(5.2)	2.9
0.0	0.3	(0.3)	PACE	1.0	0.9	0.1
(0.1)	(0.1)	0.0	MSSP	(0.3)	(0.4)	0.1
(0.7)	(0.9)	0.2	Covered CA	(1.4)	(2.4)	1.0
27.5	**7.0**	**20.5**	**Total Operating Income (Loss)**	**57.1**	**12.9**	**44.3**
			Non-Operating Income (Loss)			
14.2	8.3	5.9	Net Investment Income/Expense	46.5	25.0	21.5
(5.9)	(0.1)	(5.8)	Other Income/Expense	0.0	(16.5)	(0.4)
8.3	**8.2**	**0.1**	**Total Non-Operating Income/(Loss)**	**30.0**	**24.6**	**5.4**
35.8	**15.2**	**20.6**	**TOTAL**	**87.1**	**37.4**	**49.7**

CalOptima Health - Consolidated
Enrollment Summary
For the Three Months Ending September 30, 2025

September 2025					July - September 2025			
Actual	**Budget**	**$ Variance**	**%Variance**	**Enrollment (by Aid Category)**	**Actual**	**Budget**	**$ Variance**	**%Variance**
152,063	147,660	4,403	3.0%	SPD	456,467	442,241	14,226	3.2%
252,438	258,905	(6,467)	(2.5%)	TANF Child	764,218	778,580	(14,362)	(1.8%)
125,087	129,020	(3,933)	(3.0%)	TANF Adult	380,333	389,206	(8,873)	(2.3%)
3,016	2,512	504	20.1%	LTC	8,380	7,537	843	11.2%
324,901	333,259	(8,358)	(2.5%)	MCE	989,167	1,008,393	(19,226)	(1.9%)
9,038	9,098	(60)	(0.7%)	WCM	27,167	27,325	(158)	(0.6%)
866,543	**880,454**	**(13,911)**	**(1.6%)**	**Medi-Cal Total**	**2,625,732**	**2,653,282**	**(27,550)**	**(1.0%)**
18,242	**17,774**	**468**	**2.6%**	**OneCare**	**54,086**	**53,204**	**882**	**1.7%**
529	**537**	**(8)**	**(1.5%)**	**PACE**	**1,586**	**1,599**	**(13)**	**(0.8%)**
556	**558**	**(2)**	**(0.4%)**	**MSSP**	**1,660**	**1,674**	**(14)**	**(0.8%)**
885,314	**898,765**	**(13,451)**	**(1.5%)**	**CalOptima Health Total**	**2,681,404**	**2,708,085**	**(26,681)**	**(1.0%)**
				Enrollment (by Network)				
345,640	348,960	(3,320)	(1.0%)	HMO	1,035,743	1,054,062	(18,319)	(1.7%)
162,903	164,147	(1,244)	(0.8%)	PHC	493,812	495,331	(1,519)	(0.3%)
65,403	67,407	(2,004)	(3.0%)	Shared Risk Group	199,889	202,925	(3,036)	(1.5%)
292,597	299,940	(7,343)	(2.4%)	Fee for Service	896,288	900,964	(4,676)	(0.5%)
866,543	**880,454**	**(13,911)**	**(1.6%)**	**Medi-Cal Total**	**2,625,732**	**2,653,282**	**(27,550)**	**(1.0%)**
18,242	**17,774**	**468**	**2.6%**	**OneCare**	**54,086**	**53,204**	**882**	**1.7%**
529	**537**	**(8)**	**(1.5%)**	**PACE**	**1,586**	**1,599**	**(13)**	**(0.8%)**
556	**558**	**(2)**	**(0.4%)**	**MSSP**	**1,660**	**1,674**	**(14)**	**(0.8%)**
885,314	**898,765**	**(13,451)**	**(1.5%)**	**CalOptima Health Total**	**2,681,404**	**2,708,085**	**(26,681)**	**(1.0%)**

Note:* Total membership does not include MSSP

CalOptima Health
Enrollment Trend by Network
Fiscal Year 2026

	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	YTD Actual	YTD Budget	Variance
HMOs															
SPD	20,739	20,738	20,896										62,373	60,177	2,196
TANF Child	73,203	72,978	72,855										219,036	230,037	(11,001)
TANF Adult	67,587	67,579	68,311										203,477	204,664	(1,187)
LTC	3	12	(1)										14	3	11
MCE	182,912	181,318	182,080										546,310	554,888	(8,578)
WCM	1,508	1,526	1,499										4,533	4,291	242
Total	345,952	344,151	345,640										1,035,743	1,054,060	**(18,317)**
PHCs															
SPD	4,775	4,791	4,754										14,320	13,817	503
TANF Child	129,804	128,525	127,408										385,737	385,830	(93)
TANF Adult	3,936	3,870	3,761										11,567	11,826	(259)
LTC													0		0
MCE	21,807	21,373	20,988										64,168	65,618	(1,450)
WCM	6,119	5,909	5,992										18,020	18,240	(220)
Total	166,441	164,468	162,903										493,812	495,331	**(1,519)**
Shared Risk Groups															
SPD	3,418	3,327	3,355										10,100	9,504	596
TANF Child	18,444	18,179	17,845										54,468	53,898	570
TANF Adult	11,382	11,126	10,872										33,380	34,223	(843)
LTC		1											1		1
MCE	34,473	33,658	33,030										101,161	104,171	(3,010)
WCM	226	252	301										779	1,129	(350)
Total	**67,943**	**66,543**	**65,403**										**199,889**	**202,925**	**(3,036)**
Fee for Service (Dual)															
SPD	107,827	107,645	108,097										323,569	310,098	13,471
TANF Child		1											1		1
TANF Adult	876	859	867										2,602	3,363	(761)
LTC	2,311	2,446	2,667										7,424	6,681	743
MCE	3,187	3,126	3,065										9,378	15,306	(5,928)
WCM	15	26	15										56	43	13
Total	**114,216**	**114,103**	**114,711**										**343,030**	**335,491**	**7,539**
Fee for Service (Non-Dual - Total)															
SPD	15,643	15,501	14,961										46,105	48,645	(2,540)
TANF Child	35,975	34,671	34,330										104,976	108,815	(3,839)
TANF Adult	44,785	43,246	41,276										129,307	135,130	(5,823)
LTC	286	305	350										941	853	88
MCE	93,242	89,170	85,738										268,150	268,408	(258)
WCM	1,296	1,252	1,231										3,779	3,622	157
Total	**191,227**	**184,145**	**177,886**										**553,258**	**565,473**	**(12,215)**
Grand Totals															
SPD	152,402	152,002	152,063										456,467	442,241	14,226
TANF Child	257,426	254,354	252,438										764,218	778,580	(14,362)
TANF Adult	128,566	126,680	125,087										380,333	389,206	(8,873)
LTC	2,600	2,764	3,016										8,380	7,537	843
MCE	335,621	328,645	324,901										989,167	1,008,393	(19,226)
WCM	9,164	8,965	9,038										27,167	27,325	(158)
Total MediCal MM	**885,779**	**873,410**	**866,543**										**2,625,732**	**2,653,282**	**(27,550)**
OneCare	**17,971**	**17,873**	**18,242**										**54,086**	**53,204**	**882**
PACE	**528**	**529**	**529**										**1,586**	**1,599**	**(13)**
MSSP	**553**	**551**	**556**										**1,660**	**1,674**	**(14)**
Grand Total	**904,278**	**891,812**	**885,314**										**2,681,404**	**2,708,085**	**(26,681)**

Note:* Total membership does not include MSSP

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ENROLLMENT– SEPTEMBER MONTH:

Overall, September enrollment was 885,314

- Unfavorable to budget 13,451 or 1.5%
- Decreased 5,969 or 0.7% from Prior Month (PM) (August 2025)
- Decreased 28,187 or 3.1% from Prior Year (PY) (September 2024)

Medi-Cal enrollment was 866,543

- Unfavorable to budget 13,911 or 1.6%
- Temporary Assistance for Needy Families (TANF) unfavorable to budget 10,400
- Medi-Cal Expansion (MCE) unfavorable to budget 8,358
- Whole Child Model (WCM) unfavorable to budget 60
- Seniors and Persons with Disabilities (SPD) favorable to budget 4,403
- Long-Term Care (LTC) favorable to budget 504
- Decreased 6,867 or 0.8% from PM

OneCare enrollment was 18,242

- Favorable to budget 468 or 2.6%
- Increased 369 or 2.1% from PM

PACE enrollment was 529

- Unfavorable to budget 8 or 1.5%
- No change from PM

MSSP enrollment was 556

- Unfavorable to budget 2 or 0.4%
- Increased 5 or 0.9% from PM

CalOptima Health
Medi-Cal
Statement of Revenues and Expenses
For the Three Months Ending September 30, 2025

Month to Date					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
866,543	**880,454**	**(13,911)**	**(1.6%)**	**Member Months**	**2,625,732**	**2,653,282**	**(27,550)**	**(1.0%)**
				Revenues				
590,336,455	353,258,583	237,077,872	67.1%	Medi-Cal Capitation Revenue	1,298,045,656	1,065,254,456	232,791,200	21.9%
590,336,455	**353,258,583**	**237,077,872**	**67.1%**	**Total Operating Revenue**	**1,298,045,656**	**1,065,254,456**	**232,791,200**	**21.9%**
				Medical Expenses				
112,574,021	113,140,040	566,019	0.5%	Provider Capitation	337,888,326	341,504,776	3,616,450	1.1%
72,056,997	65,508,155	(6,548,842)	(10.0%)	Facilities Claims	213,726,301	200,780,922	(12,945,379)	(6.4%)
69,873,603	73,531,159	3,657,556	5.0%	Professional Claims	218,190,764	224,282,201	6,091,437	2.7%
46,223,456	48,736,854	2,513,398	5.2%	MLTSS	128,510,477	149,052,388	20,541,911	13.8%
11,030,251	9,532,667	(1,497,584)	(15.7%)	Incentive Payments	33,146,504	28,713,324	(4,433,180)	(15.4%)
8,895,325	10,995,941	2,100,616	19.1%	Medical Management	25,847,278	33,062,482	7,215,204	21.8%
223,308,247	1,844,034	(221,464,213)	(12,009.8%)	Other Medical Expenses	226,908,293	5,560,976	(221,347,317)	(3,980.4%)
543,961,900	**323,288,850**	**(220,673,050)**	**(68.3%)**	**Total Medical Expenses**	**1,184,217,944**	**982,957,069**	**(201,260,875)**	**(20.5%)**
46,374,556	**29,969,733**	**16,404,823**	**54.7%**	**Gross Margin**	**113,827,712**	**82,297,387**	**31,530,325**	**38.3%**
				Administrative Expenses				
11,624,032	12,187,581	563,549	4.6%	Salaries, Wages & Employee Benefits	34,686,364	36,685,540	1,999,176	5.4%
979,765	1,389,629	409,863	29.5%	Professional Fees	3,138,287	4,089,078	950,791	23.3%
2,195,534	2,226,968	31,434	1.4%	Purchased Services	5,355,457	6,569,903	1,214,446	18.5%
423,687	478,060	54,373	11.4%	Printing & Postage	1,307,857	1,448,180	140,323	9.7%
812,783	947,712	134,930	14.2%	Depreciation & Amortization	2,415,258	2,843,136	427,878	15.0%
2,750,502	4,309,555	1,559,053	36.2%	Other Operating Expenses	8,370,024	12,945,474	4,575,450	35.3%
74,242	(741,376)	(815,618)	(110.0%)	Indirect Cost Allocation, Occupancy	(1,535,343)	(2,224,128)	(688,785)	(31.0%)
18,860,545	**20,798,129**	**1,937,584**	**9.3%**	**Total Administrative Expenses**	**53,737,904**	**62,357,183**	**8,619,279**	**13.8%**
				Non-Operating Income (Loss)				
(5,274,430)	-	(5,274,430)	(100.0%)	Community Reinvestment	(15,724,510)	-	(15,724,510)	(100.0%)
1,395	-	1,395	100.0%	Other Income/Expense	4,507	-	4,507	100.0%
(5,273,035)	**-**	**(5,273,035)**	**(100.0%)**	**Total Non-Operating Income (Loss)**	**(15,720,004)**	**-**	**(15,720,004)**	**(100.0%)**
22,240,975	**9,171,604**	**13,069,371**	**142.5%**	**Change in Net Assets**	**44,369,804**	**19,940,204**	**24,429,600**	**122.5%**
92.1%	***91.5%***	***0.6%***		***Medical Loss Ratio***	***91.2%***	***92.3%***	***(1.0%)***	
3.2%	***5.9%***	***2.7%***		***Admin Loss Ratio***	***4.1%***	***5.9%***	***1.7%***	

MEDI-CAL INCOME STATEMENT– SEPTEMBER MONTH:

REVENUES are $590.3 million, favorable to budget $237.1 million:

- Unfavorable volume variance of $5.6 million
- Favorable price related variance of $242.7million
  - $212.1 million of revenue received for Calendar Year (CY) 2023 Hospital Directed Payments (DP)
  - $9.1 million of revenue received for CY 2024 Quality Incentive Pool Program (QIP)
  - $15.2 million due to release of accruals relating to updated CY 2025 population acuity estimates
  - $2.1 million due to Student Behavioral Health Incentive Program (SBHIP)
  - $4.2 million due to favorable member mix offset by Proposition 56, Enhanced Care Management (ECM) and Unsatisfactory Immigration Status (UIS) risk corridors

MEDICAL EXPENSES are $544.0 million, unfavorable to budget $220.7 million:

- Favorable volume variance of $5.1 million
- Unfavorable price related variance of $225.8 million:
  - Other Medical Expenses unfavorable variance of $221.5 million primarily due to CY 2023 Hospital DP and CY 2024 QIP
  - Facilities Claims expense unfavorable variance of $7.6 million due to reclassification of Managed Long-Term Services and Supports (MLTSS) claims to facilities claims and change in Incurred But Not Reported (IBNR) reserves
  - Incentive Payments expense unfavorable variance of $1.6 million
  - Provider Capitation expense unfavorable variance of $1.2 million
  - Offset by:
    - Professional Claims expense favorable variance of $2.5 million due to
    - Medical Management expense favorable variance of $1.9 million
    - MLTSS expense favorable variance of $1.7 million

ADMINISTRATIVE EXPENSES are $18.9 million, favorable to budget $1.9 million:

- Non-Salary expense favorable to budget $1.4 million
- Salaries, Wages & Employee Benefits expense favorable to budget $0.6 million

CHANGE IN NET ASSETS is $22.2 million, favorable to budget $13.1 million

CalOptima Health
OneCare
Statement of Revenues and Expenses
For the Three Months Ending September 30, 2025

Month to Date					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
18,242	**17,774**	**468**	**2.6%**	**Member Months**	**54,086**	**53,204**	**882**	**1.7%**
				Revenues				
25,504,990	27,579,698	(2,074,708)	(7.5%)	Medicare Part C Revenue	76,395,841	83,088,485	(6,692,644)	(8.1%)
10,545,150	9,557,329	987,821	10.3%	Medicare Part D Revenue	30,911,292	28,659,029	2,252,263	7.9%
36,050,141	**37,137,027**	**(1,086,886)**	**(2.9%)**	**Total Operating Revenue**	**107,307,133**	**111,747,514**	**(4,440,381)**	**(4.0%)**
				Medical Expenses				
14,441,234	16,068,026	1,626,792	10.1%	Provider Capitation	43,517,288	48,402,234	4,884,946	10.1%
5,382,667	4,946,918	(435,749)	(8.8%)	Facilities Claims	14,949,868	15,107,578	157,710	1.0%
2,043,439	1,955,933	(87,506)	(4.5%)	Professional Claims	7,014,838	5,964,288	(1,050,550)	(17.6%)
9,308,310	10,203,975	895,665	8.8%	Prescription Drugs	29,808,854	31,178,227	1,369,373	4.4%
596,948	645,510	48,562	7.5%	Incentive Payments	2,234,533	1,891,836	(342,697)	(18.1%)
1,027,600	1,496,403	468,803	31.3%	Medical Management	3,117,495	4,501,567	1,384,072	30.7%
351,530	112,289	(239,241)	(213.1%)	Other Medical Expenses	1,512,854	336,119	(1,176,735)	(350.1%)
33,151,727	**35,429,054**	**2,277,327**	**6.4%**	**Total Medical Expenses**	**102,155,731**	**107,381,849**	**5,226,118**	**4.9%**
2,898,414	**1,707,973**	**1,190,441**	**69.7%**	**Gross Margin**	**5,151,402**	**4,365,665**	**785,737**	**18.0%**
				Administrative Expenses				
1,052,696	1,195,364	142,668	11.9%	Salaries, Wages & Employee Benefits	3,022,970	3,571,958	548,988	15.4%
43,248	117,716	74,468	63.3%	Professional Fees	112,889	353,148	240,259	68.0%
453,361	459,323	5,962	1.3%	Purchased Services	981,601	1,314,333	332,732	25.3%
107,335	121,107	13,772	11.4%	Printing & Postage	225,147	363,321	138,174	38.0%
146,998	112,453	(34,545)	(30.7%)	Other Operating Expenses	292,522	350,995	58,473	16.7%
416,925	1,198,167	781,242	65.2%	Indirect Cost Allocation, Occupancy	2,780,165	3,594,501	814,336	22.7%
2,220,563	**3,204,130**	**983,567**	**30.7%**	**Total Administrative Expenses**	**7,415,294**	**9,548,256**	**2,132,962**	**22.3%**
677,851	**(1,496,157)**	**2,174,008**	**145.3%**	**Change in Net Assets**	**(2,263,893)**	**(5,182,591)**	**2,918,698**	**56.3%**
92.0%	***95.4%***	***(3.4%)***		***Medical Loss Ratio***	***95.2%***	***96.1%***	***(0.9%)***	
6.2%	***8.6%***	***2.5%***		***Admin Loss Ratio***	***6.9%***	***8.5%***	***1.6%***	

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ONECARE INCOME STATEMENT– SEPTEMBER MONTH:

REVENUES are $36.1 million, unfavorable to budget $1.1 million:

- Favorable volume related variance of $1.0 million
- Unfavorable price related variance of $2.1 million driven by lower than anticipated Risk Adjustment Factor (RAF)

MEDICAL EXPENSES are $33.2 million, favorable to budget $2.3 million:

- Unfavorable volume related variance of $0.9 million
- Favorable price related variance of $3.2 million
  - Provider Capitation expense favorable variance of $2.0 million
  - Prescription Drugs expense favorable variance of $1.2 million

ADMINISTRATIVE EXPENSES are $2.2 million, favorable to budget $1.0 million

- Non-Salary expense favorable to budget $0.8 million
- Salaries, Wages & Employee Benefits expense favorable to budget $0.1 million

CHANGE IN NET ASSETS is $0.7 million, favorable to budget $2.2 million

CalOptima Health
PACE
Statement of Revenues and Expenses
For the Three Months Ending September 30, 2025

Month to Date					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
529	**537**	**(8)**	**(1.5%)**	**Member Months**	**1,586**	**1,599**	**(13)**	**(0.8%)**
				Revenues				
3,603,652	3,668,780	(65,128)	(1.8%)	Medi-Cal Capitation Revenue	10,861,077	10,924,356	(63,279)	(0.6%)
838,732	818,791	19,941	2.4%	Medicare Part C Revenue	2,475,028	2,459,286	15,742	0.6%
414,777	323,943	90,834	28.0%	Medicare Part D Revenue	1,086,266	968,214	118,052	12.2%
4,857,160	**4,811,514**	**45,646**	**0.9%**	**Total Operating Revenue**	**14,422,370**	**14,351,856**	**70,514**	**0.5%**
				Medical Expenses				
1,451,363	1,573,214	121,851	7.7%	Medical Management	4,264,830	4,735,734	470,904	9.9%
1,097,559	804,568	(292,991)	(36.4%)	Facilities Claims	2,909,008	2,435,542	(473,466)	(19.4%)
918,349	759,606	(158,743)	(20.9%)	Professional Claims	2,490,549	2,298,637	(191,912)	(8.3%)
600,631	697,869	97,238	13.9%	Prescription Drugs	1,757,554	2,112,419	354,865	16.8%
67,691	36,982	(30,709)	(83.0%)	MLTSS	121,819	107,717	(14,102)	(13.1%)
291,410	272,180	(19,230)	(7.1%)	Patient Transportation	911,042	819,977	(91,065)	(11.1%)
4,427,003	**4,144,419**	**(282,584)**	**(6.8%)**	**Total Medical Expenses**	**12,454,803**	**12,510,026**	**55,223**	**0.4%**
430,157	**667,095**	**(236,938)**	**(35.5%)**	**Gross Margin**	**1,967,568**	**1,841,830**	**125,738**	**6.8%**
				Administrative Expenses				
183,669	183,045	(624)	(0.3%)	Salaries, Wages & Employee Benefits	548,889	551,429	2,540	0.5%
58,565	13,941	(44,624)	(320.1%)	Professional Fees	63,584	41,615	(21,969)	(52.8%)
64,927	69,662	4,735	6.8%	Purchased Services	233,617	208,986	(24,631)	(11.8%)
52,334	21,787	(30,547)	(140.2%)	Printing & Postage	50,477	65,361	14,884	22.8%
886	1,622	736	45.4%	Depreciation & Amortization	2,658	4,866	2,208	45.4%
13,834	11,112	(2,722)	(24.5%)	Other Operating Expenses	32,650	33,544	894	2.7%
10,810	17,494	6,684	38.2%	Indirect Cost Allocation, Occupancy	44,149	52,482	8,333	15.9%
385,025	**318,663**	**(66,362)**	**(20.8%)**	**Total Administrative Expenses**	**976,024**	**958,283**	**(17,741)**	**(1.9%)**
45,132	**348,432**	**(303,300)**	**(87.0%)**	**Change in Net Assets**	**991,544**	**883,547**	**107,997**	**12.2%**
91.1%	***86.1%***	***5.0%***		***Medical Loss Ratio***	***86.4%***	***87.2%***	***(0.8%)***	
7.9%	***6.6%***	***(1.3%)***		***Admin Loss Ratio***	***6.8%***	***6.7%***	***(0.1%)***	

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CalOptima Health
Multipurpose Senior Services Program (MSSP)
Statement of Revenues and Expenses
For the Three Months Ending September 30, 2025

Month to Date					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
556	**558**	**(2)**	**(0.4%)**	**Member Months**	**1,660**	**1,674**	**(14)**	**(0.8%)**
				Revenues				
246,838	249,054	(2,216)	(0.9%)	Revenue	735,406	747,162	(11,756)	(1.6%)
246,838	**249,054**	**(2,216)**	**(0.9%)**	**Total Operating Revenue**	**735,406**	**747,162**	**(11,756)**	**(1.6%)**
				Medical Expenses				
208,615	194,133	(14,482)	(7.5%)	Medical Management	591,401	582,399	(9,002)	(1.5%)
29,451	32,959	3,508	10.6%	Waiver Services	105,610	98,877	(6,733)	(6.8%)
208,615	194,133	(14,482)	(7.5%)	Total Medical Management	591,401	582,399	(9,002)	(1.5%)
29,451	32,959	3,508	10.6%	Total Waiver Services	105,610	98,877	(6,733)	(6.8%)
238,066	**227,092**	**(10,974)**	**(4.8%)**	**Total Program Expenses**	**697,012**	**681,276**	**(15,736)**	**(2.3%)**
8,771	**21,962**	**(13,191)**	**(60.1%)**	**Gross Margin**	**38,394**	**65,886**	**(27,492)**	**(41.7%)**
				Administrative Expenses				
91,049	122,649	31,600	25.8%	Salaries, Wages & Employee Benefits	290,198	369,527	79,329	21.5%
1,457	1,500	43	2.9%	Professional Fees	4,371	4,500	129	2.9%
13	-	(13)	(100.0%)	Purchased Services	21	-	(21)	(100.0%)
6,759	8,520	1,761	20.7%	Other Operating Expenses	18,896	25,560	6,664	26.1%
3,893	7,583	3,690	48.7%	Indirect Cost Allocation, Occupancy	19,053	22,749	3,696	16.2%
103,172	**140,252**	**37,080**	**26.4%**	**Total Administrative Expenses**	**332,540**	**422,336**	**89,796**	**21.3%**
(94,400)	**(118,290)**	**23,890**	**20.2%**	**Change in Net Assets**	**(294,146)**	**(356,450)**	**62,304**	**17.5%**
96.4%	***91.2%***	***5.3%***		***Medical Loss Ratio***	***94.8%***	***91.2%***	***3.6%***	
41.8%	***56.3%***	***14.5%***		***Admin Loss Ratio***	***45.2%***	***56.5%***	***11.3%***	

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CalOptima Health
Covered CA
Statement of Revenues and Expenses
For the Three Months Ending September 30, 2025

Month to Date					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
-	**-**	**-**	**0.0%**	**Member Months**	**-**	**-**	**-**	**0.0%**
				Revenues				
-	-	-	0.0%	Medi-Cal Capitation Revenue	-	-	-	0.0%
-	**-**	**-**	**0.0%**	**Total Operating Revenue**	**-**	**-**	**-**	**0.0%**
				Medical Expenses				
-	44,984	44,984	100.0%	Medical Management	-	134,952	134,952	100.0%
-	**44,984**	**44,984**	**100.0%**	**Total Medical Expenses**	**-**	**134,952**	**134,952**	**100.0%**
-	**(44,984)**	**44,984**	**(100.0%)**	**Gross Margin**	**-**	**(134,952)**	**134,952**	**(100.0%)**
				Administrative Expenses				
70,435	319,346	248,911	77.9%	Salaries, Wages & Employee Benefits	197,104	744,810	547,706	73.5%
579,875	418,333	(161,542)	(38.6%)	Professional Fees	1,192,025	1,254,999	62,974	5.0%
-	52,000	52,000	100.0%	Purchased Services	-	156,000	156,000	100.0%
-	21	21	100.0%	Printing & Postage	-	63	63	100.0%
-	43,221	43,221	100.0%	Other Operating Expenses	-	129,663	129,663	100.0%
650,310	**832,921**	**182,611**	**21.9%**	**Total Administrative Expenses**	**1,389,129**	**2,285,535**	**896,406**	**39.2%**
				Non-Operating Income (Loss)				
-	-	-	0.0%	Net Operating Tax	-	-	-	0.0%
-	-	-	0.0%	Net QAF & IGT Income/Expense	-	-	-	0.0%
-	-	-	0.0%	Other Income/Expense	-	-	-	0.0%
-	**-**	**-**	**0.0%**	**Total Non-Operating Income (Loss)**	**-**	**-**	**-**	**0.0%**
(650,310)	**(877,905)**	**227,595**	**25.9%**	**Change in Net Assets**	**(1,389,129)**	**(2,420,487)**	**1,031,358**	**42.6%**
0.0%	***0.0%***	***0.0%***		***Medical Loss Ratio***	***0.0%***	***0.0%***	***0.0%***	
0.0%	***0.0%***	***0.0%***		***Admin Loss Ratio***	***0.0%***	***0.0%***	***0.0%***	

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CalOptima Health
Building - 505 City Parkway
Statement of Revenues and Expenses
For the Three Months Ending September 30, 2025

Month to Date					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
				Revenues				
-	-	-	0.0%	Rental Income	-	-	-	0.0%
-	**-**	**-**	**0.0%**	**Total Operating Revenue**	**-**	**-**	**-**	**0.0%**
				Administrative Expenses				
65,567	29,708	(35,859)	(120.7%)	Purchased Services	179,312	89,124	(90,188)	(101.2%)
185,353	191,643	6,290	3.3%	Depreciation & Amortization	556,060	574,929	18,869	3.3%
23,371	25,124	1,753	7.0%	Insurance Expense	70,119	75,372	5,253	7.0%
114,094	219,809	105,715	48.1%	Repair & Maintenance	417,507	659,427	241,920	36.7%
98,814	59,093	(39,721)	(67.2%)	Other Operating Expenses	268,082	177,279	(90,803)	(51.2%)
(487,200)	(525,376)	(38,176)	(7.3%)	Indirect Cost Allocation, Occupancy	(1,491,081)	(1,576,128)	(85,047)	(5.4%)
-	**1**	**1**	**100.0%**	**Total Administrative Expenses**	**-**	**3**	**3**	**100.0%**
-	**(1)**	**1**	**(100.0%)**	**Change in Net Assets**	**-**	**(3)**	**3**	**(100.0%)**

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CalOptima Health
Building - 500 City Parkway
Statement of Revenues and Expenses
For the Three Months Ending September 30, 2025

Month to Date					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
				Revenues				
130,875	118,206	12,669	10.7%	Rental Income	392,626	354,618	38,008	10.7%
130,875	**118,206**	**12,669**	**10.7%**	**Total Operating Revenue**	**392,626**	**354,618**	**38,008**	**10.7%**
				Administrative Expenses				
-	-	-	0.0%	Professional Fees	-	-	-	0.0%
65,355	19,131	(46,224)	(241.6%)	Purchased Services	124,646	57,393	(67,253)	(117.2%)
58,871	75,663	16,792	22.2%	Depreciation & Amortization	177,442	226,989	49,547	21.8%
8,600	9,245	645	7.0%	Insurance Expense	25,799	27,735	1,936	7.0%
109,911	104,657	(5,254)	(5.0%)	Repair & Maintenance	224,676	313,971	89,295	28.4%
47,283	31,298	(15,985)	(51.1%)	Other Operating Expenses	107,781	93,894	(13,887)	(14.8%)
(30,714)	(25,416)	5,298	20.8%	Indirect Cost Allocation, Occupancy	(69,932)	(76,248)	(6,317)	(8.3%)
259,306	**214,578**	**(44,728)**	**(20.8%)**	**Total Administrative Expenses**	**590,413**	**643,734**	**53,321**	**8.3%**
(128,431)	**(96,372)**	**(32,059)**	**(33.3%)**	**Change in Net Assets**	**(197,786)**	**(289,116)**	**91,330**	**31.6%**

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CalOptima Health
Building - 7900 Garden Grove Blvd
Statement of Revenues and Expenses
For the Three Months Ending September 30, 2025

Month to Date					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
				Revenues				
-	-	-	0.0%	Rental Income	-	-	-	0.0%
-	**-**	**-**	**0.0%**	**Total Operating Revenue**	**-**	**-**	**-**	**0.0%**
				Administrative Expenses				
-	-	-	0.0%	Professional Fees	-	-	-	0.0%
32,734	3,333	(29,401)	(882.1%)	Purchased Services	101,474	9,999	(91,475)	(914.8%)
9,397	9,651	254	2.6%	Depreciation & Amortization	28,192	28,953	761	2.6%
4,751	-	(4,751)	(100.0%)	Insurance Expense	14,252	-	(14,252)	(100.0%)
595	28,533	27,938	97.9%	Repair & Maintenance	(1,307)	85,599	86,906	101.5%
1,516	720	(796)	(110.5%)	Other Operating Expenses	2,486	2,160	(326)	(15.1%)
-	-	-	0.0%	Indirect Cost Allocation, Occupancy	-	-	-	0.0%
48,993	**42,237**	**(6,756)**	**(16.0%)**	**Total Administrative Expenses**	**145,097**	**126,711**	**(18,386)**	**(14.5%)**
(48,993)	**(42,237)**	**(6,756)**	**(16.0%)**	**Change in Net Assets**	**(145,097)**	**(126,711)**	**(18,386)**	**(14.5%)**

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OTHER PROGRAM INCOME STATEMENTS – SEPTEMBER MONTH:

PACE

- **CHANGE IN NET ASSETS** is $45,132, unfavorable to budget $0.3 million

MSSP

- **CHANGE IN NET ASSETS** is ($94,400), favorable to budget $23,890

Covered CA

- **CHANGE IN NET ASSETS** is ($0.7) million, favorable to budget $0.2 million

NON-OPERATING INCOME STATEMENTS – SEPTEMBER MONTH:

BUILDING 500 City Parkway

- **CHANGE IN NET ASSETS** is ($128,431), unfavorable to budget $32,059
  - Net of $130,875 in rental income and $259,306 in expenses

BUILDING 7900 Garden Grove Blvd

- **CHANGE IN NET ASSETS** is ($49,012), unfavorable to budget $6,775

INVESTMENT INCOME

- Favorable variance of $5.9 million compared to budget. Overall net investment income of $14.2 million due to interest income

CalOptima Health
Balance Sheet
September 30, 2025

		September-25	August-25	$ Change	% Change
ASSETS					
Current Assets					
	Cash and Cash Equivalents	529,228,976	485,883,719	43,345,257	8.9%
	Short-term Investments	1,438,154,754	1,500,773,614	(62,618,860)	(4.2%)
	Capitation Receivable	455,576,184	452,366,783	3,209,401	0.7%
	Receivables - Other	86,563,533	86,860,642	(297,109)	(0.3%)
	Prepaid Expenses	24,490,152	15,720,349	8,769,802	55.8%
	Total Current Assets	**2,534,013,599**	**2,541,605,108**	**(7,591,508)**	**(0.3%)**
Board Designated Assets					
	Board Designated Reserves	1,604,696,215	1,599,085,594	5,610,621	0.4%
	Statutory Designated Reserves	134,144,257	133,740,414	403,843	0.3%
	Total Designated Assets	**1,738,840,472**	**1,732,826,007**	**6,014,464**	**0.3%**
Restricted Deposit		**300,000**	**300,000**	**-**	**0.0%**
Capital Assets, Net		**102,831,594**	**102,443,520**	**388,073**	**0.4%**
Total Assets		**4,375,985,665**	**4,377,174,635**	**(1,188,971)**	**(0.0%)**
Deferred Outflows of Resources					
	Advance Discretionary Payment	-	-	-	0.0%
	Net Pension	27,437,072	27,437,072	-	0.0%
	Other Postemployment Benefits	1,189,000	1,189,000	-	0.0%
	Total Deferred Outflows of Resources	**28,626,072**	**28,626,072**	**-**	**0.0%**
TOTAL ASSETS AND DEFERRED OUTFLOWS OF RESOURCES		**4,404,611,737**	**4,405,800,707**	**(1,188,971)**	**(0.0%)**
LIABILITIES					
Current Liabilities					
	Accounts Payable	102,805,275	107,236,859	(4,431,584)	(4.1%)
	Medical Claims Liability	1,052,501,127	1,058,343,475	(5,842,347)	(0.6%)
	Accrued Payroll Liabilities	27,598,083	25,485,551	2,112,532	8.3%
	Deferred Revenue	14,728,656	52,839,094	(38,110,439)	(72.1%)
	Other Current Liabilities	-	-	-	0.0%
	Capitation & Withholds	168,197,198	164,213,847	3,983,351	2.4%
	Total Current Liabilities	**1,365,830,338**	**1,408,118,826**	**(42,288,487)**	**(3.0%)**
	GASB 96 Subscription Liabilities	19,540,147	19,540,147	-	0.0%
	Community Reinvestment	103,822,622	98,548,192	5,274,430	5.4%
	Capital Lease Payable	233,561	237,530	(3,969)	(1.7%)
	Postemployment Health Care Plan	17,312,195	17,284,806	27,389	0.2%
	Net Pension Liability	5,840,992	5,840,992	-	0.0%
	Total Liabilities	**1,512,579,855**	**1,549,570,492**	**(36,990,638)**	**(2.4%)**
Deferred Inflows of Resources					
	Net Pension	1,321,519	1,321,519	-	0.0%
	Other Postemployment Benefits	2,988,000	2,988,000	-	0.0%
	Total Deferred Inflows of Resources	**4,309,519**	**4,309,519**	**-**	**0.0%**
Net Position					
	Required TNE	131,812,377	128,423,137	3,389,240	2.6%
	Funds in excess of TNE	2,755,909,986	2,723,497,559	32,412,427	1.2%
	Total Net Position	**2,887,722,363**	**2,851,920,696**	**35,801,667**	**1.3%**
TOTAL LIABILITIES & DEFERRED INFLOWS & NET POSITION		**4,404,611,737**	**4,405,800,707**	**(1,188,971)**	**(0.0%)**

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BALANCE SHEET – SEPTEMBER MONTH:

ASSETS of $4.4 billion decreased $1.2 million from August or 0.0%

- Operating Cash and Short-term Investments decreased $19.3 million due to cut-off timing, with an additional claims run of $17.0 million for September and the current month including both the receipt and payment of $221.1 million in Private Hospital Directed Payments (PHDP), Enhanced Payment Program (EPP) and QIP State directed payments
- Prepaid Expenses increased $8.8 million due to variability in the renewal of annual IT maintenance contracts, along with an increase of $2.5 million in deposits for the OneCare (OC) Flex Cards
- Total Designated Assets increased $6.0 million due to interest income
- Capitation Receivables increased $3.2 million primarily due to the routine variability of capitation checks

LIABILITIES of $1.5 billion decreased $37.0 million from August or 2.4%

- Deferred Revenue decreased $38.1 million due to the recognition of $34.0 million of September Centers for Medicare & Medicaid Services (CMS) revenue received in August and $2.1 million in revenue received for SBHIP
- Medical Claims Liabilities decreased $5.8 million due to variability in claims experience
- Accounts Payable decreased $4.4 million based on month end cut-off
- Community Reinvestment increased $5.3 million based on income which includes a release of acuity accrual for Fiscal Year (FY) 2025
- Capitation & Withholds increased $4.0 million

NET ASSETS of $2.9 billion, increased $35.8 million from August or 1.3%

CalOptima Health
Board Designated Reserve and TNE Analysis
as of September 30, 2025

Board Designated Reserves

Investment Account Name	Market Value	CalOptima Policy Compliance Level		Variance	
		Low	High	Mkt - Low	Mkt - High
Payden & Rygel Tier One	802,340,607				
MetLife Tier One	802,355,608				
Board Designated Reserves	1,604,696,215	1,082,540,573	1,732,064,917	522,155,642	(127,368,702)
Current Reserve Level (X months of average monthly revenue) [1]	*3.71*	*2.50*	*4.00*		

Statutory Designated Reserves

Investment Account Name	Market Value	CalOptima Policy Compliance Level		Variance	
		Low	High	Mkt - Low	Mkt - High
Payden & Rygel Tier Two	67,192,404				
MetLife Tier Two	66,951,852				
Statutory Designated Reserves	134,144,257	131,812,377	144,993,614	2,331,880	(10,849,358)
Current Reserve Level (X min. TNE) [1]	*1.02*	*1.00*	*1.10*		

[1] *See CalOptima Health Policy GA.3001: Statutory and Board-Designated Reserve Funds for more information.*

CalOptima Health
Statement of Cash Flow
September 30, 2025

	September 2025	July - September 2025
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	35,801,667	87,138,662
Adjustments to reconcile change in net assets		
to net cash provided by operating activities		
Depreciation & Amortization	1,067,291	3,179,610
Changes in assets and liabilities:		
Prepaid expenses and other	(8,769,802)	(13,307,090)
Capitation receivable	(2,912,293)	206,972,017
Medical claims liability	(5,842,347)	4,763,788
Deferred revenue	(38,110,439)	(7,325,907)
Payable to health networks	3,983,351	14,203,833
Accounts payable	(4,431,584)	(131,181,232)
Accrued payroll	2,139,920	(2,184,510)
Other accrued liabilities	5,270,461	18,415,466
Net cash provided by/(used in) operating activities	(11,803,775)	180,674,637
GASB 68, GASB 75 and Advance Discretionary Payment Adjustments	-	-
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES:		
Net Asset transfer from Foundation	-	-
Net cash provided by (used in) in capital and related financing activities	-	-
CASH FLOWS FROM INVESTING ACTIVITIES:		
Change in Investments	62,618,860	(97,228,153)
Change in Property and Equipment	(1,455,364)	(7,388,499)
Change in Restricted Deposit & Other	-	-
Change in Board Designated Reserve	(6,014,464)	(22,032,963)
Change in Homeless Health Reserve	-	-
Net cash provided by/(used in) investing activities	55,149,032	(126,649,616)
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS	43,345,257	54,025,021
CASH AND CASH EQUIVALENTS, beginning of period	485,883,719	475,203,955
CASH AND CASH EQUIVALENTS, end of period	**529,228,976**	**529,228,976**

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CalOptima Health
Spending Plan
For the Three Months Ending September 30, 2025

Item Description	Amount (millions)	Approved Initiative	Expense to Date	%
Total Net Position @ 9/30/2025	**$2,887.7**			**100.0%**
Resources Assigned				
Board Designated Reserve[1]	**$1,604.7**			**55.6%**
Statutory Designated Reserve[1]	**$134.1**			**4.6%**
Capital Assets, net of Depreciation	**$102.8**			**3.6%**
Resources Allocated[3]				
Homeless Health Initiative[2]	$19.1	$65.9	$46.8	0.7%
Housing and Homelessness Incentive Program[2]	24.9	87.4	62.5	0.9%
Intergovernmental Transfers (IGT)[4]	40.4	52.1	11.7	1.4%
Digital Transformation and Workplace Modernization[3]	25.9	100.0	74.1	0.9%
CalFresh Outreach Strategy	0.0	2.0	2.0	0.0%
CalFresh and Redetermination Outreach Strategy	1.7	6.0	4.3	0.1%
Coalition of Orange County Community Health Centers Grant	25.7	50.0	24.3	0.9%
Mind OC Grant (Irvine)	0.0	15.0	15.0	0.0%
General Awareness Campaign	0.3	4.7	4.4	0.0%
Member Health Needs Assessment	0.6	1.3	0.7	0.0%
Five-Year Hospital Quality Program Beginning MY 2023	117.8	153.5	35.7	4.1%
Skilled Nursing Facility Access Program	10.0	10.0	0.0	0.3%
In-Home Care Pilot Program with the UCI Family Health Center	2.0	2.0	0.0	0.1%
National Alliance for Mental Illness Orange County Peer Support Program Grant	3.0	5.0	2.0	0.1%
Stipend Program for Master of Social Work Students Grant	0.0	5.0	5.0	0.0%
Wellness & Prevention Program Grant	1.3	2.7	1.4	0.0%
CalOptima Health Provider Workforce Development Fund Grant	44.3	50.0	5.7	1.5%
Distribution Event - Naloxone Grant	2.2	15.0	12.8	0.1%
Garden Grove Bldg. Improvement	9.7	10.5	0.8	0.3%
CalOptima Health Community Reinvestment Program	38.0	38.0	0.0	1.3%
Dyadic Services Program Academy	1.0	1.9	0.9	0.0%
Outreach Strategy for newly eligible Adult Expansion members	2.1	7.6	5.5	0.1%
Quality Initiatives from unearned Pay for Value Program	18.6	23.3	4.7	0.6%
Expansion of CalOptima Health OC Outreach and Engagement Strategy	0.0	1.0	1.0	0.0%
Medi-Cal Provider Rate Increases	263.1	526.2	263.1	9.1%
Homeless Prevention and Stabilization Pilot Program	0.2	0.3	0.1	0.0%
OneCare Member Engagement and Education	0.3	0.3	0.0	0.0%
Medi-Cal Eligibility Outreach Strategy	0.8	0.8	0.0	0.0%
Subtotal:	**$653.0**	**$1,237.2**	**$584.2**	**22.6%**
Resources Available for New Initiatives				
Unallocated/Unassigned[1]	**$393.0**			**13.6%**

[1] Total Designated Reserves and unallocated reserve amount can support approximately 180 days of CalOptima Health's current operations.

[2] See HHI and HHIP summaries and Allocated Funds for list of Board Approved Initiatives. Amount reported includes only portion funded by reserves.

[3] On June 6, 2024, the Board of Directors approved an update to the Digital Transformation Strategy which will impact these figures beginning July 2024.

[4] On June 5, 2025, the Board of Directors approved the close out of Board-approved initiatives and transfer of remaining funds back to unallocated reserves.

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CalOptima Health
Key Financial Indicators
As of September 30, 2025

	Item Name	September 2025 Actual	September 2025 Budget	September 2025 Variance	September 2025 %	July - September 2025 Actual	July - September 2025 Budget	July - September 2025 Variance	July - September 2025 %
Income Statement	Member Months	885,314	898,765	(13,451)	(1.5%)	2,681,404	2,708,085	(26,681)	(1.0%)
	Operating Revenue	631,490,594	395,456,178	236,034,416	59.7%	1,420,510,565	1,192,100,988	228,409,577	19.2%
	Medical Expenses	581,778,696	363,134,399	(218,644,297)	(60.2%)	1,299,525,490	1,103,665,172	(195,860,318)	(17.7%)
	General and Administrative Expense	22,219,615	25,294,095	3,074,480	12.2%	63,850,891	75,571,593	11,720,702	15.5%
	Non-Operating Income/(Loss)	8,309,384	8,194,730	114,654	1.4%	30,004,478	24,584,190	5,420,288	22.0%
	Summary of Income & Expenses	35,801,667	15,222,414	20,579,253	135.2%	87,138,662	37,448,413	49,690,249	132.7%

Ratios	Medical Loss Ratio (MLR)	Actual	Budget	Variance	Actual	Budget	Variance
	Consolidated	92.1%	91.8%	0.3%	91.5%	92.6%	(1.1%)

Ratios	Administrative Loss Ratio (ALR)	Actual	Budget	Variance	Actual	Budget	Variance
	Consolidated	3.5%	6.4%	2.9%	4.5%	6.3%	1.8%

Key:

> 0%	
> -20%, < 0%	
< -20%	

Investment	Investment Balance (excluding CCE)	Current Month	Prior Month	Change	%
	@9/30/2025	3,147,748,842	3,199,650,807	(51,901,965)	(1.6%)

Unallocated/Unassigned Reserve Balance	Current Month @ September 2025	Fiscal Year Ending June 2024	Change	%
Consolidated	393,022,107	264,975,684	128,046,423	48.3%
*Days Cash On Hand**	180			

*Total Designated Reserves and unallocated reserve amount can support approximately 180 days of CalOptima Health's current operations.

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CalOptima Health
Digital Transformation Strategy ($100 million total reserve)
Funding Balance Tracking Summary
For the Three Months Ending September 30, 2025

	September 2025				July 2025 - September 2025				All Time to Date			
	Actual Spend	Approved Budget	Variance $	Variance %	Actual Spend	Approved Budget	Variance $	Variance %	Actual Spend	Approved Budget	Variance $	Variance %
Capital Assets (Cost, Information Only):												
Total Capital Assets	**930,325**	**281,373**	**(648,952)**	**(230.6%)**	**1,457,845**	**283,646**	**(1,174,199)**	**(414.0%)**	**17,068,796**	**27,053,763**	**9,984,967**	**36.9%**
Operating Expenses:												
Salaries, Wages & Benefits	-	-	-	0.0%	-	-	-	0.0%	17,826,058	17,826,058	-	0.0%
Professional Fees	191,010	250,000	58,990	23.6%	647,284	750,000	102,716	13.7%	7,448,095	7,550,811	102,716	1.4%
Purchased Services	74,915	-	(74,915)	0.0%	8,361	-	(8,361)	0.0%	1,341,030	1,332,669	(8,361)	(0.6%)
GASB 96 Amortization Expenses	-	-	-	0.0%	-	-	-	0.0%	2,563,169	2,563,169	-	0.0%
Other Expenses	486,762	182,292	(304,470)	(167.0%)	1,307,076	546,876	(760,200)	(139.0%)	22,402,817	21,642,617	(760,200)	(3.5%)
Medical Management	(458,513)	0	458,513	0.0%	0	0	0	0.0%	5,502,156	5,502,156	0	0.0%
Total Operating Expenses	**294,174**	**432,292**	**138,118**	**32.0%**	**1,962,721**	**1,296,876**	**(665,845)**	**(51.3%)**	**57,083,327**	**56,417,482**	**(665,845)**	**(1.2%)**

Funding Balance Tracking:	Approved Budget	Actual Spend	Variance
Beginning Funding Balance	100,000,000	100,000,000	-
Less:			
Capital Assets[1]	38,931,116	17,068,796	21,862,320
FY2023 Operating Budget[2]	8,381,011	8,381,011	-
FY2024 Operating Budget	22,788,092	22,788,092	-
FY2025 Operating Budget	24,289,000	23,951,502	337,498
FY2026 Operating Budget	5,187,500	1,962,721	3,224,779
Ending Funding Balance	**423,281**	**25,847,877**	**25,424,596**
Add: Prior year unspent Operating Bu	**337,498**		
Total Available Funding	**760,779**		

[1] Staff will continue to monitor the project status of DTS' Capital Assets.
[2] Unspent budget from this period is added back to available DTS funding.
[3] On June 6, 2024, the Board of Directors approved an update to the Digital Transformation Strategy which will impact these figures beginning July 2024.

Note: Report includes applicable transactions for GASB 96, Subscriptions - Based Information Technology Arrangements.

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CalOptima Health
Summary of Homeless Health Initiatives (HHI) and Allocated Funds
As of September 30, 2025

Summary by Funding Source:	Total Funds	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funds Available for New Initiatives
HHI - IGT'S	64,131,301	64,131,301	46,765,350	17,365,951	-
HHI - Existing Reserves	1,800,000	1,800,000	-	1,800,000	-
HHIP	40,100,000	40,100,000	-	40,100,000	-
Total	**106,031,301**	**106,031,301**	**46,765,350**	**59,265,951**	**-**

Funds Allocation, approved initiatives:	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funding Source(s)
Enhanced Medi-Cal Services at the Be Well OC Regional Mental Health and Wellness Campus	11,400,000	11,400,000	-	IGT's
Recuperative Care	6,194,190	6,194,190	-	IGT's
Medical Respite	250,000	250,000	-	IGT's
Day Habilitation (County for HomeKey)	2,500,000	-	2,500,000	IGT's
Clinical Field Team Start-up & Federally Qualified Health Center (FQHC)	1,600,000	1,600,000	-	IGT's
CalOptima Health Homeless Response Team	1,681,734	1,681,734	-	IGT's
Homeless Coordination at Hospitals	10,000,000	9,956,478	43,522	IGT's
CalOptima Health Days, Homeless Clinical Access Program (HCAP) and FQHC Administrative Support	963,261	925,540	37,721	IGT's
FQHC (Community Health Center) Expansion	21,902	21,902	-	IGT's
HCAP and CalOptima Health Days	9,888,914	4,655,022	5,233,892	IGT's
Vaccination Intervention and Member Incentive Strategy[2]	54,649	54,649	-	IGT's
Street Medicine[1]	14,376,652	7,749,821	6,626,831	IGT's & Existing Reserves
Outreach and Engagement	7,000,000	2,276,015	4,723,985	IGT's
Housing and Homelessness Incentive Program (HHIP)[3]	40,100,000	-	40,100,000	IGT's & Existing Reserves
Subtotal of Approved Initiatives	**106,031,300**	**46,765,350**	**59,265,951**	
Transfer of funds to HHIP[3]	(40,100,000)	-	(40,100,000)	
Program Total	**65,931,300**	**46,765,350**	**19,165,951**	

[1]On August 7, 2025, CalOptima Health's Board of Directors approved $9.3 million to expand the Street Medicine Program - $3.2 million remaining from Street Medicine Initiative (from the Homeless Health Initiatives Reserve), $1.8 million from Existing Reserves, and $4.3 million from Intergovernmental Transfer balance resulting from a June 5, 2025, Board of of Director action, to fund 2-year grant agreements to Healthcare in Action (Anaheim), Celebrating Life Community Health Center (Costa Mesa), and AltaMed (Santa Ana).

[2]On June 5, 2025 the Board of Directors approved the close out of the Vaccination Intervention and Member Incentive Strategy program and transfer of the remaining funds of $68,699 to unallocated reserves for new initiatives.

[3]On September 1, 2022, CalOptima Health's Board of Directors approved reallocation of $40.1 million from HHI to HHIP.

CalOptima Health
Summary of Housing and Homelessness Incentive Program (HHIP) and Allocated Funds
As of September 30, 2025

Summary by Funding Source:	Total Funds[1]	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funds Available for New Initiatives
DHCS HHIP Funds	72,931,189	54,930,994	32,970,535	21,960,459	$18,000,195
Existing Reserves & HHI Transfer	87,384,530	87,384,530	62,511,836	24,872,694	-
Total	**160,315,719**	**142,315,524**	**95,482,371**	**46,833,154**	**18,000,195**

Funds Allocation, approved initiatives:	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funding Source(s)
Office of Care Coordination	2,200,000	2,200,000	-	HHI
Pulse For Good	1,400,000	869,850	530,150	HHI
Equity Grants for Programs Serving Underrepresented Populations	4,621,311	3,696,311	925,000	HHI & DHCS
Infrastructure Projects	5,832,314	5,580,354	251,960	HHI
Capital Projects	108,247,369	74,146,735	34,100,634	HHI, DHCS & Existing Reserves
System Change Projects	10,184,530	8,323,680	1,860,850	DHCS
Non-Profit Healthcare Academy	700,000	655,391	44,609	DHCS
Total of Approved Initiatives	**$133,185,524[1]**	**$95,472,320**	**$37,713,204**	

[1]Total funding $160.3 million: $40.1 million Board-approved reallocation from HHI, $47.2 million from CalOptima Health existing reserves and $73.0 million from DHCS HHIP incentive payments.

CalOptima Health
Fiscal Year 2025-26 Budget Allocation Changes
Reporting Changes as of September 30, 2025

Transfer Month	Line of Business	From	To	Amount	Reason to Re-Allocate Funds
July	Medi-Cal	Human Resources - Training & Seminar - New: 7 Habits of Highly Effective People	Human Resources - Cert./Cont. Education - Educational Reimbursement	$90,000	For Educational Reimbursement
July	Medi-Cal	Human Resources - Professional Fees - Executive Recruiters, Direct Hire & Conversion Fees	Human Resources - Advertising - Combined: Recruitment & Job Postings Network	$90,000	For LinkedIn Advertising
July	Medi-Cal	IS - Infrastructure - Maintenance HW/SW - Oracle Software License	IS - Infrastructure - Maintenance HW/SW - Server - HP Server Maintenance	$28,150	For HP Maintenance Coverage
July	Medi-Cal	IS - Application Development - Prof Fees - Development and QA Professional Services	IS - Application Development - Purch Svcs - General - Managed Services for Website Support	$120,250	For American Eagle maintenance support
August	Medi-Cal	ITS - Infrastructure - Other Operating Expenses - Oracle Software License	ITS - Infrastructure - Other Operating Expenses - Server - VMWare	$140,238	For VMWare
August	Medi-Cal	ITS - Infrastructure - Other Operating Expenses - Palo Alto Firewall	ITS - Infrastructure - Professional Fees - IT Advisory Subscription	$162,890	For Professional Services
August	Medi-Cal	ITS - Application Development - Automation Application for the Board and Committee Material Preparation	ITS - Application Development - Policies and Regulation Compliance Identification - Readily Compliance Project	$65,000	For Readily Compliance Project
September	Medi-Cal	ITS - Infrastructure - Maintenance HW/SW Network Connectivity Maintenance and Support	ITS - Infrastructure - Maintenance HW/SW Maintenance of Operations and Desktop	$52,420	For Right Fax.
September	Medi-Cal	Customer Service - Member Communication	Human Resources - Consulting / Professional Fees	$70,000	For leadership development

This report summarizes budget transfers between general ledger classes that are greater than $10,000 and less than $250,000.
This is the result of Board Resolution No. 12-0301-01 which permits the CEO to make budget allocation changes within certain parameters.

Board of Directors Meeting
November 6, 2025

Monthly Compliance Report

The purpose of this report is to provide compliance updates to CalOptima Health's Board of Directors including, but not limited to, updates on internal and health network monitoring and audits conducted by CalOptima Health's Delegation Oversight and Internal Audit departments, regulatory audits, privacy updates, fraud, waste, and abuse (FWA) updates, and any notices of non-compliance or enforcement action issued by regulators.

A. UPDATES ON REGULATORY AUDITS

1. Medicare

a. Calendar Year (CY) 2019 Part C Risk Adjustment Data Validation (RADV) Audit (CON19 RADV) *(applicable to OneCare)*

Update

- September 12, 2025 – Centers for Medicare & Medicaid Services (CMS) extended the deadline to submit medical records to November 10, 2025.
- The Financial Analysis team is leading the effort to retrieve relevant provider medical records for submission to CMS.

Previously Reported

- June 12, 2025 - CMS notified CalOptima Health its OneCare contract (H5433) had been selected for a Payment Year (PY) 2019 Contract-Level Risk Adjustment Data Validation (CON19 RADV) audit.
- CMS will be conducting a medical record review to validate the accuracy of a subset of PY 2019 risk adjustment data and payments associated with encounters with dates of service from January 1, 2018, through December 31, 2018.
- Medical record submission window will close on September 15, 2025.

Background

- The PY 2019 RADV audit will focus on risk adjusted payments made to Medicare Advantage Organizations (MAO) for the 2019 coverage year that CMS believes may be at higher risk for overpayments.

b. Annual Compliance Program Effectiveness (CPE) Audit (*applicable to OneCare)*

Update

- October 1, 2025 – Cases selected by the auditor for presentation of the process flow for management of specific compliance issues (tracers) presentation and associated attachments were submitted to the auditor.

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- Below are key dates for the audit:
  - Audit Webinar Week 10/6/25 – 10/10/25
  - Exit Conference 10/10/25
- Draft Audit Report Available 10/27/25

Previously Reported

- Kick off meeting conducted 8/6/25.
- Audit Webinar Week 10/6/25 – 10/10/25.
- Independent consultant conducted two pre-training sessions with CalOptima Health on 8/6/25 and 8/12/25.
- August 25, 2025 – Audit Engagement received.
- August 28, 2025 – Pre-Audit deliverables submitted to the auditor.

Background

- CalOptima Health is required to conduct an independent audit on the effectiveness of its Compliance program on an annual basis, and to share the results with the governing body.
- CalOptima Health engaged an independent consultant to conduct the audit to ensure that its Compliance Program is administering the elements of an effective compliance program as outlines in the CMS Medicare Part C and D Program Audit Protocols.
- The audit will start in early August, 2025 and continue through November, 2025.
- The audit review period will be from 2/3/25 through 8/1/25.

c. Calendar Year (CY) 2024 Centers for Medicare & Medicaid (CMS) Financial Audit *(applicable to PACE)*

Update

- 9/24/25 - Contract selection received.
- 9/30/25 – Certified Public Accounting (CPA) firm selected by CMS.
- 10/1/25 – Document Request List received from CPA firm to begin the audit process.
- 10/2/25 – Audit workplan and documents request distributed to impacted departments.

Background

- At least one-third of Medicare Advantage Organizations (MAOs) are selected for the annual audit of financial records, which will include data relating to Medicare utilization, costs, and computation of the bid. CMS will audit and inspect any books and records of the MAO that pertain to 1) the ability of the organization to bear the risk of potential financial losses, or 2) services performed or determinations of amounts payable under the contract. The Pharmacy Benefit Management (PBM) company will also be required to provide CMS with all requested supporting documentation for this audit.
- CMS contracted with Myers and Stauffer to conduct the audit. Myers and Stauffer will act in the capacity of CMS agents and request records and supporting documentation for, but not limited to, the following items:
  - Claims data
  - Solvency
  - Enrollment
  - Base year entries on the bids
  - Medical and/or drug expenses
  - Related party transactions

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- General administrative expenses
- Direct and Indirect Remuneration (DIR)

2. Medi-Cal

a. 2025 Department of Health Care Services (DHCS) Routine Medical Audit

Update

- 10/1/25: **DHCS has accepted 2 of the 4 Final Corrective Action Plans (CAPs)**.
- The status of the remaining 2 open CAPs is as follows:
  - 1 CAP is Partially Accepted: DHCS requested additional information that was submitted on 10/1/25.
  - 1 CAP is under DHCS review: No additional information has been requested, and no outstanding deliverables are due.
- **At this time, no additional deliverables are due to DHCS.**

Audit Details and Background – previously reported

- 8/1/25: Final CAP updates & deliverables submitted to DHCS
- 6/26/25: CalOptima Health submitted its timely CAP response to DHCS.
  - DHCS accepted 1 of the 4 CAPs; 3 CAPs remained open until additional information and future deliverables were provided.
- The DHCS Routine Medical Audit consisted of DHCS's review of both the Primary (aka "Main Contract") and Secondary contracts (aka "State Supported Services"). The report findings are as follows:
  - **Primary/Main Contract**
    - **4 Findings** across 3 audit categories.

Category #	Audit Area	# of Findings
1	Utilization Management	1
2	Case Management and Coordination of Care	2
3	Network and Access to Care	0
4	Member's Rights	0
5	Quality Management	0
6	Administrative and Organizational Capacity	1

  - **Secondary Contract - State Supported Services (SSS)**
    - **No Findings**

- October 23, 2024 – DHCS engaged CalOptima Health in its annual, routine medical audit.
  - The audit consisted of an evaluation of CalOptima Health's compliance with its contract and regulations in six (6) categories:
    - Utilization Management (UM)
    - Case management and coordination of care
      - New area audited in this category:
        - Enhanced Care Management (ECM)
    - Availability and accessibility

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- Member's rights
- Quality management
- Administrative and organizational capacity
  - New area audited in this category:
    - Encounters

- New areas audited
  - Enhanced Care Management (ECM)
  - Encounters
- The audit was considered a limited-scope audit and required the participation of two (2) CalOptima Health Networks: Children's Hospital of Orange County Health Alliance (CHOC) and Optum for UM only
- Onsite interviews were conducted with CalOptima Health staff, including Medical Director, Director of Quality Management, Director of Utilization Management, Member Services Manager, Provider Relations Manager, Health Education Coordinator, Grievance Coordinator, and other staff as necessary.
- The audit involved a review of pre-onsite documents, staff interviews and medical record review.

➢ January 27, 2025 through January 29, 2025 – DHCS conducted the onsite visit with an Entrance Conference and conducted staff interviews throughout the rest of the onsite visit.

➢ 5/27/25: DHCS finalized its draft report and CalOptima Health received its formal CAP Request from DHCS.
- The report was consistent with the draft report with four findings.

B. REGULATORY NOTICES OF NON-COMPLIANCE

➢ CalOptima Health did not receive any notices of non-compliance from its regulators for the month of September 2025.

C. UPDATES ON HEALTH NETWORK MONITORING AND AUDITS

➢ Heritage Provider Network (HPN) – Regal Medical Group/Heritage Provider Network MSO (Management Services Organization) – Lookback period July 1, 2024, to March 31, 2025.

➢ Noble Mid-Orange County/HealthSmart MSO – Lookback period August 1, 2024, to June 30, 2025.

D. INTERNAL AUDIT DEPARTMENT (IAD)

a. Internal Annual Audits in Process

➢ 2025 Claims Administration (Medi-Cal)
➢ 2025 Claims Administration (OneCare)
➢ 2025 Utilization Management (Medi-Cal)
➢ 2025 Utilization Management (OneCare)
➢ 2025 Pharmacy ODAG Part B (OneCare)

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b. Competed Internal Annual Audit

- 2025 Case Management (OneCare) - completed on 9/16/25

c. Ad Hoc Internal Audits

- CalAIM Community Supports Housing Transition and Navigation Services
- CalAIM Community Supports Program Oversight Practices

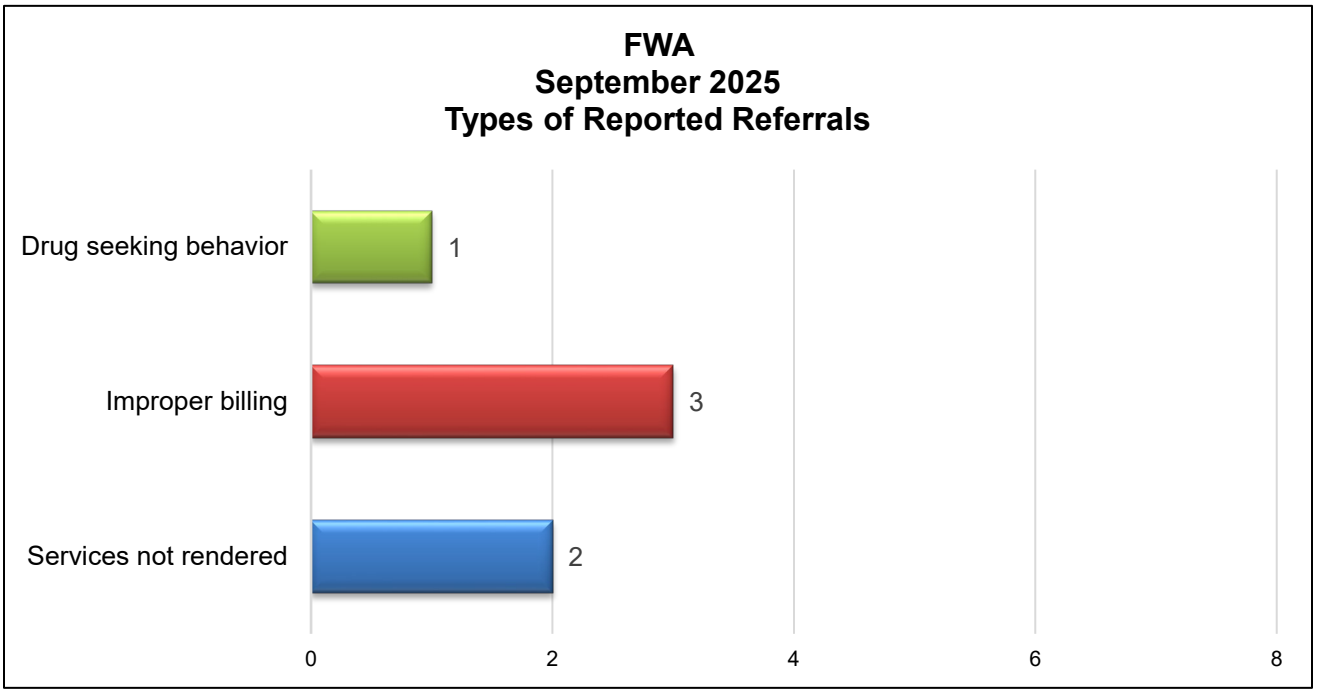
d. Board-Approved Grants and Initiatives Review

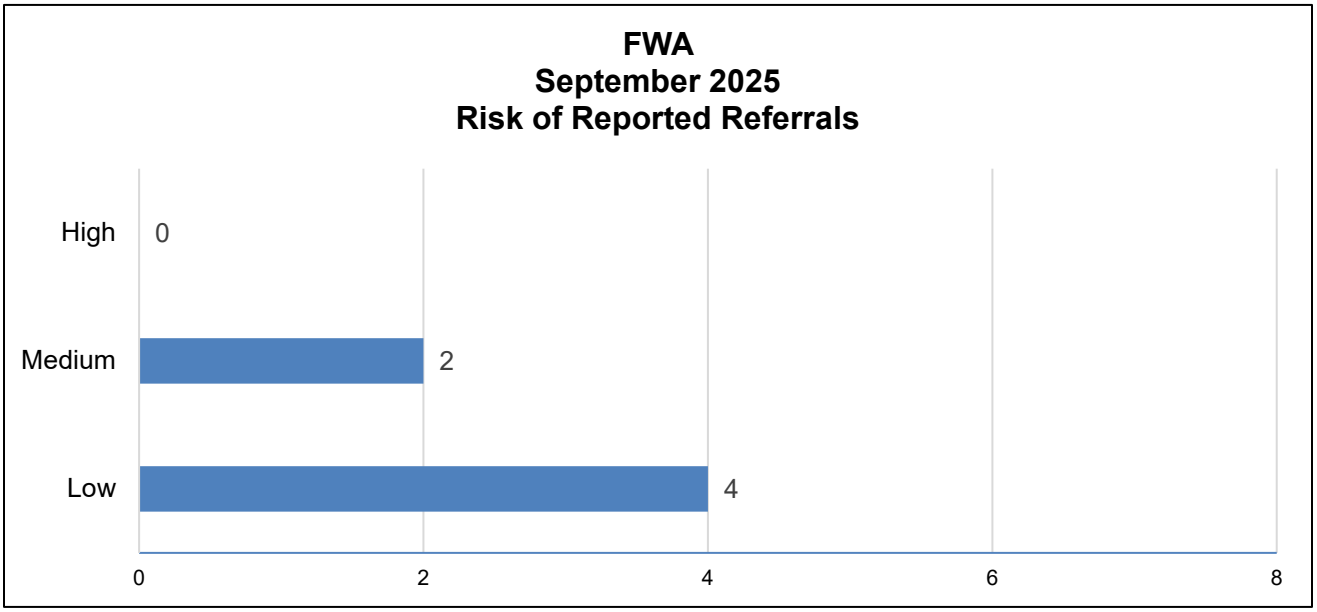
Grants currently under review include:

- Be Well/Mind OC, Irvine
  - Grant is in process
  - Review to resume upon close of grant
- Coalition of Orange County Community Health Centers, MAT (Medication Assisted Treatment) Connect
  - Grant has closed
  - Closeout review is in process

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E. FRAUD, WASTE & ABUSE (FWA) INVESTIGATIONS



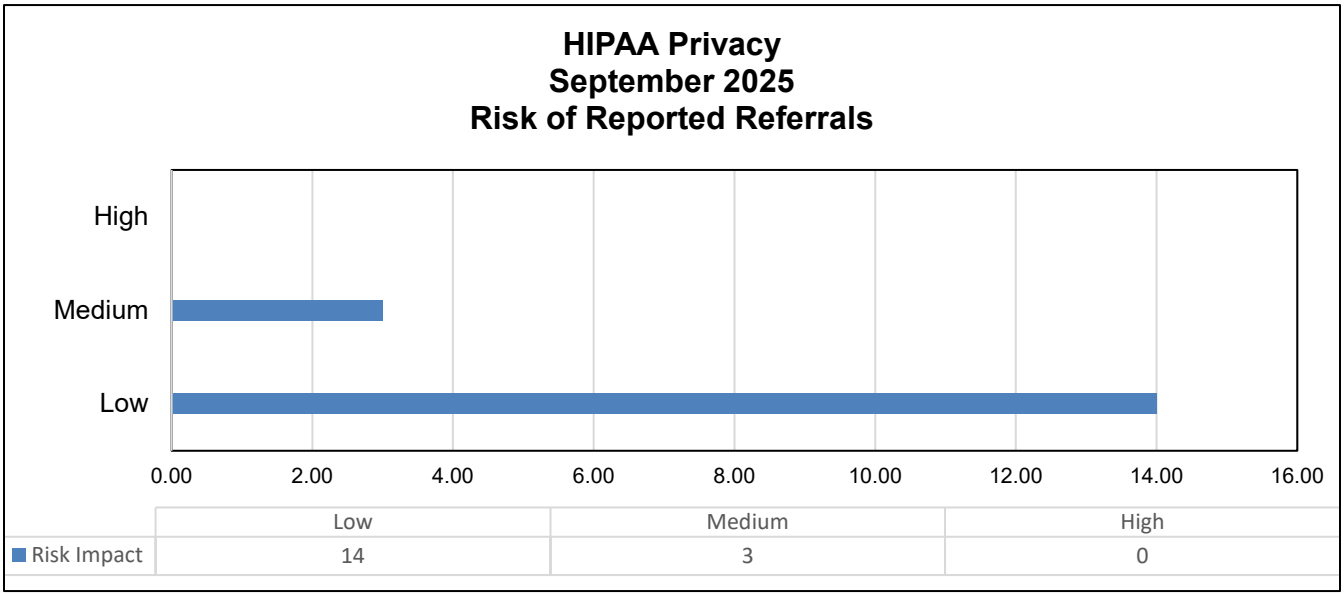


Total Number of New Cases Referred to DHCS (State)	6
Total Number of New Cases Referred to DHCS and CMS	4
Total Number of Referrals Reported	**6**

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F. PRIVACY UPDATE





Total Number of Referrals Reported to DHCS (State)	17
Total Number of Referrals / Breaches Reported to DHCS and Office for Civil Rights (OCR)	0

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CHAMBER HILL

MEMORANDUM

TO: CalOptima Health
Board of Directors

FROM: Chamber Hill Strategies

DATE: October 27, 2025

SUBJECT: Board of Directors Report – November 2025

CalOptima Health, Chamber Hill Strategies Maintain Outreach During Shutdown

CalOptima Health and Chamber Hill Strategies (CHS) continued engagement with congressional offices throughout October as the federal government shutdown continued. Despite limited activity on Capitol Hill, CHS maintained contact with key members of the Orange County congressional delegation and other offices with jurisdiction over health programs to highlight CalOptima Health's priorities and the importance of sustaining Medicaid support for Orange County residents. Delegation offices contacted included: Sen. Alex Padilla (D-CA), Sen. Adam Schiff (D-CA), Rep. Lou Correa (D-CA-46), Rep. Young Kim (R-CA-40), Rep. Derek Tran (D-CA-45), Rep. Dave Min (D-CA-47), Rep. Linda Sánchez (D-CA-38), and Rep. Mike Levin (D-CA-49).

CalOptima Health on Capitol Hill

On Thursday, October 9, CalOptima Health Chief Executive Officer Michael Hunn participated in a series of meetings on Capitol Hill, accompanied by Veronica Carpenter, Chief Administrative Officer, and Donna Laverdiere, Executive Director of Strategic Development. Meetings included Sen. Adam Schiff (D-CA), Rep. Derek Tran (D-CA-45), and staff to Sen. Alex Padilla (D-CA), Rep. Lou Correa (D-CA-46), Rep. Young Kim (R-CA-40), and Rep. David Valadao (R-CA-22). During the meetings, Mr. Hunn discussed the challenges that CalOptima Health and social service agencies will face as they implement new Medicaid work requirements and six-month eligibility redeterminations established by the One Big Beautiful Bill Act (H.R. 1, Public Law No: 119-21), which was signed into law on July 4. He underscored the need for adequate time, resources, financial support, and technology integration to help agencies manage data and maintain continuity of coverage for CalOptima Health members. Mr. Hunn also highlighted the CalOptima Health Board's approval of a $19 million investment to assist local partners and community organizations in preparing for these federal policy changes through communications, outreach, and member-education efforts.

Federal Funding Debate, Shutdown, and Outlook

The federal government shut down on October 1 after the Senate failed to advance the House-passed continuing resolution (CR) (H.R. 5371, the Continuing Appropriations and Extensions Act, 2026). The legislation, also referred to as a CR, would have funded government operations at current levels through November 21 and extended several expiring health provisions—including Medicare telehealth flexibilities, funding for community health centers, and Medicaid disproportionate share hospital (DSH) payments. By not voting to invoke cloture and end debate on the Senate floor, Senate Democrats blocked consideration of the measure over its exclusion of an extension of the advance premium tax credits (APTCs), which help lower the cost of marketplace coverage, while also advocating for measures to undo Medicaid provisions in the One Big Beautiful Bill Act. Throughout October, the House remained out of session, and Speaker Mike Johnson (R-LA-04) reiterated that the chamber would not reconvene until the Senate acts on the House-passed bill. With the November 21 date approaching, speculation has increased that whenever an agreement is reached, Congress will likely extend funding for the federal government at current levels into early 2026—if not through Fiscal Year 2026, which runs through September 30 of next year.

Extending Premium Tax Credits Slowly Gains Support

While House and Senate Democrats have insisted on including an extension of APTCs, which are set to expire at the end of 2025, in government funding legislation, House and Senate Republican leaders have repeatedly stated that they will not include APTCs in this government funding bill. Apart from this debate, some Republicans are known to be pushing for an extension of APTCs before year's end. Reps. Jen Kiggans (R-VA-02) and Tom Suozzi (D-NY-03) have introduced the Bipartisan Premium Tax Credit Extension Act (H.R. 5145), which would extend APTCs for purchasing coverage under the health insurance marketplace for 1 year through 2026. The bill initially launched with 15 bipartisan cosponsors, including Reps. Young Kim (R-CA-40) and David Valadao (R-CA-22). Since being introduced in September, the bill has steadily gained support and now has 28 cosponsors (14 Republicans, 14 Democrats), including California Reps. Josh Harder (D-CA-09), Jim Costa (D-CA-21), and Salud Carbajal (D-CA-24).

SNAP Funding to Run Out in November, Both Parties Weigh In

With the shutdown continuing, the Trump Administration has indicated that it does not have the authority to shift existing funds to sustain the Supplemental Nutrition Assistance Program (SNAP) into November. The program requires roughly $9 billion each month, but the reserve currently holds about $5 billion. Several states have begun notifying beneficiaries that benefits will not be available beginning in November if the shutdown continues. Both parties in Congress responded, with 214 House Democrats sending a letter to Agriculture Secretary Brooke Rollins urging the Administration to use the contingency reserve for SNAP and any other statutory authority available to issue benefits in November. All five Democrats representing Orange County in the House—Reps. Linda Sánchez (D-CA-38), Lou Correa (D-CA-46), Mike Levin (D-CA-49), Dave Min (D-CA-47), and Derek Tran (D-CA-45)—signed the letter. The White House has reportedly concluded that it cannot use SNAP's contingency reserve due to the lapse in appropriations. On the Republican side, Sen. Josh Hawley (R-MO) and Rep.

Mariannette Miller-Meeks (R-IA-01) have responded by introducing the "Keep SNAP Funded Act" in the Senate (S. 3024) and House (H.R. 5822), respectively, to authorize emergency funding to continue SNAP benefits during the shutdown.

Administration Announces Further Reductions in Federal Workforce

Following the federal government shutdown, the Trump Administration confirmed that it plans to move forward with a reduction-in-force (RIF) across several federal departments, including the U.S. Department of Health and Human Services (HHS). However, actions by a federal court have halted those actions for the time being. CHS will continue to monitor implementation closely for any downstream effects on Medicaid and Medicare operations, grant processing, or guidance activities.

CMS Staff Returning to Work Amid Ongoing Shutdown

The Centers for Medicare & Medicaid Services (CMS) announced it will recall all furloughed staff effective October 27 to ensure adequate support for the current Medicare and upcoming Marketplace open-enrollment periods. Staff will be temporarily paid using user fee revenues collected from researchers who access CMS data. The move could help mitigate further delays in the release of the CY 2026 Medicare payment rules, which are typically published around November 1.

CALOPTIMA HEALTH - STATE LEGISLATIVE REPORT
October 27, 2025

General Update

The deadline for Governor Newsom to act on bills from the 2025 Legislative Session was October 13. He signed 794 of the 917 bills presented to him this year, resulting in a 13.4% veto rate—below the 42-year average of 15.8%. However, the total number of bills introduced that advanced to the Governor's desk was 38%—significantly lower than the 33-year average of 45%.

A bit of good news: State revenues continue to outperform expectations. August revenues were up $1.7 billion (13%), September increased by $2.3 billion (16%), and early October are trending above the May budget projections. While these short-term gains are not sufficient to close the larger budget deficit—estimated between $17 billion and $24 billion—they will likely help moderate General Fund shortfalls over the next few years. This overall projected deficit does not account for the devastating, but still evolving, impacts anticipated under federal H.R. 1.

Budget Update

The nonpartisan Legislative Analyst's Office (LAO) recently released a report outlining major challenges ahead for the Medi-Cal budget resulting from the federal government's H.R. 1. The LAO report makes clear that H.R. 1 will affect millions of Medi-Cal enrollees, as well as hospitals, providers, and state and county governments. The full scope of these impacts will take years to fully assess. The report states, "The state does not have the fiscal capacity to backfill all of the lost federal revenue from H.R. 1."

The link for the LAO Report can be found here:
https://lao.ca.gov/Publications/Report/5083?utm_source=substack&utm_medium=email

Three Categories Affected by H.R. 1

1) Changes to Provider Tax Rules – This is expected to be, by far, the largest direct cost to the State General Fund with an anticipated loss of billions of dollars annually. California currently has four provider taxes shown below.

Figure 2 from LAO report

California's Four Provider Taxes and Fees:

Tax or Fee	Charged Providers	Approximate Annual Revenue	General Use
Managed Care Organization Tax	Health plans	Around $7.5 billion (net)[a]	Increased Medi-Cal provider rates and General Fund savings.
Hospital Quality Assurance Fee	Private hospitals	Over $5 billion[b]	Supplemental Medi-Cal payments to private hospitals and General Fund savings.
Long-Term Care Quality Assurance Fees	Long-term care facilities	Around $700 million	Portion of state cost of long-term care facility reimbursement rates.
Ground Emergency Medical Transport (GEMT) Quality Assurance Fee	Private GEMT providers	$55 million	Increased Medi-Cal payments to private ground emergency transport providers and General Fund savings.

[a]Reflects revenue that is directly available to the state for higher provider rates and General Fund savings.

[b]Does not reflect proposed increase to fee, bringing annual to around $10 billion, that is pending federal approval.

2) Changes to Eligibility and Cost Sharing Requirements for Adults – This category affects adults, particularly those without children. Childless adults are among the most expensive population because of the relatively high federal share of cost (90%). Under H.R. 1, the following will be required for this population:

- Community Engagement – Beginning at the end of 2026, these adults must comply with a new community engagement requirement. They will need to verify they have at least 80 hours per month of work, education, or community service.
- Increased frequency of Eligibility Determinations – Determinations will increase from once to twice per year.
- Cost-Sharing for Certain Services – Beginning in 2028, new copayments of up to $35 per service for those with incomes above 100% of the poverty line. Primary care and behavioral health services are exempt.

3) Changes for Immigrant Populations – Rules for the immigrant populations are changed under H.R.1 related to federal funding for comprehensive coverage and limited coverage for pregnancy and emergency-related care.

- Limits Eligibility to Lawful Permanent Residents – H.R. 1 narrows the definition of which immigrant groups are considered to have Satisfactory Immigration Status (SIS), generally limiting eligibility to lawful permanent residents. This excludes some populations who were previously eligible, such as refugees and asylum grantees, categorizing them as having Unsatisfactory Immigration Status (UIS).
- Reduces Funding for UIS Childless Adults – H.R. 1 reduces the federal matching rate for emergency services provided to childless adults with UIS. Beginning in October 2026, that match rate will be reduced from 90% to 50% for these services.

Issues for Legislative Consideration

1) How Should the State Restructure Provider Taxes?

- Legislative Action Could Preserve Large Health Plan Tax by Shifting the Tax Burden – Proposition 35 allows the Legislature to amend its provisions with a three-fourths vote in each house if the amendment furthers the intent and purpose. Thus, the Legislature potentially could amend the limit on taxing commercial enrollment, enabling the State to have a large and proportionate tax.
- Many Potential Adjustments to Private Hospital Fee – The State has a wider array of choices to make with this fee. Prop 52, which provides the parameters of the fee, does not limit fee levels on hospital services provided by commercial insurance.

2) How Should the State Implement Eligibility and Cost-Sharing Requirements?

- State Could Track Work Completion Through Income – H.R. 1 grants states certain flexibilities to track beneficiary compliance. For example, compliance via an income-based approach where enrollees are required to earn at least $580 per month (federal minimum wage x 80 hours).
- State Could Exempt More Adults from Community Engagement Requirements – An example might be to exempt members that reside in a county with high unemployment rates relative to the national average. This could exclude a few hundred thousand members.
- Enhanced Federal Funds Could Assist with State IT Needs – States might be eligible for enhanced federal funding to upgrade their Medicaid IT systems in response to H.R. 1.
- Expanding Flexibilities Could Limit Disenrollments at Relatively Low State Cost… But With Added Complexity – The State needs to explore the pros and cons of pursuing some of H.R. 1's flexibilities while ensuring their implementation would not add to other problems.
- State Could Consider Many Ways to Structure Cost-Sharing Requirements – H.R. 1 allows the States to decrease the cost-sharing amounts.

3) How Can the Legislature Weigh In On These Implementation Decisions?

- Recommend Legislature Consider Two Key Questions at Oversight Hearings
  - What are the Objectives?
  - What are the Options to Accomplish These Objections?
- Recommend Legislature Set Goals in Statute, Where Possible

Key Legislation Updates

Medi-Cal: Field Medicine (formerly Street Medicine) – AB 543 (González-D) – Would allow a Medi-Cal member experiencing homelessness (or at-risk) to seek Medi-Cal covered services directly from a field medicine provider. The bill sponsor accepted an amendment by the Local Health Plans of California (LHPC) requiring field medicine providers to contract with plans. The Governor signed this bill on October 6.

Prior Authorization – SB 306 (Becker-D) – Would prohibit health plans from imposing prior authorization on a covered service for a period of one year, if 90% or more of requests for that service were approved in the prior year. The bill was amended in Assembly Appropriations on July 17 at the last minute as a "Special Order of Business." The amendments exempted Medi-Cal managed care plans. The Governor signed the bill on October 6.

California's Essential Health Benefits (EHB) – SB 62 (Menjivar-D) – Proposed EHB coverage expansion includes fertility treatments (including in-vitro fertilization); annual hearing exams and hearing aids; and mobility devices (walkers, wheelchairs and scooters). SB 62 codifies the proposed changes for the CMS application submittal. The effective date, if approved, is January 2027. The Governor signed the bill on October 13.

Proposition Update

Election Rigging Response Act (Proposition 50) – Proposition 50, appearing on the November 4, 2025, special election ballot, is a legislatively referred constitutional amendment that would temporarily shift control of congressional redistricting away from California's independent Citizens Redistricting Commission and give it to the Legislature. If approved, the new Legislature-drawn congressional map would govern U.S. House elections in 2026, 2028, and 2030 before authority reverts to the commission after the 2030 Census.

The most recent polling indicates that support for Proposition 50 is increasing, showing a clear majority supporting the measure in the high 50th to low 60th percentiles. In addition, statewide ballot returns thus far indicate a strong early turnout with a Democratic registration skew.

2025–26 Legislative Tracking Matrix

Bill Number Author	Bill Summary	Bill Status	Position/Notes
Behavioral Health			
SB 483 Stern	**Mental Health Diversion:** Would require that a court be satisfied that a recommended mental health treatment program is consistent with the underlying purpose of mental health diversion and meets the specialized treatment needs of the defendant. ***Potential CalOptima Health Impact*:** Increased oversight of behavioral health treatment for members.	**07/16/2025** Passed Assembly Public Safety Committee; referred to Assembly Appropriations Committee **06/04/2025** Passed Senate floor	CalOptima Health: Watch
SB 626 Smallwood-Cuevas	**Maternal Mental Health Screenings and Treatment:** Would require a licensed health care practitioner who provides perinatal care for a patient to screen, diagnose and treat the patient for a maternal mental health condition. ***Potential CalOptima Health Impact:*** Increased access to behavioral health services for eligible members.	**07/15/2025** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **06/02/2025** Passed Senate floor	CalOptima Health: Watch CAHP: Oppose
SB 812 Allen	**Qualified Youth Drop-In Center Health Care Coverage:** Would require a health plan to provide coverage for mental health and substance use disorders at a qualified youth drop-in center, defined as a center providing behavioral or primary health and wellness services to youth 12 to 25 years of age with the capacity to provide services before and after school hours and that has been designated by or embedded with a local educational agency or institution of higher education. ***Potential CalOptima Health Impact*:** Increased access to behavioral health services for CalOptima Health Medi-Cal youth members.	**07/16/2025** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **05/28/2025** Passed Senate floor	CalOptima Health: Watch CAHP: Concerns
AB 37 Elhawary	**Behavioral Health Workforce:** Would require the California Workforce Development Board to study how to expand the workforce of mental health service providers providing services to homeless persons. ***Potential CalOptima Health Impact*:** Increased access to behavioral health services for members experiencing homelessness.	**03/13/2025** Referred to Assembly Labor and Employment Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 348 Krell	**Full-Service Partnership:** Establishes presumptive eligibility for Full-Service Partnership programs contingent upon meeting criteria and receiving recommendation for enrollment by a licensed behavioral health clinician. ***Potential CalOptima Health Impact*:** Increased continuity of care for members with serious mental illness.	**10/13/2025** Signed into law	CalOptima Health: Watch
AB 384 Connolly	**Inpatient Prior Admission Authorization:** Would prohibit a health plan from requiring prior authorization for admission to medically necessary 24-hour care in inpatient settings, including general acute care hospitals and psychiatric hospitals, for mental health and substance use disorders (SUDs) as well as for any medically necessary services provided to a beneficiary while admitted for that care. ***Potential CalOptima Health Impact*:** Modified utilization management (UM) procedures for covered Medi-Cal benefits.	**04/22/2025** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch CAHP: Oppose
AB 423 Davies	**Disclosures for Alcoholism, Drug Abuse Recovery or Treatment Programs and Facilities:** Would mandate a business-operated recovery residence to register its location with the California Department of Health Care Services (DHCS). ***Potential CalOptima Health Impact*:** Increased oversight for members who have received SUD treatment.	**02/18/2025** Referred to Assembly Health Committee	CalOptima Health: Watch
AB 618 Krell	**Behavioral Health Data Sharing:** Would require each Medi-Cal managed care plan (MCP), county specialty mental health plan (MHP) and Drug Medi-Cal program to electronically share data for its members to support coordination of behavioral health services. Would also require DHCS to determine minimum data elements and the frequency and format of data sharing through a stakeholder process and guidance, with final guidance to be published by January 1, 2027. ***Potential CalOptima Health Impact*:** Increased coordination between Medi-Cal delivery systems regarding behavioral health services.	**07/07/2025** Passed Senate Health Committee; referred to Senate Appropriations Committee **06/03/2025** Passed Assembly floor	**05/07/2025** CalOptima Health: SUPPORT LHPC: Sponsor

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 877 Dixon	**Nonmedical SUD Treatment:** Would require DHCS and the California Department of Managed Health Care (DMHC) to send a letter to the chief financial officer of every health plan (including a Medi-Cal MCP) that provides SUD coverage in residential facilities. The letter must inform the plan that SUD treatment in licensed or unlicensed facilities is almost exclusively nonmedical, with rare exceptions, including for billing purposes. These provisions would be repealed on January 1, 2027. ***Potential CalOptima Health Impact*:** Enhanced transparency and clarity around nonmedical treatment provided for SUDs.	**03/03/2025** Referred to Assembly Health Committee	CalOptima Health: Watch
AB 951 Ta	**Autism Diagnosis:** Prohibits a health plan from requiring an enrollee previously diagnosed with pervasive developmental disorder or autism to receive a diagnosis to maintain coverage for behavioral health treatment for their condition. ***Potential CalOptima Health Impact*:** Increased access to care for specific behavioral health treatments.	**07/30/2025** Signed into law	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
Budget			
H.R. 1 Arrington (TX)	**One Big Beautiful Bill Act:** Makes substantial changes to Medicaid program funding and policies, including but not limited to the following: • Work, community service and/or education requirement of 80 hours per month for able-bodied adults without dependents (with exceptions for pregnant women, foster youth, medically frail, caregivers and others), effective December 31, 2026, or no later than December 31, 2028 • Increased frequency of eligibility redeterminations for Medicaid Expansion (MCE) enrollees from annually to every six months, effective December 31, 2026 • Emergency Medicaid services provided to all undocumented beneficiaries subject to the traditional Federal Medical Assistance Percentage (FMAP) — 50% in California — regardless of the FMAP for which those would otherwise be eligible, effective October 1, 2026 Cost-sharing for MCE enrollees with incomes of 100–138% Federal Poverty Level (FPL), not to exceed $35 per service and 5% of total income, and not to be applied to primary, prenatal, pediatric, or emergency care, effective October 1, 2028 • Prohibition on any new or increased provider taxes, effective immediately • Significant restrictions on current Managed Care Organization (MCO) taxes, which could effectively repeal California's MCO tax that was recently made permanent by Proposition 35 (2024), with a potential winddown period of up to three fiscal years (FYs) ***Potential CalOptima Health Impact*:** Reduced funding to CalOptima Health and contracted providers; decreased number of members; increased administrative costs; implementation of co-pay systems; increased financial and administrative burdens for some existing members; decreased health care utilization by some existing members; reduced benefits for some existing members. A separate overview is also enclosed.	**07/04/2025** Signed into law	**05/20/2025** CalOptima Health: OPPOSE

Bill Number Author	Bill Summary	Bill Status	Position/Notes
SB 101 Wiener **AB 102** Gabriel	**Budget Act of 2025:** Makes appropriations for the government of the State of California for FY 2025–26. Total spending is $321 billion, of which $228.4 billion is from the General Fund. ***Potential CalOptima Health Impact:*** An overview of the FY 2025–26 Enacted State Budget is enclosed.	**06/30/2025** Signed into law	CalOptima Health: Watch
AB 100 Gabriel	**Budget Acts of 2023 and 2024:** Increases Medi-Cal's current FY 2024–25 General Fund appropriation by $2.8 billion and federal funds appropriation by $8.25 billion in order to solve a deficiency in the Medi-Cal budget. ***Potential CalOptima Health Impact:*** Continued funding for current Medi-Cal rates and initiatives through June 30, 2025.	**04/14/2025** Signed into law	CalOptima Health: Watch
AB 116 Committee on Budget	**Health Omnibus Trailer Bill:** Consolidates and enacts certain budget trailer bill language containing policy changes needed to implement health-related budget expenditures. Provisions related to the Medi-Cal program include but are not limited to the following: • Enrollment freeze for undocumented individuals 19 years or older, effective no sooner than January 1, 2026, with exceptions for pregnant individuals • Implementation of $30 monthly premiums for undocumented individuals ages 19-59, effective no sooner than July 1, 2027 • Reinstatement of the asset limit at $130,000 for individuals, adding $65,000 for each additional household member, capping at 10 members, effective January 1, 2026 • Enacts PACE provider sanctions, effective immediately ***Potential CalOptima Health Impact:*** An overview of the FY 2025–26 Enacted State Budget is enclosed.	**06/30/2025** Signed into law	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
California Advancing and Innovating Medi-Cal (CalAIM)			
SB 324 Menjivar	**Enhanced Care Management (ECM) and Community Supports Contracting:** Would require a Medi-Cal MCP to give preference to contracting with community providers that demonstrate capability of providing access and meeting quality requirements when covering the ECM benefit and/or Community Supports. In addition, would require DHCS to develop standardized templates to be used by MCPs. Would also require DHCS to develop guidance to allow community providers to subcontract with other community providers. ***Potential CalOptima Health Impact*:** Increased collaboration with community providers and standardized contracts.	**07/01/2025** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **05/27/2025** Passed Senate floor	CalOptima Health: Watch CAHP: Watch LHPC: Oppose
AB 543 Gonzalez	**Street Medicine:** Authorizes a Medi-Cal MCP to elect to offer Medi-Cal covered services through a street medicine provider. MCPs that elect to do so would be required to allow a Medi-Cal beneficiary who is experiencing homelessness to receive those services directly from a contracted street medicine provider, regardless of the beneficiary's network assignment. Additionally, requires the MCP to allow a contracted street medicine provider enrolled in Medi-Cal to directly refer the beneficiary for covered services within the appropriate network and share that information with the relevant county for inclusion in CalSAWS. ***Potential CalOptima Health Impact*:** Continued access to street medicine services for members experiencing homelessness.	**10/06/2025** Signed into law	CalOptima Health: Watch CAHP: Watch
Covered Benefits			
SB 40 Wiener	**Insulin Coverage:** Prohibits a health plan, effective January 1, 2026 (or a policy offered in the individual or small group market, effective January 1, 2027), from imposing a copayment or other cost sharing of more than $35 for a 30-day supply of an insulin prescription drug or imposing a deductible, coinsurance, or any other cost sharing on an insulin prescription drug. Additionally, requires a health plan to cover all types of insulin without step therapy on and after January 1, 2026. ***Potential CalOptima Health Impact:*** Decreased out-of-pocket costs for future members enrolled in Covered California line of business; new UM procedures.	**10/13/2025** Signed into law	CalOptima Health: Watch CAHP: Oppose

Bill Number Author	Bill Summary	Bill Status	Position/Notes
SB 62 Menjivar **AB 224** Bonta	**Essential Health Benefits (EHBs):** Expresses the intent of the Legislature to review California's EHB benchmark plan and establish a new benchmark plan for the 2027 plan year. Additionally, upon approval from the United States Department of Health and Human Services and by January 1, 2027, requires the new benchmark plan include certain additional benefits, including coverage for fertility services, hearing aids and exams, and durable medical equipment. ***Potential CalOptima Health Impact:*** New covered benefits for future members enrolled in Covered California line of business.	**10/13/2025** SB 62 signed into law **10/13/2025** AB 224 signed into law	CalOptima Health: Watch CAHP: Concerns
SB 535 Richardson **AB 575** Arambula	**Obesity Care Access Act:** Would require an individual or group health care plan that provides coverage for outpatient prescription drug benefits to cover at least one specified anti-obesity medication and bariatric surgery for the treatment of obesity. ***Potential CalOptima Health Impact:*** Expanded covered benefits for future members enrolled in Covered California line of business.	**07/15/2025** SB 535 passed Assembly Health Committee; referred to Assembly Appropriations Committee **05/28/2025** SB 535 passed Senate floor **02/24/2025** AB 575 referred to Assembly Health Committee	CalOptima Health: Watch CAHP: Oppose
AB 242 Boerner	**Genetic Disease Screening:** Would expand statewide newborn screenings to include Duchenne muscular dystrophy by January 1, 2027. ***Potential CalOptima Health Impact:*** Expanded covered benefits for members.	**04/01/2025** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch
AB 298 Bonta	**Cost-Sharing Under Age 21:** Effective January 1, 2026, would prohibit a health plan from imposing a deductible, coinsurance, copayment, or other cost-sharing requirement for in-network health care services provided to an individual under 21 years of age, with certain exceptions for high deductible health plans that are combined with a health savings account. ***Potential CalOptima Health Impact:*** Increased costs for CalOptima Health; decreased costs for future members enrolled in Covered California line of business under 21 years of age.	**02/10/2025** Referred to Assembly Health Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 350 Bonta	**Fluoride Treatments:** Would require a health plan to provide coverage for fluoride varnish in the primary care setting for children under 21 years of age by January 1, 2026. ***Potential CalOptima Health Impact:*** New covered benefit for pediatric members.	**08/29/2025** Passed Senate Appropriations Committee; referred to Senate floor **07/02/2025** Passed Senate Health Committee **06/02/2025** Passed Assembly floor	CalOptima Health: Watch CAHP: Oppose
AB 432 Bauer-Kahan	**Menopause:** Would have required a health plan that covers outpatient prescription drugs to provide coverage for evaluation and treatment options for symptoms of perimenopause and menopause. Would also have required a health plan to annually provide clinical care recommendations for hormone therapy to all contracted primary care providers who treat individuals with perimenopause and menopause. ***Potential CalOptima Health Impact:*** New covered benefits for members; increased communications to providers.	**10/13/2025** Vetoed	CalOptima Health: Watch CAHP: Oppose
AB 636 Ortega	**Diapers:** Would add diapers as a covered Medi-Cal benefit for the following individuals, contingent upon an appropriation by the Legislature: • Children greater than three years of age diagnosed with a condition that contributes to incontinence • Other individuals under 21 years of age to address a condition pursuant to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) standards ***Potential CalOptima Health Impact:*** New covered benefit for pediatric members.	**04/01/2025** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
Medi-Cal Eligibility and Enrollment			
AB 315 Bonta	**Home and Community-Based Alternatives (HCBA) Waiver:** Would remove the cap on the number of HCBA Waiver slots and instead require DHCS to enroll all eligible individuals who apply for HCBA Waiver services. By March 1, 2026, would require DHCS to seek any necessary waiver amendments to ensure there is sufficient capacity to enroll all individuals currently on a waiting list. Would also require DHCS by March 1, 2026, to submit a rate study to the Legislature addressing the sustainability, quality and transparency of rates for the HCBA Waiver. ***Potential CalOptima Health Impact*:** Expanded member access to HCBA Waiver services.	**03/25/2025** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch
AB 974 Patterson	**Managed Care Enrollment Exemption:** Would exempt any dual-eligible and non-dual-eligible beneficiaries who receive services from a regional center and who use the Medi-Cal fee-for-service delivery system as a secondary form of health care coverage from mandatory enrollment in a Medi-Cal MCP. ***Potential CalOptima Health Impact:*** Decreased number of members.	**04/22/2025** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch
AB 1012 Essayli	**Unsatisfactory Immigration Status:** Would make an individual who does not have satisfactory immigrant status ineligible for Medi-Cal benefits. In addition, would transfer funds previously appropriated for such eligibility to a newly created Serving our Seniors Fund to restore and maintain payments for Medicare Part B premiums for eligible individuals. ***Potential CalOptima Health Impact:*** Decreased number of members.	**02/21/2025** Introduced	CalOptima Health: Watch
AB 1161 Harabedian	**State of Emergency Continuous Eligibility:** Would require DHCS and the California Department of Social Services to provide continuous eligibility for its applicable programs (including Medi-Cal and CalFresh) to all beneficiaries within a geographic region who have been affected by a state of emergency or a health emergency. ***Potential CalOptima Health Impact*:** Extended Medi-Cal eligibility for certain members.	**04/29/2025** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **04/08/2025** Passed Assembly Human Services Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
Medi-Cal Operations and Administration			
SB 278 Cabaldon	**Health Data HIV Test Results:** Authorizes disclosures of HIV test results that identify or include identifying characteristics of a Medi-Cal beneficiary without written authorization of the member or their representative to the MCP for quality improvement efforts such as value-based payment and incentive programs. ***Potential CalOptima Health Impact:*** Increased quality oversight of HIV program development.	**10/13/2025** Signed into law	CalOptima Health: Watch
SB 497 Wiener	**Legally Protected Health Care Activity:** Prohibits a health care provider, health plan, or contractor from releasing medical information related to a person seeking or obtaining gender-affirming health care or mental health care in response to a criminal or civil action. Also prohibits these entities from cooperating with or providing medical information to an individual, agency, or department from another state or to a federal law enforcement agency or in response to a foreign subpoena. ***Potential CalOptima Health Impact:*** Increased protection of medical information related to gender-affirming care; increased staff training regarding disclosure processes.	**10/13/2025** Signed into law	CalOptima Health: Watch
SB 530 Richardson	**Medi-Cal Time and Distance Standards:** Extends current Medi-Cal time and distance standards until January 1, 2029. In addition, requires a Medi-Cal MCP to ensure that each subcontractor network complies with certain appointment time standards and incorporate into reporting to DHCS, unless already required to do so. Additionally, the use of telehealth providers to meet time or distance standards does not absolve the MCP of responsibility to provide a beneficiary with access, including transportation, to in-person services if the beneficiary prefers. ***Potential CalOptima Health Impact:*** Increased oversight of contracted providers; increased reporting to DHCS.	**10/06/2025** Signed into law	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
SB 660 Menjivar	**California Health and Human Services Data Exchange Framework (DxF):** Requires the Center for Data Insights and Innovation within California Health and Human Services Agency (CalHHS) to absorb all functions related to the DxF initiative, including the data sharing agreement and policies and procedures, by January 1, 2026. Additionally, expands DxF to include social services information. ***Potential CalOptima Health Impact:*** Increased care coordination with social service providers.	**10/03/2025** Signed into law	CalOptima Health: Watch
AB 45 Bauer-Kahan	**Reproductive Data Privacy:** Prohibits the collection, use, disclosure, sale, sharing, or retention of the information of a person who is physically located at, or within a precise geolocation of, a family planning center, except any collection or use necessary to perform services or provide goods that have been requested. Also authorizes an aggrieved person to institute and prosecute a civil action against any person or organization in violation of these provisions. ***Potential CalOptima Health Impact:*** Increased safeguards regarding reproductive health information.	**09/26/2025** Signed into law	CalOptima Health: Watch
AB 257 Flora	**Specialty Telehealth Network Demonstration:** Would require the establishment of a demonstration project or grant program for a telehealth and other virtual services specialty care network designed to serve patients of safety-net providers. ***Potential CalOptima Health Impact:*** Expanded member access to telehealth specialists.	**03/25/2025** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch CAHP: Oppose
AB 316 Krell	**Artificial Intelligence Defenses:** Prohibits a defendant that developed or used artificial intelligence from asserting a defense that artificial intelligence autonomously caused the alleged harm to the plaintiff. ***Potential CalOptima Health Impact:*** Increased liability related to UM procedures.	**10/13/2025** Signed into law	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 403 Ortega	**Medi-Cal Community Health Service Workers:** Would require DHCS to annually review the Community Health Worker (CHW) benefit and present an analysis to the Legislature beginning July 1, 2027. The analyses would include an assessment of Medi-Cal MCP outreach and education efforts, CHW utilization and services, demographic disaggregation of the CHWs and beneficiaries receiving services, and fee-for-service reimbursement data. ***Potential CalOptima Health Impact:*** New reporting requirements to DHCS.	**03/25/2025** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch
AB 577 Wilson	**Prescription Drug Antisteering:** Would prohibit a health plan or pharmacy benefit manager (PBM) from engaging in specified steering practices, including requiring an enrollee to use a retail pharmacy for dispensing prescription oral medications and imposing any requirements, conditions or exclusions that discriminate against a physician in connection with dispensing prescription oral medications. Additionally, would require a health care provider, physician's office, clinic or infusion center to obtain consent from an enrollee and disclose a good faith estimate of the applicable cost-sharing amount before supplying or administering an injected or infused medication. ***Potential CalOptima Health Impact:*** Increased oversight of contracted PBM and referral processes.	**04/29/2025** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch
AB 688 Gonzalez	**Telehealth for All Act of 2025:** Beginning in 2028 and every two years thereafter, requires DHCS to use Medi-Cal data and other data sources to produce analyses in a publicly available Medi-Cal telehealth utilization report. ***Potential CalOptima Health Impact:*** New reporting requirements to DHCS.	**10/07/2025** Signed into law	CalOptima Health: Watch
AB 980 Arambula	**Health Plan Duty of Care:** As it pertains to the required "duty of ordinary care" by a health plan, would define "medically necessary health care service" to mean legally prescribed medical care that is reasonable and comports with the medical community standard. ***Potential CalOptima Health Impact:*** Modified UM procedures.	**04/22/2025** Re-referred to Assembly Health Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
Older Adult Services			
SB 242 Blakespear	**Medicare Supplemental Coverage Open Enrollment Periods:** Would make Medicare supplemental benefit plans available to qualified applicants with end stage renal disease under the age of 64 years. Would also create an annual open enrollment period for Medicare supplemental benefit plans and prohibit such plans from denying an application or adjusting premium pricing due to a preexisting condition. Additionally, would authorize premium rates offered to applicants during the open enrollment period to vary based on the applicant's age at the time of issue, but would prohibit premiums from varying based on age after the contract is issued. ***Potential CalOptima Health Impact:*** Expanded Medicare coverage options for dual-eligible members.	**04/30/2025** Passed Senate Health Committee; referred to Senate Appropriations Committee	CalOptima Health: Watch CAHP: Oppose
SB 412 Limón	**Home Care Aides:** Requires a home care organization to ensure that a home care aide completes training related to the special care needs of clients with dementia prior to providing care and annually thereafter. ***Potential CalOptima Health Impact:*** New training requirements for PACE staff.	**10/06/2025** Signed into law	CalOptima Health: Watch
Providers			
SB 32 Weber Pierson	**Timely Access to Care:** Would require DHCS, DMHC and the California Department of Insurance to consult stakeholders for the development and adoption of geographic accessibility standards of perinatal units to ensure timely access for enrollees by July 1, 2027. ***Potential CalOptima Health Impact:*** Additional timely access standards; increased contracting with perinatal units.	**07/01/2025** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **06/02/2025** Passed Senate floor	CalOptima Health: Watch LHPC: Oppose
SB 250 Ochoa Bogh	**Medi-Cal Provider Directory — Skilled Nursing Facilities:** Requires an annually updated provider directory issued by a Medi-Cal MCP to include skilled nursing facilities as a searchable provider type. ***Potential CalOptima Health Impact:*** Modifications to CalOptima Health's online provider directory.	**10/03/2025** Signed into law	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
SB 306 Becker	**Prior Authorization Exemption:** No later than January 1, 2028, requires health plans — except Medi-Cal MCPs — to eliminate prior authorization for the most frequently approved health care services, except in cases of fraudulent provider activity or clinically inappropriate care. ***Potential CalOptima Health Impact:*** In future Covered California line of business, implementation of new UM procedures to assess prior authorization approval rates; decreased number of prior authorizations; decreased care coordination for members.	**10/06/2025** Signed into law	CalOptima Health: Watch CAHP: Oppose Unless Amended LHPC: Oppose Unless Amended
SB 504 Laird	**HIV Reporting:** Authorizes a health care provider for a patient with an HIV infection that has already been reported to a local health officer to communicate with a local health officer or the California Department of Public Health (CDPH) to obtain public health recommendations on care and treatment or to refer the patient to services provided by CDPH. ***Potential CalOptima Health Impact:*** Increased coordination of care for HIV-positive members.	**10/13/2025** Signed into law	CalOptima Health: Watch
AB 29 Arambula	**Adverse Childhood Experiences (ACEs) Screening Providers:** Would require DHCS to include community-based organizations, local health jurisdictions and doulas as qualified providers for ACEs trauma screenings and require clinical or other appropriate referrals as a condition of Medi-Cal payment for conducting such screenings. ***Potential CalOptima Health Impact:*** Increased access to care for pediatric members with ACEs.	**04/01/2025** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch
AB 50 Bonta	**Over-the-Counter Contraceptives:** Allows pharmacists to provide over-the-counter hormonal contraceptives without following certain procedures and protocols, such as requiring patients to complete a self-screening tool. As such, these requirements are limited to prescription-only hormonal contraceptives. ***Potential CalOptima Health Impact:*** Increased member access to hormonal contraceptives.	**09/26/2025** Signed into law	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 55 Bonta	**Alternative Birth Centers Licensing:** Removes the requirement for alternative birth centers to provide comprehensive perinatal services as a condition of CDPH licensing and Medi-Cal reimbursement. ***Potential CalOptima Health Impact:*** Decreased member access to comprehensive perinatal services; reduced operating requirements for alternative birth centers.	**10/11/2025** Signed into law	CalOptima Health: Watch LHPC: Support
AB 220 Jackson	**Medi-Cal Subacute Care Authorization:** Would require a provider seeking prior authorization for pediatric subacute or adult subacute care services under the Medi-Cal program to submit a specified form. Additionally, would prohibit a Medi-Cal MCP from developing or using its own criteria for medical necessity and from requiring a subsequent treatment authorization request upon a patient's return from a bed hold for acute hospitalization. ***Potential CalOptima Health Impact:*** Modified UM procedures and forms.	**09/04/2025** Passed Senate floor; referred to Assembly for concurrence in amendments **05/29/2025** Passed Assembly floor	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 280 Aguiar-Curry	**Provider Directory Accuracy:** Would require health plans — except Medi-Cal MCPs — to maintain accurate provider directories, starting with minimum 60% accuracy by July 1, 2026, and increasing to 95% by July 1, 2029, or otherwise receive administrative penalties. If a patient relies on inaccurate directory information, would require the provider to be reimbursed at the out-of-network rate without the patient incurring charges beyond in-network cost-sharing amounts. Would also allow DMHC to update standardized formats to collect directory information as well as establish methodologies to ensure accuracy, such as use of a central utility, by January 1, 2026. Additionally, would require a health plan to provide information about in-network providers to enrollees upon request, including whether the provider is accepting new patients at the time, and would limit the cost-sharing amounts an enrollee is required to pay for services from those providers under specified circumstances. Would also require that, within 30 days of receiving a request from a health plan, a provider must confirm that its information is current and accurate or update the required information. ***Potential CalOptima Health Impact:*** In future Covered California line of business, increased oversight of provider directory; increased coordination with contracted providers; increased penalty payments to DMHC.	**07/09/2025** Passed Senate Health Committee; referred to Senate Appropriations Committee **06/02/2025** Passed Assembly floor	CalOptima Health: Watch CAHP: Oppose LHPC: Oppose
AB 375 Nguyen	**Qualified Autism Service Paraprofessional:** Would expand the definition of "health care provider" to also include a qualified autism service paraprofessional. ***Potential CalOptima Health Impact:*** Increased access to autism services for eligible members; additional provider contracting and credentialing.	**04/08/2025** Passed Assembly Business and Professions Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch
AB 416 Krell	**Involuntary Commitment:** Authorizes a person to be taken into custody by an emergency physician under the Lanterman-Petris-Short Act and exempts the emergency physician from criminal and civil liability. ***Potential CalOptima Health Impact:*** New legal standards for certain CalOptima Health providers.	**10/13/2025** Signed into law	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 510 Addis	**Utilization Review Peer-to-Peer Review:** Would allow a provider to request review of a decision to delay, deny or modify health services by another physician or peer health care professional matching the specialty of the service within two business days. In urgent cases, responses must match the urgency of the patient's condition. If these deadlines are not met, the authorization request would be automatically approved. ***Potential CalOptima Health Impact***: Expedited and modified UM, grievance and appeals procedures for covered Medi-Cal benefits; increased hiring of specialists to review grievances and appeals.	**04/22/2025** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch CAHP: Oppose Unless Amended LHPC: Oppose Unless Amended
AB 512 Harabedian	**Prior Authorization Timelines:** Would have shortened the timeline for prior or concurrent authorization requests to no more than 24 hours via electronic submission or 48 hours via non-electronic submission for *urgent* requests and three business days via electronic submission or five business days via non-electronic submission for *standard* requests, starting from plan receipt of the information reasonably necessary and requested by the plan to make the determination. ***Potential CalOptima Health Impact***: Expedited and modified UM procedures for covered Medi-Cal benefits.	**10/06/2025** Vetoed	CalOptima Health: Watch CAHP: Oppose Unless Amended LHPC: Oppose Unless Amended
AB 517 Krell	**Wheelchair Prior Authorization:** Would prohibit a Medi-Cal MCP from requiring prior authorization for the repair of a Complex Rehabilitation Technology (CRT)-powered wheelchair, if the cost of repair does not exceed $1,250. Would also no longer require a prescription or documentation of medical necessity, if the wheelchair has already been approved for use by the patient. Additionally, would require supplier documentation of the repair. ***Potential CalOptima Health Impact:*** Modified UM procedures for a covered Medi-Cal benefit.	**04/08/2025** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 539 Schiavo	**One-Year Prior Authorization Approval:** Would require a prior authorization for a health care service to remain valid for a period of at least one year, or throughout the course of prescribed treatment if less than one year, from the date of approval. ***Potential CalOptima Health Impact:*** Modified UM procedures for covered Medi-Cal benefits; decreased number of prior authorizations; increased costs.	**05/12/2025** Passed Assembly floor; referred to Senate	CalOptima Health: Watch CAHP: Oppose Unless Amended LHPC: Oppose Unless Amended
AB 787 Papan	**Provider Directory Disclosures:** Would require a health plan to include in its provider directory a statement advising an enrollee to contact the plan for assistance in finding an in-network provider. Would also require the plan to respond within one business day if contacted for such assistance and to provide a list of in-network providers confirmed to be accepting new patients within two business days for urgent requests and five business days for nonurgent requests. Medi-Cal MCPs would not be required to distribute a printed provider directory. ***Potential CalOptima Health Impact:*** Expanded customer service support and staff training; technical changes to CalOptima Health's provider directory.	**06/18/2025** Passed Senate Health Committee; referred to Senate Appropriations Committee **05/05/2025** Passed Assembly floor	CalOptima Health: Watch
AB 1041 Bennett	**Provider Credentialing:** Requires a health plan — except a Medi-Cal MCP — to credential a provider within 90 days from the receipt of a completed application, or otherwise conditionally approve the credential. A plan is required to notify the provider whether the application is complete within 10 days of receipt. Additionally, requires a health plan to subscribe to and use the Council for Affordable Quality Healthcare credentialing form on and after January 1, 2028. ***Potential CalOptima Health Impact:*** Expedited and modified credentialing procedures for interested providers in future Covered California line of business.	**10/11/2025** Signed into law	CalOptima Health: Watch CAHP: Oppose LHPC: Oppose Unless Amended

Bill Number Author	Bill Summary	Bill Status	Position/Notes
Rates & Financing			
SB 339 Cabaldon	**Medi-Cal Laboratory Rates:** Would require Medi-Cal reimbursement rates for clinical laboratory or laboratory services to *equal* the lowest of the following metrics: 1. the amount billed; 2. the charge to the general public; 3. 100% of the lowest maximum allowance established by Medicare; or 4. a reimbursement rate based on an average of the lowest amount that other payers and state Medicaid programs are paying. For any such services related to the diagnosis and treatment of sexually transmitted infections on or after July 1, 2027, the Medi-Cal reimbursement rates shall not consider the rates described in clause (4) listed above. ***Potential CalOptima Health Impact*:** Increased payments to contracted clinical laboratories.	**04/29/2025** Passed Senate Judiciary Committee; referred to Senate Appropriations Committee **04/23/2025** Passed Senate Health Committee	CalOptima Health: Watch

Information in this document is subject to change as bills proceed through the legislative process.

CAHP: California Association of Health Plans
LHPC: Local Health Plans of California

Last Updated: October 21, 2025

2025 Federal Legislative Dates

January 3	119th Congress, 1st Session convenes
July 25–September 1	Summer recess for House
August 2–September 1	Summer recess for Senate
December 19	1st session adjourns

Source: Floor Calendars, United States Congress: https://www.congress.gov/calendars-and-schedules

2025 State Legislative Dates

January 6	Legislature reconvenes
January 10	Proposed budget must be submitted by Governor
February 21	Last day for legislation to be introduced
April 10–20	Spring recess
May 2	Last day for policy committees to hear and report to fiscal committees any fiscal bills introduced in that house
May 9	Last day for policy committees to hear and report to the Floor any non-fiscal bills introduced in that house
May 23	Last day for fiscal committees to hear and report to the Floor any bills introduced in that house
June 2–6	Floor session only
June 6	Last day for each house to pass bills introduced in that house
June 15	Budget bill must be passed by midnight
July 18	Last day for policy committees to hear and report bills in their second house to fiscal committees or the Floor
July 18–August 17	Summer recess
August 29	Last day for fiscal committees to report bills in their second house to the Floor
September 2–12	Floor session only
September 5	Last day to amend bills on the Floor
September 12	Last day for each house to pass bills; interim recess begins upon adjournment
October 12	Last day for Governor to sign or veto bills passed by the Legislature

Source: 2025 Legislative Deadlines, California State Assembly: http://assembly.ca.gov/legislativedeadlines

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About CalOptima Health

CalOptima Health is a county organized health system that administers health insurance programs for low-income children, adults, seniors and people with disabilities. As Orange County's community health plan, our mission is to serve member health with excellence and dignity, respecting the value and needs of each person. We provide coverage through three major programs: Medi-Cal, OneCare (HMO D-SNP) and the Program of All-Inclusive Care for the Elderly (PACE).

H.R. 1: One Big Beautiful Bill Act

Fiscal Year 2025 Federal Budget Reconciliation

As signed into law on July 4, 2025

Please note that H.R. 1 includes several distinct implementation dates over the coming years, but there are no major immediate impacts to Medicaid beneficiaries until 2026.

In addition, most Medicaid provisions of H.R. 1 still require federal rulemaking by the U.S. Centers for Medicare and Medicaid Services (CMS) and subsequent state implementation by the California State Legislature and/or the California Department of Health Care Services (DHCS).

MEDICAID HIGHLIGHTS
Eligibility
Work, community service and/or education requirement of **80 hours per month** for able-bodied adults ages 19–64 (with exceptions for short-term hardship, parents with dependents under age 14, pregnant women, medically frail, caregivers and others), effective **December 31, 2026** (or no later than **December 31, 2028**, at the discretion of the U.S. Secretary of Health and Human Services [HHS])
Increased frequency of eligibility redeterminations for Medicaid Expansion (MCE) enrollees from annually to **every six months**, effective **December 31, 2026**
Financing
Prohibition on any new or increased provider taxes, effective **immediately**
Existing provider taxes (except those related to nursing or intermediate care facilities) would be gradually reduced from the current maximum **6.0%** hold harmless threshold to a new **3.5%** hold harmless threshold by **0.5% annually** from **October 1, 2027, through October 1, 2031**
Significant restrictions on current Managed Care Organization (MCO) taxes, which could effectively **repeal** California's MCO tax that was recently made permanent by Proposition 35 (2024), with a potential winddown period of up to **three fiscal years** at the discretion of the HHS Secretary
Cap on new state-directed payments (SDPs) at **100%** of the Medicare payment rate, effective **immediately**; gradually reduces existing SDPs to that cap by **10% annually**, starting **January 1, 2028**
Emergency Medicaid services provided to all undocumented beneficiaries would be subject to the traditional Federal Medical Assistance Percentage (FMAP) — **50%** in California — regardless of the FMAP for which those would otherwise be eligible, effective **October 1, 2026**
Access
Cost-sharing for MCE enrollees with incomes of **100–138%** Federal Poverty Level (FPL), not to exceed **$35** per service and **5.0%** of total income, and not to be applied to primary, prenatal, pediatric, behavioral or emergency care, effective **October 1, 2028**
Temporary **one-year** prohibition on all Medicaid funding to Planned Parenthood, effective **immediately**

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Fiscal Year 2025–26 Enacted State Budget

On May 14, Governor Gavin Newsom released a Fiscal Year (FY) 2025–26 Revised State Budget Proposal, known as the May Revision. On June 13, the State Senate and State Assembly both passed a counterproposal — Senate Bill (SB) 101 — as a placeholder budget to meet the June 15 constitutional deadline while negotiations with the governor on a final budget remained ongoing.

On June 24, Gov. Newsom and legislative leaders announced a final budget agreement. After both houses of the Legislature passed the agreed-upon revisions as Assembly Bill (AB) 102 on June 27, Gov. Newsom signed both SB 101 and AB 102 into law. Additionally, the Legislature passed and the governor signed the consolidated Health Trailer Bill (AB 116) containing policy changes needed to implement health-related budget expenditures. Together, these bills represent the FY 2025-26 Enacted State Budget.

MEDI-CAL HIGHLIGHTS
Unsatisfactory Immigration Status (UIS)-Member Impacts
Freeze on *new* enrollment of UIS individuals ages 19+ (except those who are pregnant or one-year postpartum), effective **January 1, 2026**, including a three-month grace/cure period for re-enrollment following payment of outstanding premium balances; *currently enrolled* individuals are not affected
Implementation of $30/month premiums for UIS individuals ages 19–59, effectively **July 1, 2027**
Elimination of dental coverage for UIS individuals ages 19+, effective **July 1, 2026**
Elimination of Prospective Payment System rates to Federally Qualified Health Centers for state-only-funded services provided to UIS individuals, effective **July 1, 2026**
All-Member Impacts
Reinstatement of asset limit at $130,000 for individuals (plus $65,000 for each additional household member) in non-Modified Adjusted Gross Income eligibility categories, effective **January 1, 2026**
Elimination of pharmacy coverage for GLP-1 agonists for weight loss; coverage for diabetes and on a case-by-case basis will continue, effective **January 1, 2026**
Elimination of pharmacy coverage of some over-the-counter drugs, including COVID-19 antigen tests, vitamins and certain antihistamines, such as dry eye products, effective **January 1, 2026**
Implementation of prior authorization for hospice services, effective **July 1, 2026**
Limitation on capitation payments to Program of All-Inclusive Care for the Elderly (PACE) organizations at the midpoint of the actuarial rate ranges, effective **January 1, 2027**
Elimination of the Workforce and Quality Incentive Program (WQIP) for skilled nursing facilities, effective **December 31, 2025**, with all close-out activities to be completed by January 1, 2027

State agencies, including the California Department of Health Care Services, will begin implementing the policies included in the enacted budget. Staff will continue to monitor these policies and provide updates regarding issues that have a significant CalOptima Health impact. In addition, the Legislature will continue to advance policy bills through the legislative process. Bills with funding allocated in the enacted budget are more likely to be passed and signed into law. The Legislature has until September 12 to pass legislation, and Gov. Newsom has until October 12 to either sign or veto that passed legislation.

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CalOptima Health Community Outreach Summary — October and November 2025

Background

CalOptima Health is committed to serving the community by sharing information with current and potential members, as well as strengthening relationships with community partners. To this end, our team attends community coalitions, collaborative meetings and advisory groups and supports our community partners' public activities. Participation includes providing Medi-Cal educational materials and, if criteria are met, financial support and/or CalOptima Health-branded items.

CalOptima Health's participation in public activities promotes:

- Member interaction/enrollment in a CalOptima Health program
- Community awareness of CalOptima Health
- Partnerships that increase positive visibility and relationships with community organizations

Community Outreach Highlight

CalOptima Health is excited to host its second annual Thanksgiving Food Distribution and Open House Event for members on Saturday, November 22, from 9 a.m. to 1 p.m. at the CalOptima Health building in Orange.

To help ensure families can enjoy a Thanksgiving meal, members will receive a choice of a turkey, ham, or Northgate gift voucher (for vegetarian options), along with traditional side items. One holiday meal per family, while supplies last.

In addition to the food distribution, members will have the opportunity to connect with various CalOptima Health departments to learn more about our Medi-Cal programs and supportive services. Participating departments include Customer Service, Behavioral Health Integration, Culture and Linguistics, PACE, OneCare, Long-Term Services and Supports, Case Management, and CalAIM.

We are also proud to partner with community organizations to support the broader needs of our members. The County of Orange Social Services Agency will be on-site to assist with Medi-Cal and CalFresh enrollment, 211OC will be available to connect members with community resources, and Mercy Health will provide on-site vaccinations.

This annual event reflects CalOptima Health's continued commitment to supporting the health and well-being of our members and their families. We look forward to celebrating the Thanksgiving holiday together again this year.

Summary of Public Activities

As of October 10, CalOptima Health plans to participate in, organize or convene 101 public activities in October and November. There were 65 public activities in October, including 14 community/collaborative meetings, 42 community events, seven community-based presentations, one Community Connections Meeting and one Health Network Forum. In November, there will be 36 public activities, including 15 community/collaborative meetings, 20 community events, and one Health Network Forum. A summary of the agency's participation in community events throughout Orange County is attached.

Endorsements

CalOptima Health provided five endorsements since the last reporting period (i.e., letters of support, program/public activity events with support or use of name/logo). Endorsement requests must meet the requirements of CalOptima Health's Policy AA.1214: Guidelines for Endorsements by CalOptima Health, for Letters of Support and Use of CalOptima Health's Name and Logo. For more information on policy requirements, please visit: https://www.caloptima.org/en/About/CommunityRelations/CommunityOutreach.aspx.

1. Letter of support for PATH's proposal in response to the County of Orange's Services Coordination, Permanent Housing Delivery, and Prevention and Shelter Diversion Services RFP.
2. Letter of support for Illumination Health + Home's Richard Lehn Intergenerational Campus located in Santa Ana.
3. Use of CalOptima Health's name and logo for South OC's For All flyer and collaboratives website.
4. Letter of support of Orange County United Way's application to the County of Orange to help fund WelcomeHomeOC.
5. Letter in support of WISEplace's application to the County of Orange to help fund their Homeless Prevention & Shelter Diversion Services (Rapid Re-Housing Program).

For additional information or questions, contact CalOptima Health Community Relations Director Tiffany Kaaiakamanu at 714-222-0637 or tkaaiakamanu@caloptima.org.

Attachment to the November 6, 2025, CalOptima Health Outreach Summary

Community events hosted by CalOptima Health and community partners in October and November 2025:

October 2025

October 1, 11 a.m.–2 p.m., Vanguard Wellness Fair, hosted by Partners4Wellness

Vanguard University, 15872 S. Harbor Blvd., Costa Mesa

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

October 1, Noon–4 p.m., Health and Benefits Fair, hosted by Northgate Gonzalez Market

Northgate Gonzalez Market, 2300 Harbor Blvd., Costa Mesa

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

October 1, 4–6 p.m., Back-to-School Night, hosted by ACCESS

Harbor Learning Center, 15872 Harbor Blvd., Fountain Valley

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

October 2, 8 a.m.–1:30 p.m., Anti-Poverty Summit, hosted by Community Action Partnership of Orange County

UCI Beall Applied Innovation, 5270 California Ave. #100, Irvine

- Sponsorship fee: $2,500; included six tickets to the summit and a promotional item in the goodie bag. Additionally, recognition in the event app, signage, e-communications, and social media.
- At least two staff members attended (in person)
- Health/Resource Fair, open to the public

October 2, 4–6 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services

Anaheim Neighborhood

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

October 2, 5:30–6 p.m., CalOptima Health Medi-Cal Overview in English

Legacy Prep, 1450 17th St., Santa Ana

- At least one staff member presented (in-person)
- Community-based organization presentation, open to members/community

CalOptima Health-hosted | CalFresh Outreach (e.g., colleges, food banks) | Community Presentation | Exhibitor/Attendee

October 2, 6–7 p.m., CalOptima Health Medi-Cal Overview in Spanish
Legacy Prep, 1450 17th St., Santa Ana

- At least one staff member presented (in-person)
- Community-based organization presentation, open to members/community

October 3, 9 a.m.–1 p.m., International Older Adults Celebration, hosted by the City Santa Ana
Jerome Park, 2115 W. McFadden Ave., Santa Ana

- At least two staff members attended (in person)
- Health/Resource Fair, open to the public

October 3, 9 a.m.–4 p.m., Chuseok (Korean Thanksgiving), hosted by the Korean American Seniors Association of Orange County
Garden Grove Community Center, 11300 Stanford Ave., Garden Grove

- Sponsorship fee: $1,000; included a resource booth and premier logo placement.
- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

October 4, 8 a.m.–1 p.m., Father Fest, hosted by Orange County Department of Education
Fullerton Arboretum, 1900 Associate Rd., Fullerton

- Sponsorship fee: $1,000; included a resource booth, half-page advertisement, organization name on website and written recognition in newsroom.
- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

October 4, 9 a.m.–Noon, Senior Wellness Expo, hosted by the City of Yorba Linda
Yorba Linda Community Center, 4501 Casa Loma Ave., Yorba Linda

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

October 4, 9:45 a.m.–Noon, 2025 Walk to End Alzheimer's, hosted by Alzheimer's Association of Orange County
Orange Coast College, 2701 Fairview Rd., Costa Mesa

- Sponsorship fee: $2,500; included a resource booth.
- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

October 4, 9 a.m.–1 p.m., Health Fair Trunk or Treat, hosted by Friends of Family Health Center
Friends of Family Health Center, 501 S. Idaho St., La Habra

- Sponsorship fee: $2,000; included a resource booth, logo on flyer, and shoutouts from the DJ throughout the event.
- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

CalOptima Health-hosted | CalFresh Outreach (e.g., colleges, food banks) | Community Presentation | Exhibitor/Attendee

October 4, 9 a.m.–1 p.m., Healthy Living Expo, hosted by the City of Irvine
Irvine Civic Center, 1 Civic Center Plaza, Irvine

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

October 4, 10 a.m.–1 p.m., Older Adult Health Fair, hosted by the City of Anaheim
Brookhurst Community Center, 2271 W. Crescent Ave., Anaheim

- Registration fee: $50; included a resource booth.
- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

October 5, 9 a.m.–3 p.m., Bi-annual Community Health Fair, hosted by the Asian American Women Association of Orange County
St. Cecilia Catholic Church, 1301 Sycamore Ave., Tustin

- Sponsorship fee: $2,000; included a resource booth, logo on flyer, and shoutouts from the DJ throughout the event.
- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

October 7, 10–11 a.m., CalOptima Health Medi-Cal Overview in English
Tower on 19th, 678 W. 19th St., Costa Mesa

- At least one staff member presented (in-person)
- Community-based organization presentation, open to members/community

October 7, 4–6 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services
Anaheim Neighborhood

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

October 8, 8:30–11 a.m., CalOptima Health Medi-Cal Overview in English and Spanish
Portola Middle School, 270 N. Palm Dr., Orange

- At least one staff member presented (in-person)
- Community-based organization presentation, open to members/community

October 8, 11 a.m.–1 p.m., Health and Wellness Fair, hosted by Golden West College
Golden West College, 15744 Goldenwest St., Huntington Beach

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

October 9, 4–6 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services
Anaheim Neighborhood

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

CalOptima Health-hosted CalFresh Outreach (e.g., colleges, food banks) Community Presentation
Exhibitor/Attendee

October 9, 8 a.m.–4:45 p.m., Brave Leaders Bold Moves Summit, hosted by Orange County Grantmakers

Anaheim Marriott Suites Garden Grove, 12015 Harbor Blvd., Garden Grove

- Sponsorship fee: $2,500; included two tickets to the summit, organization name recognition on page and logo visibility on emails and event signage.
- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

October 10, 9 a.m.–1 p.m., Senior Summit, hosted by the County of Orange Supervisor Katrina Foley in partnership with CalOptima Health

Aliso Viejo Ranch, 100 Park Ave., Aliso Viejo

- At least five staff members attended (in person)
- Health/Resource Fair, open to the public

October 11, 8–11:30 a.m., 15th Annual Walk for Independence, hosted by Project Independence

TeWinkle Park, 970 Arlington Dr., Costa Mesa

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

October 11, 10 a.m.–1:30 p.m., Older Adult Health Fair, hosted by the City of Anaheim

Downtown Anaheim Community Center, 250 E. Center St., Anaheim

- Registration fee: $150; included resource booth.
- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

October 11, 10 a.m.–2 p.m., October DV Awareness Month Resource Fair, hosted by the Orange County Family Justice Center

Orange County Family Justice Center, 150 W. Vermont Ave., Anaheim

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

October 11, 4–6 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services

Anaheim Neighborhood

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

October 14, 4–6 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services

Anaheim Neighborhood

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

October 16, 4–5:30 p.m., CalOptima Health Medi-Cal Overview in Spanish

Project Access at Cypress Villa, 900 N. Cypress, La Habra

- At least one staff member presented (in-person)
- Community-based organization presentation, open to members/community

October 16, 4–6 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services

Anaheim Neighborhood

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

October 18, 8 a.m.–Noon., Community Outreach Baby Shower, hosted Orange County Global Medical Center

Orange County Global Medical Center, 10001 N. Tustin Ave., Santa Ana

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

October 18, 9:30 a.m.–Noon., Annual Hope Health Fair, hosted by Hope Community Services

Vietnamese Catholic Church, 1538 Century Blvd., Santa Ana

- Sponsorship fee: $2,500; included a resource booth and a speaking opportunity.
- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

October 18, 10 a.m.–3 p.m., Octsoberfest, hosted by Action Alliance Foundation

Kiwanisland, 9840 Larson Ave., Garden Grove

- Sponsorship fee: $3,000; included a resource booth, banner, social media and newsletter acknowledgement.
- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

October 18, 9 a.m.–1 p.m., 30th Anniversary Health and Wellness Fair, hosted by CalOptima Health

CalOptima Health, 505 City Parkway W., Orange

- At least 20 staff members attended (in person)
- Health/Resource Fair, open to the public

October 19, 9 a.m.–2 p.m., Community Resource Fair, hosted by Vital Access Care Foundation and 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

October 21, 4–6 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services

Anaheim Neighborhood

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

October 22, 8 a.m.–5 p.m., 2025 OC Public Safety and Re-entry Conference, hosted by Project Kinship

Great Wolf Lodge, 12681 Harbor Blvd., Garden Grove

- Sponsorship fee: $2,000; included a resource table, logo recognition on materials, four conference registration tickets and VIP seating for keynote speaker.
- At least two staff members attended (in person)
- Health/Resource Fair, open to the public

October 22, 4–6 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services

Anaheim Neighborhood

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

October 23, 10–11 a.m., CalOptima Health Medi-Cal Overview in English

Triangle Terrace, 555 S. Shaffer St., Orange

- At least one staff member presented (in person)
- Community-based organization presentation, open to members/community

October 23, 4–6 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services

Anaheim Neighborhood

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

October 23, 4:30–6 p.m., 2025 Trunk or Treat, hosted by the County of Orange Social Service Agency and Orangewood Foundation

Orangewood Foundation, 1575 E. 17th St., Santa Ana

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

October 23, 5–6 p.m., Parenting in the Digital World 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

CalOptima Health-hosted CalFresh Outreach (e.g., colleges, food banks) Community Presentation
Exhibitor/Attendee

October 24, 8 a.m.–3 p.m., 36th Annual Southern California Alzheimer's Disease Research Conference, hosted by UCI Mind

Irvine Mariott, 18000 Von Karman Ave., Irvine

- Sponsorship fee: $3,000; included a resource table, eight general admission tickets, logo on event website, signage podium and event emails.
- At least two staff members attended (in person)
- Health/Resource Fair, open to the public

October 24–25, 8 a.m.–2:30 p.m., Honoring Tradition, Embracing Change Conference, hosted by International Vietnamese Mental Health Association

CalOptima Health, 505 City Parkway W., Orange

- At least two staff members attended (in person)
- Health/Resource Fair, open to the public

October 25, 9 a.m.–1 p.m., Community Resource Fair and Workshop, hosted by the County of Orange Supervisor Doug Chaffee

Dale Jr. High School, 900 S. Dale Ave., Anaheim

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

October 28, 1-2:30 p.m., CalOptima Health Community Connections Meeting, hosted by CalOptima Health

CalOptima Health, 505 City Parkway W., Orange

- At least four staff members attended (in person)
- Steering committee meeting, open to collaborative members

October 28, 4–6 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services

Anaheim Neighborhood

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

October 29, 10–11:30 a.m., CalOptima Health Medi-Cal Overview in English

Laura House, Virtual

- At least one staff member presented
- Community-based organization presentation, open to members/community

October 29, 4–6 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services

Anaheim Neighborhood

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

CalOptima Health-hosted CalFresh Outreach (e.g., colleges, food banks) Community Presentation Exhibitor/Attendee

October 30, 4–6 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services

Anaheim Neighborhood

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

November 2025

November 1, 9 a.m.–Noon, Senior Resource Fair, hosted by Assemblyman Avelino Valencia and Assemblywoman Sharon Quirk-Silva

Brookhurst Community Center, 2271 W. Crescent Ave., Anaheim

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

November 4, 4–6 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services

Anaheim Neighborhood

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

November 5, 12:30–1:30 p.m., School Resource Fair, hosted by Sunny Hills High School

Sunny Hills High School, 1801 Lancer Way, Fullerton

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

November 5, 4–6 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services

Anaheim Neighborhood

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

November 6, 4–6 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services

Anaheim Neighborhood

- At least one staff member will attend (in person)
- Health/Resource Fair, open to the public

November 7, 9 a.m.–Noon, Senior Health and Wellness Fair, hosted by the City of La Habra

Our Lady of Guadalupe Catholic Church, 900 W. La Habra Blvd., La Habra

- Registration fee: $50; includes a resource table.
- At least one staff member will attend (in person)
- Health/Resource Fair, open to the public

CalOptima Health-hosted CalFresh Outreach (e.g., colleges, food banks) Community Presentation Exhibitor/Attendee

November 7, 10 a.m.–Noon, VITAS Healthcare, hosted by VITAS Healthcare

VITAS Healthcare, 310 Commerce Ste. 200, Irvine

- At least one staff member will attend (in person)
- Health/Resource Fair, open to the public

November 12, 4–6 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services

Anaheim Neighborhood

- At least one staff member will attend (in person)
- Health/Resource Fair, open to the public

November 13, 4–6 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services

Anaheim Neighborhood

- At least one staff member will attend (in person)
- Health/Resource Fair, open to the public

November 14, 8 a.m.–2 p.m., Women's Health Summit, hosted by UC Irvine

Bren Event Center, 100 Mesa Rd., Irvine

- Sponsorship fee: $1,000; includes two tickets, name and logo recognition in program, resource table, social media exposure and recognition from the stage.
- At least two staff members will attend (in person)
- Health/Resource Fair, open to the public

November 15, 9 a.m.–Noon, Family Health Fair, hosted by Melinda Hoag Smith Center for Healthy Living

Melinda Hoag Smith Center for Healthy Living, 307 Placentia Ave., Newport Beach

- At least one staff member will attend (in person)
- Health/Resource Fair, open to the public

November 15, 9 a.m.–Noon, NAMI Walks Orange County, hosted by NAMI Orange County

Angels Stadium, 2000 E. Gene Autry Way, Anaheim

- At least one staff member will attend (in person)
- Health/Resource Fair, open to the public

November 15, 8 a.m.–Noon, Community Expo and Forum, hosted by March of Dimes

Newport Civic Center, 100 Civic Center Dr., Newport Beach

- Sponsorship fee: $1,500; includes a resource table, logo and link on event website, digital program and select signage.
- At least one staff member will attend (in person)
- Health/Resource Fair, open to the public

November 18, 4–6 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services

Anaheim Neighborhood

- At least one staff member will attend (in person)
- Health/Resource Fair, open to the public

November 19, 11 a.m.–2 p.m., Homeless and Hunger Awareness Week, hosted by Golden West College

Golden West College, 15744 Goldenwest St., Huntington Beach

- At least one staff member will attend (in person)
- Health/Resource Fair, open to the public

November 19, 4–6 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services

Anaheim Neighborhood

- At least one staff member will attend (in person)
- Health/Resource Fair, open to the public

November 20, 4–6 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services

Anaheim Neighborhood

- At least one staff member will attend (in person)
- Health/Resource Fair, open to the public

November 22, 9 a.m.–1 p.m., Thanksgiving Food Distribution and Open House, hosted by CalOptima Health

CalOptima Health, 505 City Parkway W., Orange

- At least 20 staff members to attend (in person)
- Health/Resource Fair, open to the public

November 22, TBD, Caregiver Resource Fair, hosted by Congressman Lou Correa

Fullerton Community Center, 340 W. Commonwealth Ave., Fullerton

- At least one staff member will attend (in person)
- Health/Resource Fair, open to the public

November 27, 7:30 a.m.–Noon, YMCA Gives Thanks, hosted by YMCA

TBD

- Sponsorship fee: $10,000; includes a resource booth, meals for community residents, logo placement on signage, press releases, volunteer event shirts and post-event recognition.
- At least one staff member will attend (in person)
- Health/Resource Fair, open to the public

These sponsorship request(s) and community event(s) met the requirements of CalOptima Health Policy AA.1223: Participation in Community Events Involving External Entities. More information about policy requirements can be found at:
https://www.caloptima.org/en/About/CommunityRelations/CommunityOutreach.aspx

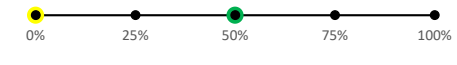
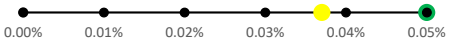
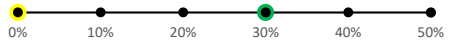
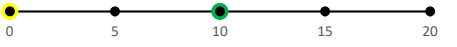
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Strategic Priority	1.0 Equity and Population Health

CalOptima Health will infuse the pursuit of health equity throughout our work and will continue to innovate and develop tools and interventions that advance the physical, behavioral, and social health of our members.

Organization Goal	3-Year Performance Metrics	Owner	Key Highlights To-Date	Actual	3-Year Target	Performance Indicators
1.1 Utilize technology and innovation to strengthen equity and population health management programs.	At least 50% of the participants who complete the 12 month program will report 5% weight loss or 0.2% decrease in Hemoglobin A1c*	Kelly Giardina	•Diabetes Prevention Program: Credentialing is complete; awaiting contracting and program setup •Diabetes Self-Management Program: undergoing redesign to enhance member outcomes •Remote Patient Monitoring (RPM): Collaborating with Goji to engage providers in adopting RPM	TBD	50%	 *New Measure - no data available at this time*
1.2 Implement a consistent model of care for population health/care management, including delegated networks.	Percentage of members successfully enrolled in Complex Case Management	Kelly Giardina	•Complex Case Management (CCM): Clinical criteria shared in the Health Network Series (UM/CM) •Member Satisfaction Survey: Insights shared with Health Networks to identify improvement opportunities •Program Oversight: Ongoing review of CCM enrollment and monthly audit outcomes in Health Network meetings •Clinical Engagement: Regular one-on-one meetings with Health Networks to reinforce expectations and discuss progress and improvements	0.04%	0.05%	 *.05% = ~400 members*
1.3 Annually assess members' health and social needs and utilize data to develop targeted interventions.	Percentage of members assessed for social needs and referred for appropriate interventions within 30 days*	Kelly Giardina	SDOH Screening Project: The team is reassessing next steps due to regulatory requirements and enterprise system considerations. Baseline measurement is not yet established	TBD	30%	 *New Measure - no data available at this time*
1.4 Increase access to preventive services for vulnerable populations in pursuit of health equity.	Number of CBOs participating in prevention campaigns and quality care gap closures*	Marie Jeannis	Began discussions with CBOs to explore using existing committees/workgroups for co-creating health equity efforts	TBD	10	 *New Measure - no data available at this time*

**New Measure - no data available*

CY2025 Q3 Strategic Plan Update : 1) Ownership of organizational goals 1.1 and 1.3 has been reassigned to reflect recent changes in departmental leadership. 2) The performance metric for organizational goal 1.4 has been revised to align with available data reporting.

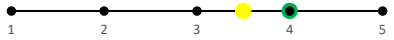
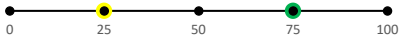
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Strategic Priority	2.0 Quality and Value
CalOptima Health is committed to providing the highest quality physical, behavioral, and social health care to our members and to ensuring sound stewardship of public dollars by achieving greater value.	

Organization Goal	3-Year Performance Metrics	Owner	Key Highlights To-Date	Actual	3-Year Target	Performance Indicators
2.1 Achieve NCQA rating of 4-stars for Medi-Cal. Achieve CMS rating of 3.5-stars for Medicare.	Medi-Cal Star Rating	Linda Lee	•NCQA 2025 Star ratings released on 9/15/2025; CalOptima Health maintained a 3.5-Star rating •Focused on performance initiatives efforts underway for the remainder of CY2025 and priority measures identified for CY2026 • Health Network and CHCN PCP Pay for Value results are currently being calculated	3.5	4	
	Medicare Star Rating	Linda Lee	•CalOptima Health's overall Star Rating improved to 3.0; Part D remained at 3.0, while Part C declined to 2.5 (CY2024 results released 10/9/2025) •Focused initiatives are being implemented for the remainder of CY2025, with priority measures set for CY2026 •Stars work teams are concentrating on the top three priority interventions through the end of the year	3	3.5	
2.2 Improve access to care by strengthening the delivery system through provider support and workforce initiatives.	Quarterly count of grievances related to Access and Availability	Michael Gomez	• Access and Availability Grievances incorporated with Network Adequacy workgroup • Orthopedic Surgery identified as the top specialty with access-related grievances; solutions are being explored to improve referral accuracy and reduce issues (*Q3 GARS data is expected to be available by mid-November) • Identifying opportunities to address access gaps through the Provider Workforce Initiative	854	640	
2.3 Increase provider engagement through improved provider tools, data exchange, and collaboration.	Overall provider satisfaction score*	Michael Gomez	• QMetrics has been engaged to conduct the annual Provider Satisfaction Survey; Updated Data files required; Survey launches in November • QIP data reporting and sharing has been facilitated with UCI Health	TBD	70%	 *New Measure - no data available at this time*
2.4 Expand the delivery of BH services, invest in the workforce, and drive quality improvement through innovation.	Percentage of Follow-Up After Emergency Department Visit for Mental Illness (FUM) within 30 days **	Carmen Katsarov	•Attended a DHCS Collaborative in Sacramento 10/7-10/8 with Orange County Health Care Agency (OCHCA) •Progress being made on data sharing between CalOptima Health and OCHCA on mental health data to assist in closing gaps in care; data should reflect in prospective rate reports starting November 2025 •FUM Reports to resume when data integration is complete	25	75	 *Percentile based HEDIS benchmarks*

**New Measure - no data available; ** Percentile based on HEDIS benchmarks*

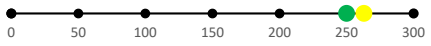
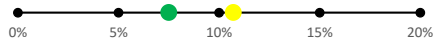
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Strategic Priority	3.0 Community Partnerships and Investments
CalOptima Health will continue to demonstrate our partnership with Orange County members, providers, county agencies, and community organizations through Medi-Cal Transformation programs and robust community investments and partnerships to advance health equity.	

Organization Goal	3-Year Performance Metrics	Owner	Key Highlights To-Date	Actual	3-Year Target	Performance Indicators
3.1 Expand social support services through Medi-Cal Transformation and other social health initiatives.	Number of members served through Street Medicine	Dr. Kelly Bruno-Nelson	• 892 Members served /422 Enrolled • 34 Members permanently housed • Street Medicine provider (AltaMed) received BOD approval in 8/25, with services to begin 12/25	892	750	
3.2 Expand community involvement in co-creation of solutions that best serve members.	Number of individuals who attend or participate in community listening sessions, focus groups, or stakeholder engagement sessions*	Marie Jeannis	• MPHNA stakeholder engagements complete for Population Health Management Committee, OCHCA/CBOs, MAC/PAC, Whole Child Model Family Advisory Committee, Health Network Forum, and Community Clinic Forum • Focus Group Planning: In progress with the MPHNA vendor, including identifying community partners and strategies for effective participant recruitment	263	250	
3.3 Prioritize community investments that advance health equity, drive prevention, and improve access to care.	Percentage of net income allocated to community investments in health equity, prevention, and access to care	Donna Laverdiere	• Community Investment & Oversight Committee continues to evaluate community investment opportunities. •Member and Population Health Needs Assessment results will inform future community investment strategies. 301 provider survey responses received, member survey launching Oct 2025, and focus group outreach in progress	10.7%	7.5%	
3.4 Ensure that all community investment programs include clear accountability metrics and regular performance monitoring requirements.	Percentage of grant agreements on track and in compliance with program objectives and budget expenditures	Dr. Kelly Bruno-Nelson	•210 Total Active Grants: Grants On Track/In Compliance: 93% (196); Grants Delayed/Amendments in Progress: 7% (14); Watch list: 0% (0)	93%	90%	

**New Measure - no data available*

CY2025 Q3 Strategic Plan Update: Ownership of organizational goal 3.4 has been reassigned to reflect recent changes in grant programs leadership.

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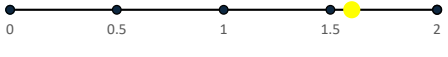
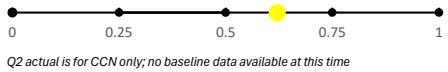
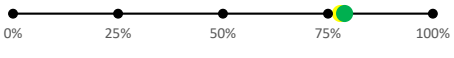
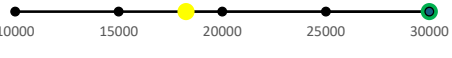
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Strategic Priority	**4.0 Operations, Finance and People**

CalOptima Health's continued investment in our performance and people are vital to ensuring the highest level of care and service to our members across their lifespan.

Organization Goal	3-Year Performance Metrics	Owner	Key Highlights To-Date	Actual	3-Year Target	Performance Indicators
4.1 Improve the turnaround time for treatment authorization for direct and delegated networks.	Treatment authorization processing time (business days) for all providers (Routine)	Kelly Giardina	• Reviewing proposed changes to finalize the enterprise prior authorization list and plan implementation •Automation Enhancements: Improved clinical rules to enable real-time notifications at submission for Medi-Cal •Process Improvements initiated IT-led efforts: Reporting Workstream, Jiva Print & Fulfillment launch, and expansion of the Clinical Configuration team (+3 FTEs)	1.53	TBD	 *Q2 actual is for CCN only; no baseline data available at this time*
	Treatment authorization processing time (calendar) for all providers (Urgent)	Kelly Giardina	****Activities same as above*	0.52	TBD	 *Q2 actual is for CCN only; no baseline data available at this time*
4.2 Improve the turnaround time for claims payment for direct and delegated networks.	Claims auto-adjudication rate - Medi-Cal	Ladan Khamseh	Rate increased from 83% to 85% as Claims and IT teams continue automating manual processes using logic enhancements in Facets	85%	84%	
	Claims auto-adjudication rate - OneCare	Ladan Khamseh	Rate remains steady at 78% as Claims and IT continue efforts to reduce manual processing through automation in Facets	78%	79%	
4.3 Launch and grow programs that take care of our members and their families across their lifespan.	Membership growth by Line of Business - OneCare	Javier Sanchez	•Annual Enrollment Period (AEP) marketing and retention campaign is scheduled to begin in October including new caregiver campaign •Agent training for 2026 benefits is underway	18,248	30,000	
	Membership growth by Line of Business - PACE	Javier Sanchez	•PACE Garden Grove: Enrollment reached 538 members as of October 1 (max capacity: 625); 87 spots remain, with capacity expected to be reached in ~7 months at the current growth rate •Expansion Planning: Staff are actively searching for additional PACE sites to accommodate continued growth	540	700	
	Membership growth by Line of Business - Covered CA*	Donna Laverdiere	•Knox-Keene License Expansion: Initial submission completed; currently addressing DMHC feedback and preparing a second submission •Detailed implementation plans nearing completion; business requirements underway and complete in the next 2 months	TBD	10,000	 *New Measure - no data available at this time*

**New Measure - no data available*

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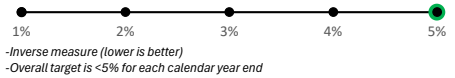
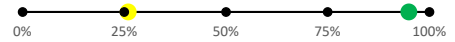
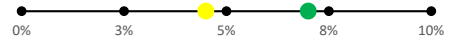
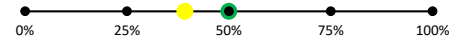
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Strategic Priority	4.0 Operations, Finance and People

CalOptima Health's continued investment in our performance and people are vital to ensuring the highest level of care and service to our members across their lifespan.

Organization Goal	3-Year Performance Metrics	Owner	Key Highlights To-Date	Actual	3-Year Target	Performance Indicators
4.4 Optimize the Medicare line of business to improve the member retention rate and support growth.	Voluntary Disenrollment rate	Javier Sanchez	•Member engagement vendor outreach to members began on 9/29; first community groups are expected to launch the week of 10/13	6.30%	5%	 *-Inverse measure (lower is better)* *-Overall target is <5% for each calendar year end*
4.5 Implement the comprehensive Digital Transformation strategic roadmap to improve member experience and efficiency.	Percentage of Digital Transformation projects completed on time and within budget	Donna Laverdiere	•CRM Project: New go-live date set for February 2026 due to scope and timing changes; Finance ERP (Dec) and WebMD Health Integration (Oct) remain on track •New call center technology provides new tools for real-time reporting and monitoring, enabling improved Average Handle Time and Hold Time through staff feedback •Application consolidation with NICE and implementation of Guided Agent Workflow for CRM are expected to further improve Average Handle Time, Hold Time, and First Call Resolution for Medi-Cal and OneCare members and providers	26%	95%	 *Rolling data based on project completion*
4.6 Optimize member engagement functions to improve member retention, satisfaction, and outcomes.	CAHPS Rating of Health Plan	Ladan Khamseh	•Retention (Risk of disenrolling during AEP) Outreach (9/23-10/27): 97% of members expressed satisfaction with OneCare •Voluntary Disenrollment Outreach (8/1-9/30): 19 members did not disenroll and remained with OneCare •Listening Post Outreach (5/1-9/30): 116 member reached and assisted with PCP changes, scheduling appointments, authorizations, lab results and education on plan benefits •After-Call Survey Results (1/1-10/14): Overall satisfaction with CS: 92.5% (Surveys 5,074; Surveys completed: 1,622; Response Rate: 32%)	3	4	
4.7 Ensure fiscal accountability and stewardship, including a balanced operating budget, quarterly budget reconciliation, and vendor and provider contracting.	Quarterly ALR measure	Nancy Huang	As of August 2025, YTD (2 Months) Consolidated financials showed ALR at 5.3% below budgeted ALR at 6.3%; $2.2M favorable Admin variance driven by Salaries, Wages, & Benefits; $6.4M favorable variance in other administrative expense categories	4.5%	7.0%	
4.8 Launch expanded employee development and retention efforts to drive employee engagement and advancement	Percentage of open positions filled by qualified internal candidates	Steve Eckberg	HR Strategic plan and annual objectives developed for FY26 to support infrastructure	39%	50%	

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Member Grievances and Appeals Report Second Quarter 2025

Quality Assurance Committee Meeting

October 8, 2025

Heather Sedillo, GARS Director

Our Mission

To serve member health with excellence and dignity, respecting the value and needs of each person.

Our Vision

Provide all members with access to care and supports to achieve optimal health and well-being through an equitable and high-quality health care system.

Agenda

- Definitions
- Executive Summary
- Grievance Volume and Trends
- Grievance Actions Taken
- Appeals Volume and Trends
- Appeals Actions Taken

CalOptima Health

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Definitions

- Grievance: An expression of dissatisfaction with any aspect of a CalOptima Health program, provider or representative.

- Appeal: A request by the member or on the member's behalf for the review of any decision to deny, modify, or discontinue a covered service.

Executive Summary

In Q2, CalOptima Health received 5,056 grievances and 501 appeals for Medi-Cal and OneCare. The average closure rate was 21 days.

Grievances

Medi-Cal: Increased from 3,675 to 4,506 (23% increase). Main issues: Provider/Staff Attitude, Plan Customer Service, referral delays, and appointment availability.

OneCare: Increased from 371 to 550 (48% increase). Main issues: Provider/Staff Attitude, Plan Customer Service, transportation services, and telephone accessibility

Appeals

Medi-Cal: Appeals increased from 265 to 406 (53% increase) with a 28% overturn rate. Main issues: CalAIM Personal Care Hours, Housing Deposits, Day Habilitation services, and specialty care requests related to Out Of Network and UCI Tertiary Level Of Care requests.

OneCare: Appeals increased from 59 to 96 (61% increase) with a decrease in overturn rate from 47% to 33%. Main issues: inpatient hospital care with Non-Contracted Providers, outpatient services related to imaging and labs, and Out Of Network specialty care requests

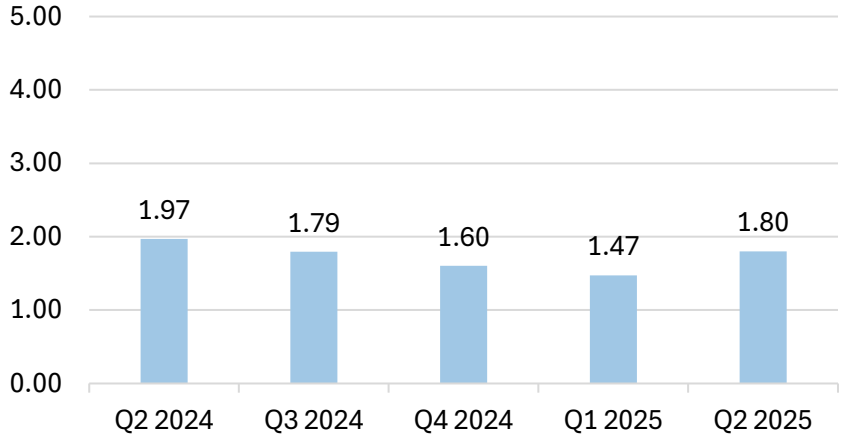
Grievances

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Grievance Volume by Line of Business (LOB)

Medi-Cal

Rate per 1,000 Member Months

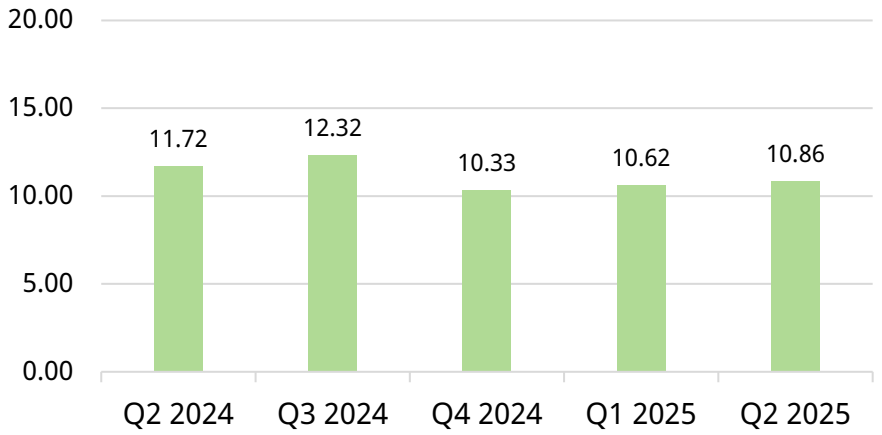


Total Grievances

Timeframe	Total Grievances
Q2 2025	4,778
Q1 2025	3,958
Q4 2024	4,298
Q3 2024	4,817
Q2 2024	5,355

OneCare

Rate per 1,000 Member Months



Total Grievances

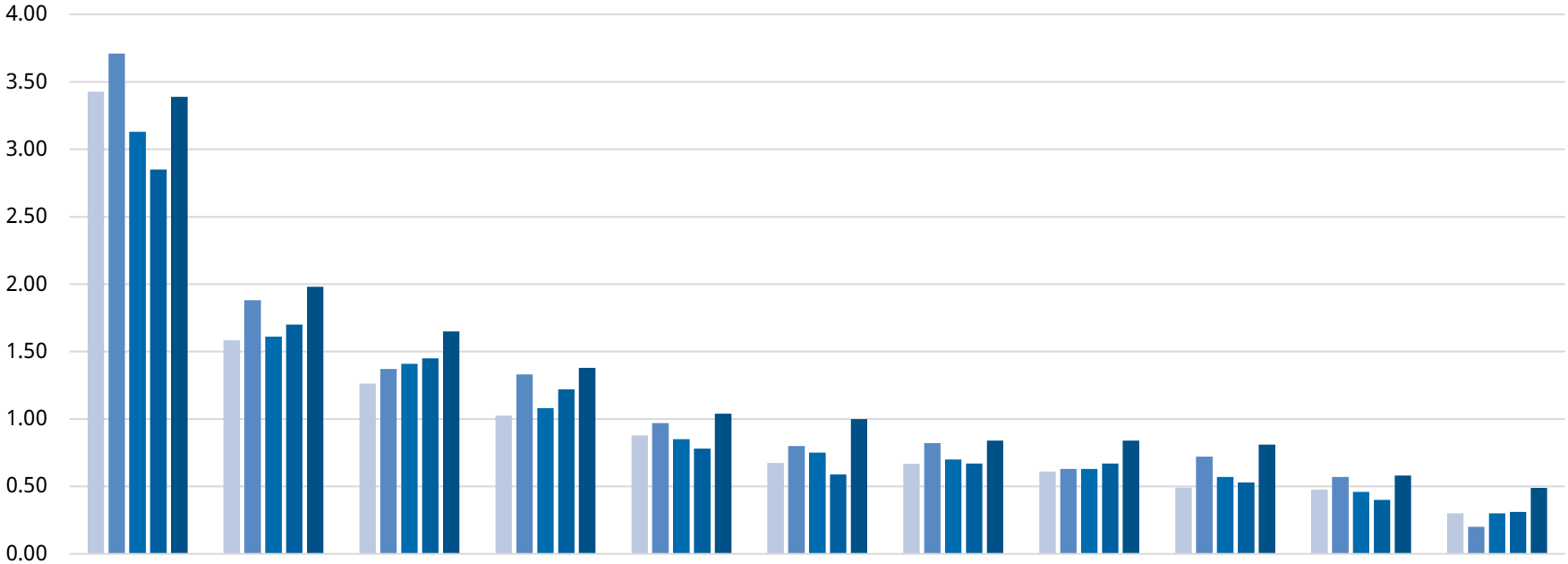
Timeframe	Total Grievances
Q2 2025	574
Q1 2025	552
Q4 2024	531
Q3 2024	639
Q2 2024	607

Health

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2024-2025 Complaint Rate per 1,000 Member Months

Q2 2024-Q2 2025
Rate per 1000 MM

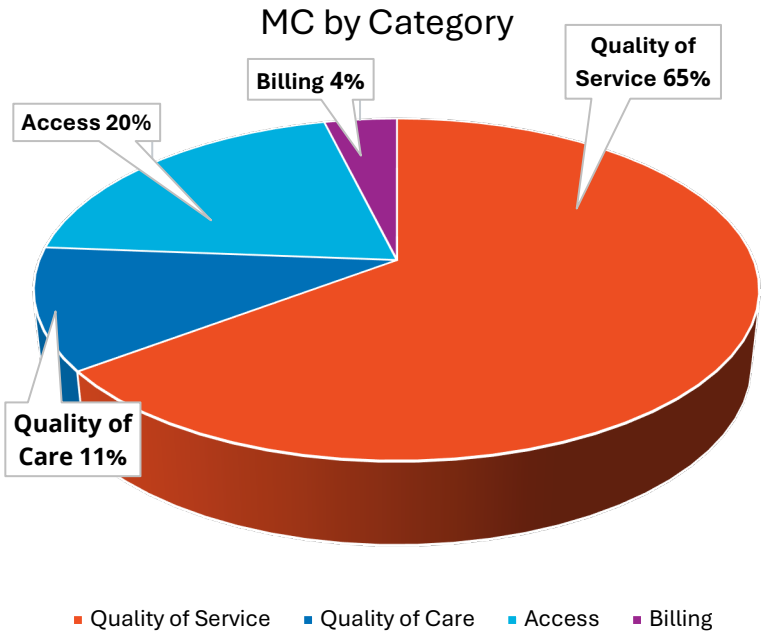


	CCN	Heritage	Optum	Prospect	AltaMed	UCMG	COD	Noble	Family Choice	CHA	AMVI
Q2 2025	3.39	1.98	1.65	1.38	1.04	1.00	0.84	0.84	0.81	0.58	0.49
Q1 2025	2.85	1.7	1.45	1.22	0.78	0.59	0.67	0.67	0.53	0.4	0.31
Q4 2024	3.13	1.61	1.41	1.08	0.85	0.75	0.70	0.63	0.57	0.46	0.3
Q3 2024	3.71	1.88	1.37	1.33	0.97	0.8	0.82	0.63	0.72	0.57	0.2
Q2 2024	3.43	1.58	1.26	1.02	0.88	0.67	0.67	0.61	0.49	0.48	0.30

CalOptima Health

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2024-2025 Grievance Type by Category



	MC Grievances				
	Q2 2024	Q3 2024	Q4 2024	Q1 2025	Q2 2025
Quality of Service	2,668	2,702	2,485	2,337	2,917
Quality of Care	505	586	480	364	518
Access	789	882	875	821	899
Billing	208	217	178	153	172
TOTAL	**4,170**	**4,387**	**4,018**	**3,675**	**4,506**

Q2 2025 Trends within each Category:

Quality of Care – Inappropriate care/treatment concerns; Authorization

Billing – Provider Direct Member Billing, Balance Billing

Access – Provider Availability, Scheduling

Quality of Service – Provider/Staff Attitude, Plan Customer Service

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Medi-Cal Grievance Trends for Q2

Quality of Service

Trend	Percentage of Total Volume
Provider / Staff Attitude	24% (698)
Plan Customer Service	15% (442)
Authorization	12% (348)

Quality of Care

Trend	Percentage of Total Volume
Inappropriate Care	34% (176)
Authorization	13% (69)
Referral	11% (56)

Access

Trend	Percentage of Total Volume
Provider Availability	15% (136)
Scheduling	14% (122)
Authorization Related	14% (122)

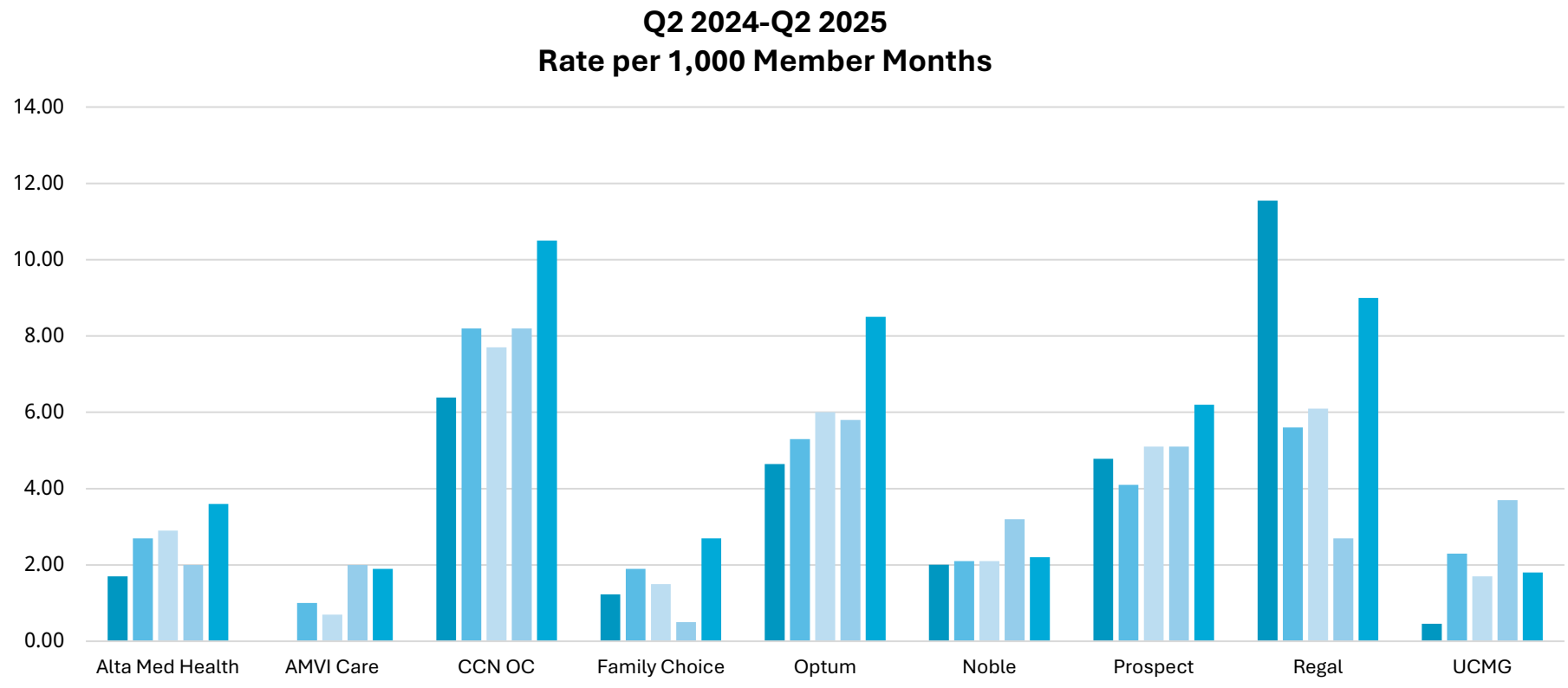
Billing

Trend	Percentage of Total Volume
Provider Direct Member Billing	65% (112)
Provider Balance Billing	31% (54)
Out of Network	1% (2)

Medi-Cal
CalOptima Health

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2024-2025 Grievance Rate per 1,000 Member Months

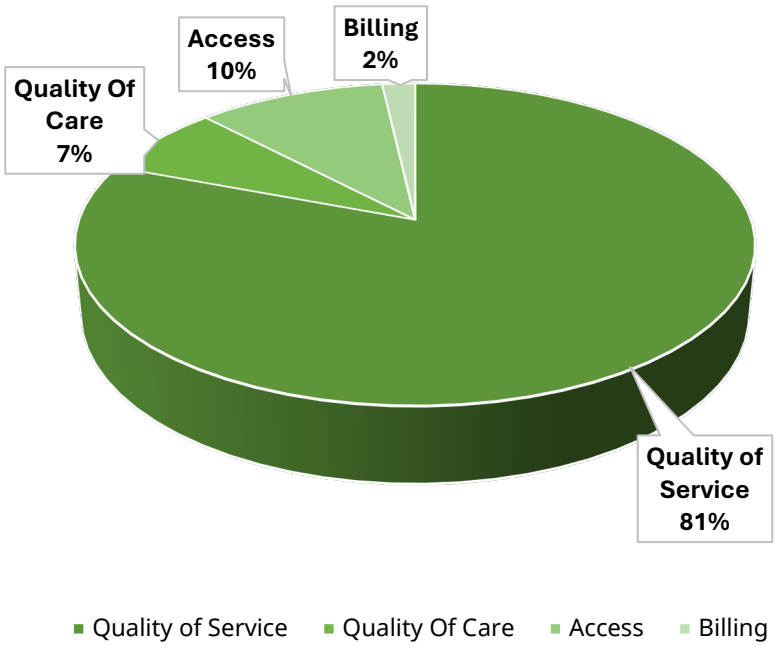


	Alta Med Health	AMVI Care	CCN OC	Family Choice	Optum	Noble	Prospect	Regal	UCMG
Q2 2025	3.60	1.90	10.50	2.70	8.50	2.20	6.20	9.00	1.80
Q1 2025	2.00	2.00	8.20	0.50	5.80	3.20	5.10	2.70	3.70
Q4 2024	2.90	0.70	7.70	1.50	6.00	2.10	5.10	6.10	1.70
Q3 2024	2.70	1.00	8.20	1.90	5.30	2.10	4.10	5.60	2.30
Q2 2024	1.70	0.00	6.39	1.23	4.64	2.01	4.79	11.54	0.46

CalOptima Health

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2025 Grievance Type by Category



	OneCare Grievances				
	Q2 2024	Q3 2024	Q4 2024	Q1 2025	Q2 2025
Quality of Service	326	371	334	302	444
Quality of Care	34	51	22	25	39
Access	47	49	49	33	57
Billing	16	15	14	11	10
TOTAL	**423**	**486**	**419**	**371**	**550**

Q2 Trends within each Category:

Quality of Service –Provider Staff Attitude, Plan Customer Service

Quality of Care – Inappropriate Care, Provider Staff Attitude

Access – Telephone Issues, Referral, Provider Availability

Billing – Provider Direct Member Billing, Balance Billing

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OneCare Grievance Trends for Q2

Quality of Service

Trend	Percentage of Total Volume
Provider / Staff Attitude	21% (94)
Plan Customer Service	20% (90)
Driver Punctuality	17% (76)

Quality of Care

Trend	Percentage of Total Volume
Inappropriate Care	62% (24)
Driver Punctuality	15% (6)
Scheduling	5% (2)

Access

Trend	Percentage of Total Volume
Provider Availability	19% (11)
Technology / Telephone	18% (10)
Authorization	11% (6)

Billing

Trend	Percentage of Total Volume
Provider Direct Member Billing	40% (4)
Provider Balance Billing	50% (5)

Actions Taken in Response to Trends

- Q2 trends identified
  - Medi-Cal and OneCare grievances about transportation providers.
  - Medi-Cal and OneCare grievances against staff at Primary Care Physicians and Specialists visits.

- Actions Taken
  - The vendor provided weekly reports on completed rides, focusing on dialysis transportation and improving on-time performance through monitoring and targeted oversight.
  - No provider trends were identified in Q2, but monthly tracking and analysis of provider-specific grievances continue. A collaborative process with Provider Services was established to review trends quarterly and implement corrective actions when needed.

CalOptima Health

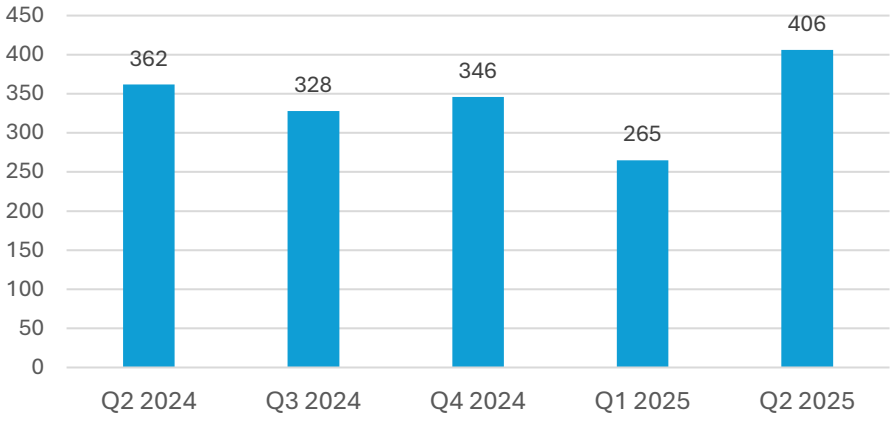
Appeals

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Appeals Volume by Line Of Business (LOB)

Medi-Cal

Total Appeals Volume

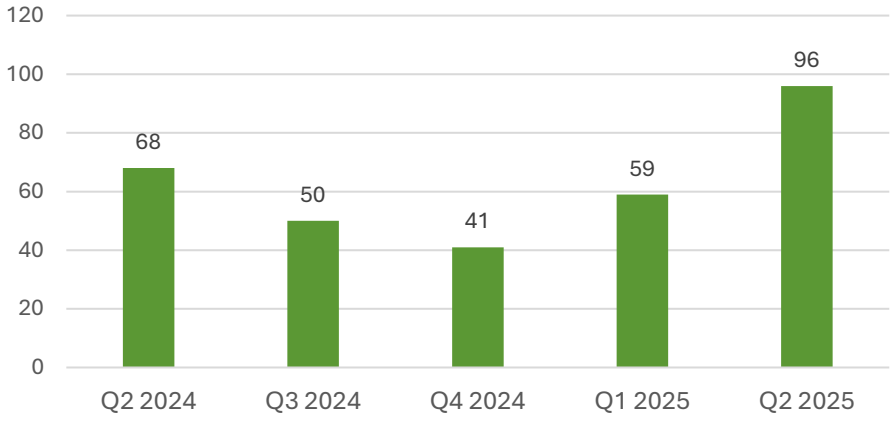


Total Appeals

Q2 2025	406
Q1 2025	265
Q4 2024	346
Q3 2024	328
Q2 2024	362

OneCare

Total Appeals Volume



Total Appeals

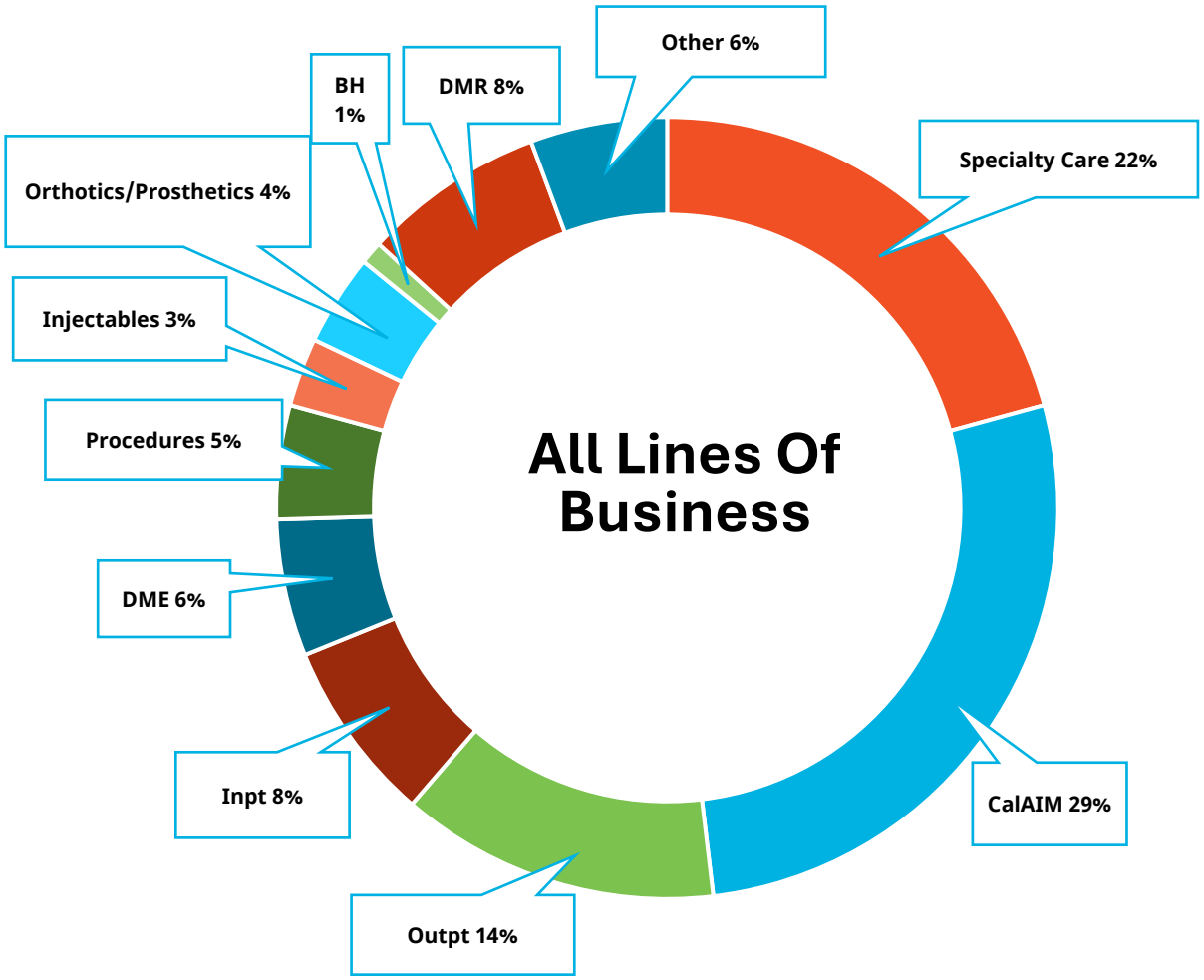
Q2 2025	96
Q1 2025	59
Q4 2024	41
Q3 2024	50
Q2 2024	68

CalOptima Health

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Appeals Overall

Service Types



Services	Qty	%
CalAIM	149	30%
Specialty Care	110	22%
Outpatient	69	14%
Inpatient	40	8%
DME	28	6%
Procedures	27	5%
Orthotics / Prosthetics	19	4%
Injectables	17	3%
DMR	8	2%
BH	6	1%
Other	28	6%

Key Notes: Increases in CalAIM (75), Outpatient (40), Specialty care (20) and Inpatient (13) appeals, and the inclusion of all NCP provider appeals have contributed to the increase in Appeals volume in Q2 compared to Q1.

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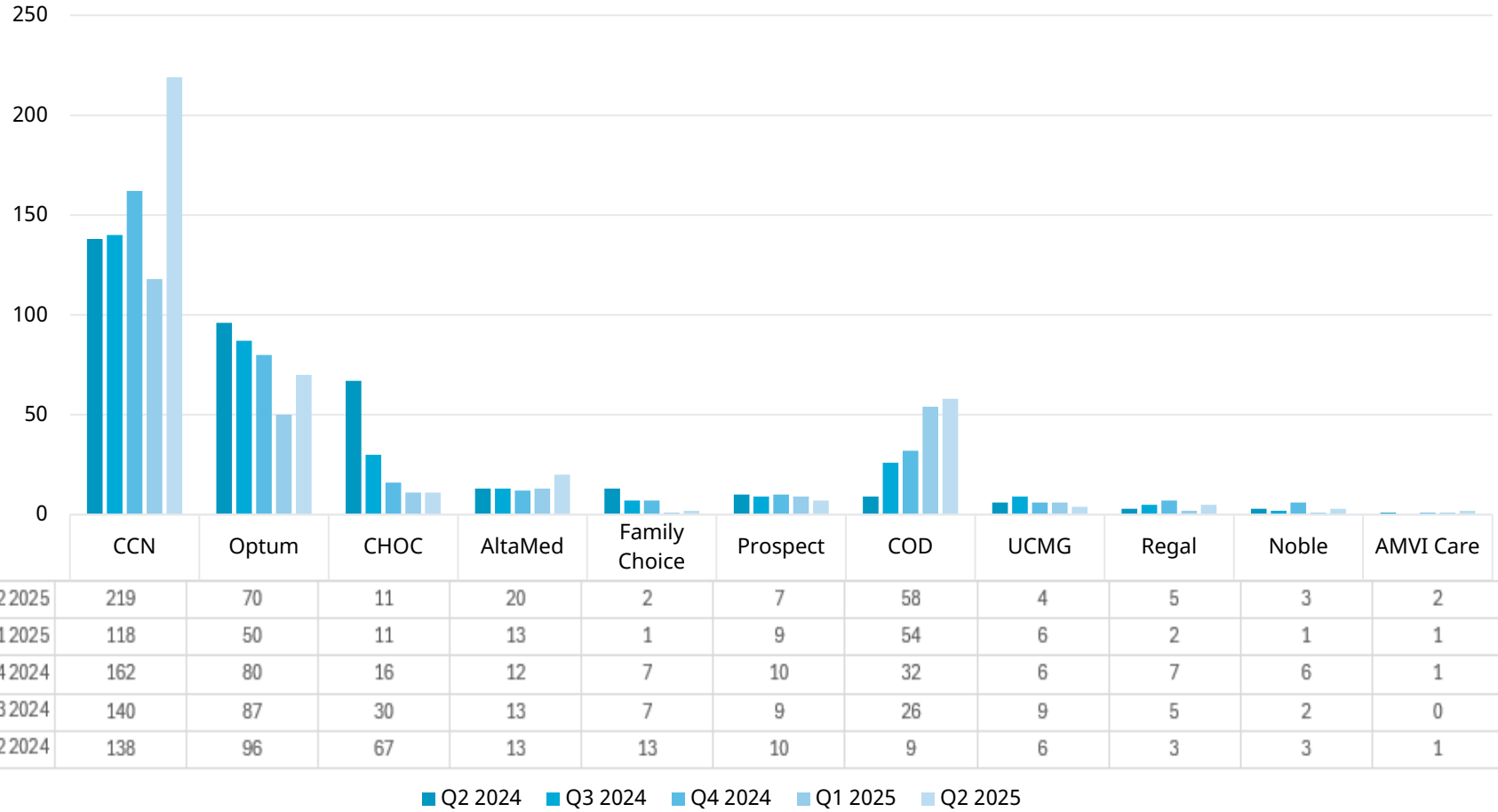
Appeal Types by LOB Q2 2025

Service Types	Medi-Cal Q2 2025 Percentage of Total Volume	OneCare Q2 2025 Percentage of Total Volume
CalAIM	34% (139)	9% (9)
Specialty Care	25% (100)	9% (9)
Outpatient Services	12% (51)	18% (17)
Procedures	6% (25)	2% (2)
DME	5% (21)	6% (6)
SNF	5% (19)	2% (2)
Injectables	4% (15)	1% (1)
Hospital Inpatient	3% (13)	34% (32)
Other	6% (23)	19% (18)
TOTAL	406	96

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MC Appeals Volume Q2 2024-Q2 2025

Q2 2024-Q2 2025
MC Appeals Volume



	CCN	Optum	CHOC	AltaMed	Family Choice	Prospect	COD	UCMG	Regal	Noble	AMVI Care
Q2 2025	219	70	11	20	2	7	58	4	5	3	2
Q1 2025	118	50	11	13	1	9	54	6	2	1	1
Q4 2024	162	80	16	12	7	10	32	6	7	6	1
Q3 2024	140	87	30	13	7	9	26	9	5	2	0
Q2 2024	138	96	67	13	13	10	9	6	3	3	1

Medi-Cal
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Medi-Cal Appeals Trends for Q2

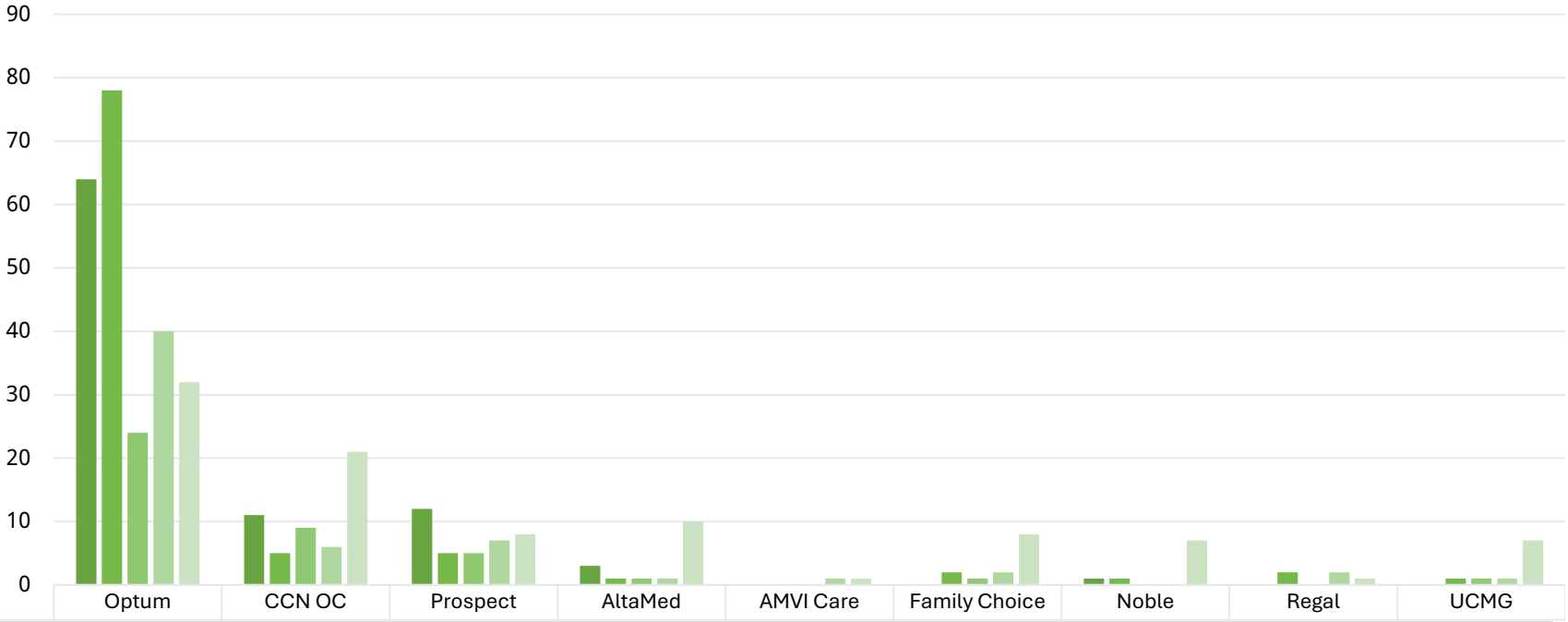
Type	Upheld Count	Overturned Count	Total	Overturn Percentage (%)
CalAIM	111	28	139	20%
Specialty Care	66	34	100	34%
Outpatient Services	34	17	51	33%
Procedures	17	8	25	32%
DME	10	11	21	52%
SNF	18	1	19	5%
Injectables	8	7	15	47%
Hospital Inpatient	9	4	13	31%
Other	18	5	23	22%

Medi-Cal
CalOptima Health

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OC Appeals Volume Q2 2024-Q2 2025

Q2 2024-Q2 2025
OC Appeals Volume



	Optum	CCN OC	Prospect	AltaMed	AMVI Care	Family Choice	Noble	Regal	UCMG
Q2 2025	32	21	8	10	1	8	7	1	7
Q1 2025	40	6	7	1	1	2	0	2	1
Q4 2024	24	9	5	1	0	1	0	0	1
Q3 2024	78	5	5	1	0	2	1	2	1
Q2 2024	64	11	12	3	0	0	1	0	0

Q2 2024 Q3 2024 Q4 2024 Q1 2025 Q2 2025

OneCare CalOptima Health

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OneCare Appeals Trends for Q2

Type	Upheld Count	Overturned Count	Total	Overturn Percentage (%)
Hospital Inpatient	19	13	32	41%
Outpatient Services	13	4	17	24%
Specialty Care	6	3	9	33%
CalAIM	8	1	9	11%
DMR	4	3	7	43%
DME	4	2	6	33%
Orthotics/Prosthetics	3	3	6	50%
Other	7	1	8	13%

Actions Taken in Response to Trends

- Q2 trends identified
  - Requests for specialists or higher-level care are being redirected to in-network providers who cannot treat the condition or see the member in a timely manner based on their needs and access to care standards.
  - Continuity of Care (COC) based on multidisciplinary care is not considered during initial reviews.

- Actions Taken
  - After an appeal is overturned, health networks receive the review criteria for educational purposes.
  - Network overturn trends are tracked and shared with the Delegation Oversight Medical Director during quarterly meetings with Health Network partners.
  - Trends are also shared with internal departments.

CalOptima Health

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CalOptima Health Board Action Agenda Referral

Action To Be Taken November 6, 2025
Regular Meeting of the CalOptima Health Board of Directors

Report Item

13. Approve Actions Related to Federal Shutdown Response Supplemental Food Support for CalOptima Health Members

Contacts

Dr. Kelly Bruno-Nelson, Executive Director, Medi-Cal and CalAIM, (657) 550-4741
Veronica Carpenter, Chief Administrative Officer, (657) 650-9531

Recommended Actions

1. Appropriate and allocate up to $7.0 million from existing reserves to fund supplemental food support for Medi-Cal members during the federal shutdown as follows:
    a. Up to $2.0 million to fund grant agreements with two Orange County food bank distribution hubs; and
    b. Up to $5.0 million to provide one $25 nonmonetary flex card to individual Medi-Cal members who are enrolled in the Supplemental Nutrition Assistance Program.
2. Authorize the Chief Executive Officer or designee to execute and administer grant agreements and release award payments up to $1.0 million each to Second Harvest Food Bank of Orange County and Community Action Partnership Orange County.
3. Make a finding that such expenditures are for a public purpose and in furtherance of CalOptima Health's mission and purpose.
4. Authorize CalOptima Health staff to work with the Social Services Agency of Orange County to determine a list of CalOptima Health members who are also receiving Supplemental Nutrition Assistance Program benefits, who will be eligible for a $25 nonmonetary flex card from CalOptima Health as additional food support while these benefits are suspended.
5. Authorize the Chief Executive Officer or designee to execute a contract amendment with Soda Health, the flex card vendor, to update the scope of work and payment terms for the administration and distribution of flex cards to Medi-Cal members eligible to receive the supplemental food support.

Background

CalFresh, federally known as the Supplemental Nutrition Assistance Program (or SNAP), helps low-income residents buy healthy food. More than 310,000 Orange County residents, including 94,000 older adults who are 60 years or older and 91,000 children, receive CalFresh. Due to the ongoing federal government shutdown, CalFresh benefits will be delayed in November, contributing to food insecurity across the county. The federal government issued guidance on Friday, October 24, 2025, that SNAP benefits will be suspended until the shutdown is resolved.

Approximately 92% of CalFresh recipients in California also have Medi-Cal coverage. Staff estimates that in Orange County, the majority (approximately 225,000) of the 310,000 individuals, including seniors and children, receiving CalFresh are also CalOptima Health members. To prevent CalOptima Health's members from experiencing additional food insecurity, and given these exceptional

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circumstances, CalOptima Health is seeking to partner with Second Harvest Food Bank of Orange County (Second Harvest) and Community Action Partnership Orange County (CAPOC), the two main food distributors in Orange County, to ensure an adequate supply of food is available.

In addition to direct food distribution, CalOptima Health is also planning to distribute grocery flex cards to dual Medi-Cal/SNAP members and OneCare/SNAP members who have had their SNAP benefits halted. This distribution of supplemental food support will further combat hunger and malnutrition among CalOptima Health membership during a national crisis.

Discussion

CalOptima Health intends to work with the two primary distributors to food pantries and food banks across Orange County. Together, Second Harvest and CAPOC annually distribute 65 million pounds of food through their combined network of nearly 600 community partner locations. Their expansive list of partners include houses of worship, schools, after-school programs, senior centers, shelters for the unhoused, soup kitchens, and transitional housing facilities, resulting in hundreds of locations throughout the county.

With the decrease in supplemental food benefits, CalOptima Health plans to work with Second Harvest and CAPOC to guarantee an increased availability of food at distributions sites throughout Orange County in support of neighbors who are at risk for experiencing hunger. CalOptima Health staff recommends a grant award of up to $1,000,000 to each organization (totaling $2,000,000) for food provision and expanded distribution hours at several sites in Orange County, particularly in districts that have a high percentage of residents with CalOptima Health coverage. These funds would support the organizations in expanded distribution and access to food through February, should SNAP benefits continue to be delayed through that time.

With CalOptima Health Board of Directors (Board) approval, staff would like to proceed with prompt development and execution of grant agreements, including scopes of work, with Second Harvest and CAPOC. These grant agreements will be in effect beginning November 1, 2025, and will continue on a month-to-month basis. The grant agreements would end either February 28, 2026, or upon the end of the federal shutdown, whichever is sooner. Staff will provide oversight of the grants pursuant to CalOptima Health Policy AA.1400: Grant Management, and will return to the Board to provide updates on the status of these grants at future meetings.

To distribute grocery flex cards to Medi-Cal members who are enrolled in SNAP, CalOptima Health will engage in two simultaneous efforts with Board approval. First, CalOptima Health staff will work with the Social Services Agency of Orange County to determine a list of CalOptima Health members receiving SNAP benefits who will be deemed eligible for a flex card. Second, staff will work with Soda Health, the OneCare flex card vendor, to develop a scope of work and contract amendment to distribute flex cards to eligible members. Once these efforts are complete, the flex card vendor will distribute one $25 nonmonetary card to each eligible member. Staff are requesting up to $5,000,000 to cover this cost.

This distribution of supplemental food support will combat hunger and malnutrition among CalOptima Health membership during a national crisis. Members will be notified of these supplemental food resources through direct mailing of the flex cards, social media outreach, e-newsletter distributions, and local network sharing (*e.g.*, 211OC and other organizations helping to communicate the information).

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Fiscal Impact

An appropriation of up to $7.0 million from existing reserves will fund the grant agreements with Second Harvest and CAPOC, and the provision of one $25 nonmonetary flex card to each individual Medi-Cal member who is enrolled in SNAP during the federal shutdown period.

Rationale for Recommendation

CalOptima is working to reduce the risk of malnutrition and hunger to members during this national crisis.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Entities Covered by this Recommended Action

/s/ Michael Hunn *10/31/2025*
Authorized Signature **Date**

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Attachment to the November 6, 2025, Board of Directors Meeting – Agenda #13

CONTRACTED/ IMPACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Community Action Partnership of Orange County	11870 Monarch Street	Garden Grove	CA	92841
Second Harvest Food Bank of Orange County, Inc.	8014 Marine Way	Irvine	CA	92618

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action to be Taken November 6, 2025
Regular Meeting of the CalOptima Health Board of Directors

Report Item

14. Adopt Resolution No. 25-1106-01 Approving the Revised *2026 CalOptima Health Compliance Plan, 2026 CalOptima Health Code of Conduct, 2026 CalOptima Health Anti-Fraud, Waste and Abuse (FWA) Plan*, *2026 CalOptima Health HIPAA Privacy and Security Program,* and Revised CalOptima Health Office of Compliance Policies and Procedures

Contact

John Tanner, Chief Compliance Officer, (657) 235-6997

Recommended Actions

Adopt Resolution No. 25-1106-01 approving:

a. Revised *2026 CalOptima Health Compliance Plan; 2026 CalOptima Health Code of Conduct; 2026 CalOptima Health Anti-Fraud, Waste and Abuse (FWA) Plan; and the 2026 CalOptima Health HIPAA Privacy and Security Program*; and
b. Revised CalOptima Health Office of Compliance policies and procedures.

Background

CalOptima Health is committed to conducting its operations in compliance with ethical standards and all applicable laws, regulations and rules, including federal and state health care program requirements. As part of that commitment, the CalOptima Health Board of Directors (Board) is annually presented with CalOptima Health's Compliance Program and associated documents (Compliance Program) for review and approval. The *2026 CalOptima Health Compliance Plan; 2026 CalOptima Health Code of Conduct; 2026 CalOptima Health Anti-Fraud, Waste and Abuse (FWA) Plan; and the 2026 CalOptima Health Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Program,* comprehensively address the fundamental elements necessary for an effective Compliance Program, including those elements identified by the Office of Inspector General (OIG) of the U.S. Department of Health and Human Services and the Centers for Medicare & Medicaid Services (CMS).

Compliance Program Elements

Federal laws and regulations (including the CMS Medicare Advantage regulations), CalOptima Health's contract with the California Department of Health Care Services (DHCS), and OIG compliance guidance require that compliance programs be reasonably designed, implemented, and enforced to ensure the programs are effective in preventing, detecting and correcting violations of standards or law. CalOptima Health's Compliance Program addresses each of the seven fundamental elements of an effective Compliance Program, in addition to FWA prevention, detection, and remediation.

Written Standards

As part of its Compliance Program, CalOptima Health develops, maintains, and distributes to its Board, employees and first tier, downstream or related Entities (FDRs) written standards in the form of the *2026 CalOptima Health Compliance Plan, 2026 CalOptima Health Code of Conduct, 2026 CalOptima Health Anti-Fraud, Waste and Abuse (FWA) Plan*, *the 2026 CalOptima Health HIPAA Privacy and Security Program* and written policies and procedures, as further detailed in the *2026 CalOptima Health Compliance Plan*. The *2026 CalOptima Health Compliance Plan* incorporates all the elements of an

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effective compliance program, as recommended by the OIG and required by CMS regulations and CalOptima Health's DHCS contract. The Compliance Program also includes a comprehensive Anti-FWA Plan, which establishes guidelines and procedures designed to prevent, detect, and remediate FWA in CalOptima Health programs.

Oversight
As CalOptima Health's governing body, the Board is responsible for ensuring and overseeing the implementation, effectiveness and continued operation of the Compliance Program. The Board delegates to the Chief Executive Officer, who then delegates to the Chief Compliance Officer, the administration of the Compliance Program's development, maintenance, implementation, monitoring and enforcement activities. The Chief Compliance Officer, in conjunction with the Compliance Committee, is accountable for the oversight and reporting roles and responsibilities set forth in the *2026 CalOptima Health Compliance Plan*. The Delegation Oversight Committee, a subcommittee of the Compliance Committee, is responsible for overseeing delegated activities.

Training and Education
Utilizing web-based courses, as well as distribution of guidelines and publications, the Compliance Program incorporates training and education regarding CalOptima Health's compliance standards and requirements, as well as specialized educational courses assigned to individuals based on their respective roles within CalOptima Health's departments and programs. Upon appointment, hire, or commencement of a contract, and annually thereafter, the Board, employees and FDRs receive *CalOptima Health's Code of Conduct* and are required to complete comprehensive training covering compliance obligations and applicable laws, FWA (where applicable), HIPAA privacy and security requirements, Health Information Technology for Economic and Clinical Health (HITECH) Act, and the Confidentiality of Medical Information Act (CMIA).

Effective Lines of Communication and Reporting
CalOptima Health utilizes various methods to communicate general information, regulatory updates, and process changes from the Chief Compliance Officer to the Board, employees, FDRs and members, including, but not limited to, presentations at meetings and updates in print and/or electronic form about how to identify, report, and prevent compliance issues and FWA. The Board, employees, FDRs and/or members receive information and reminders to report compliance concerns, questionable conduct or practices, suspected or actual non-compliance issues, and FWA incidents through one of CalOptima Health's multiple reporting mechanisms. These reporting options provide for anonymity and confidentiality (to the extent permitted by applicable law and circumstances). CalOptima Health maintains and supports a non-retaliation policy governing good-faith reports of suspected or actual non-compliance and/or FWA.

Enforcement and Disciplinary Standards
The Board, employees, and FDRs are subject to appropriate disciplinary and/or corrective actions for non-compliance with CalOptima Health's standards, requirements, or applicable laws, as specified in the Compliance Program documents and related policies and procedures, including, but not limited to,

CalOptima Health's policies and procedures on performance and behavior standards, corrective action plans, and/or sanctions. CalOptima Health implements consistent, timely and effective enforcement of standards when non-compliance or unethical behavior is determined, including any appropriate disciplinary action to address improper conduct, activity and/or behavior.

Monitoring, Auditing and Identification of Risks
CalOptima Health has implemented and continues to implement comprehensive monitoring and auditing activities, which are performed by the Delegation Oversight Department and Internal Audit Department in conjunction with CalOptima Health contract owners and functional business owners responsible for ongoing monitoring. The purpose of CalOptima Health's monitoring and auditing activities is to test and confirm compliance with all applicable regulations, contractual agreements, and federal and state laws, as well as applicable policies and procedures established to protect against non-compliance and potential FWA in CalOptima Health's programs. The *2026 CalOptima Health Compliance Plan* and related policies and procedures address the monitoring and auditing processes carried out by CalOptima Health.

Response and Remediation
Once a violation or offense has been detected or reported, CalOptima Health initiates all necessary steps to investigate, identify, and respond appropriately to the violation or offense and to prevent similar violations and offenses from occurring. As described in the *2026 CalOptima Health Compliance Plan*, CalOptima Health will conduct a timely and documented investigation and undertake appropriate corrective actions where appropriate, including, but not limited to, modifying its Compliance Program and its policies and procedures, to prevent the same or similar violation or offense from occurring in the future.

Discussion
CalOptima Health regularly reviews its *Compliance Plan, Code of Conduct, Anti-Fraud, Waste and Abuse (FWA) Plan*, and *HIPAA Privacy and Security Program* to ensure alignment with federal and state health care program requirements and laws as well as CalOptima Health operations. CalOptima Health's Chief Compliance Officer has reviewed the *2026 CalOptima Health Compliance Plan*, *2026 CalOptima Health Code of Conduct, 2026 CalOptima Health Anti-Fraud, Waste and Abuse (FWA) Plan*, *2026 CalOptima Health HIPAA Privacy and Security Program* and Office of Compliance policies and procedures to ensure consistency with applicable federal and state health care program laws, regulations, and/or guidance.

Summary of Changes
The *2026 CalOptima Health Compliance Plan*, *2026 CalOptima Health Code of Conduct, 2026 CalOptima Health Anti-Fraud, Waste and Abuse (FWA) Plan,* and *2026 CalOptima Health HIPAA Privacy and Security Program* have been updated and revised as follows:

- The ***2026 CalOptima Health Compliance Plan*** was revised to clarify the option for FDRs to attest to the adoption of their own CalOptima Health equivalent compliance plan, code of conduct, and compliance policies and procedures without the need for approval by CalOptima Health. The

website location for the CalOptima Health Code of Conduct was updated and minor grammatical edits were made to clarify language.

- The ***2026 CalOptima Health Code of Conduct*** document was redesigned to incorporate graphic design elements for a more visually appealing document promoting enhanced readability for employees, Board members, and contractors. While the contents of the Code of Conduct remain substantially the same as the prior version, the format and order of the information was changed and clarifying language was added. Additionally, a Frequently Asked Questions section was added to provide clear answers to common questions or situations about ethical standards and expected behaviors.

- The ***2026 CalOptima Health Anti-Fraud, Waste and Abuse (FWA) Plan*** was revised to add language directing FWA Plan inquiries to the CalOptima Health FWA Director, Fay Ho, and includes CalOptima Health's responsibility to submit the anti-fraud plan to the Department of Managed Health Care (DMHC). Revisions also include addition of the requirement to provide DMHC with an annual written report detailing efforts to deter, detect, and investigate fraud, and to report cases of fraud, including the number of cases prosecuted to the extent known by CalOptima Health. Applicability of the FWA Plan and detailed reporting requirements for Covered California were added. Regulatory citations were updated to align with applicable governing regulations and definitions for Covered California were also added.

- The ***2026 CalOptima Health HIPAA Privacy and Security Program*** was updated to reflect current monetary penalty standards for HIPAA Privacy Rule violations, add clarification to contact information for regulatory agencies, and update CalOptima Health policy and procedure references.

Policies and Procedures
Consistent with applicable federal and state health care program laws, regulations and/or guidance, the Chief Compliance Officer, with the support of the Office of Compliance staff, has updated the related policies and procedures. The summary of changes is included in Attachment 6. This summary contains a list of policies with substantive changes that are reflected in the policies and procedures in Attachment 7. The revised policies and procedures also reflect non-substantive changes (*i.e.*, formatting, spelling, punctuation, capitalization, minor clarifying language and/or grammatical changes).

Fiscal Impact
The recommended actions to approve the revised *2026 CalOptima Health Compliance Plan*, *2026 CalOptima Health Code of Conduct*, *2026 CalOptima Health Anti-Fraud, Waste and Abuse (FWA) Plan*, *2026 CalOptima Health HIPAA Privacy and Security Program*, and Office of Compliance policies and procedures have no anticipated fiscal impact. To the extent that there is any fiscal impact due to increases in Compliance Program resources, such impact will be addressed in separate Board actions or in future operating budgets.

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Rationale for Recommendation

To ensure CalOptima Health's continuing commitment to conducting its operations in compliance with ethical and legal standards and all applicable laws, regulations, and rules, CalOptima Health staff recommends that the Board adopt the resolution approving and adopting the updated CalOptima Health *2026 Compliance Plan, 2026 Code of Conduct, 2026 Anti-Fraud, Waste and Abuse (FWA) Plan, the 2026 HIPAA Privacy and Security Program* and related policies and procedures. These updated documents will supersede CalOptima Health's *2025 Compliance Plan*, *2025 Code of Conduct*, *2025 Health Anti-Fraud, Waste and Abuse (FWA) Plan and 2025 HIPAA Privacy and Security Program* approved on November 07, 2024.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Resolution No. 25-1106-01, Resolution Approving the *2026 CalOptima Health Compliance Plan, 2026 CalOptima Health Code of Conduct, 2026 CalOptima Health Anti-Fraud, Waste and Abuse (FWA) Plan*, *2026 CalOptima Health HIPAA Privacy and Security Program* and revised Policies and Procedures
2. 2026 CalOptima Health Compliance Plan
3. 2026 CalOptima Health Code of Conduct
4. 2026 CalOptima Health Anti-Fraud, Waste and Abuse (FWA) Plan
5. 2026 CalOptima Health HIPAA Privacy and Security Program
6. Summary of Proposed Actions to CalOptima Health Office of Compliance Policies and Procedures
7. Revised Office of Compliance Policies and Procedures

/s/ Michael Hunn *10/30/2025*
Authorized Signature **Date**

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RESOLUTION NO. 25-1106-01

RESOLUTION OF THE BOARD OF DIRECTORS OF ORANGE COUNTY HEALTH AUTHORITY dba CalOptima Health

APPROVING THE 2026 CALOPTIMA HEALTH COMPLIANCE PLAN, 2026 CALOPTIMA HEALTH CODE OF CONDUCT, 2026 CALOPTIMA HEALTH ANTI-FRAUD, WASTE AND ABUSE (FWA) PLAN, 2026 CALOPTIMA HEALTH HIPAA PRIVACY AND SECURITY PROGRAM AND REVISED OFFICE OF COMPLIANCE POLICIES AND PROCEDURES

WHEREAS, Section 4.1 of the Bylaws of the Orange County Health Authority, dba CalOptima Health, provides that the Board of Directors is the governing body of CalOptima Health, and except as otherwise provided by the Bylaws or by Ordinance, the powers of CalOptima Health shall be exercised, its property controlled, and its business and affairs conducted by or under the direction of the Board of Directors; and

WHEREAS, the Board of Directors has responsibility for approving, implementing, and monitoring a Compliance Program governing CalOptima Health's operations consistent with all applicable laws, regulations, and guidelines; and

WHEREAS, the Board of Directors supports CalOptima Health's commitment to compliant, lawful, and ethical conduct, and values the importance of compliance and ethics in CalOptima Health's operations; and

WHEREAS, the Board of Directors last reviewed and approved the CalOptima Health Compliance Program on November 07, 2024, including the Compliance Plan, Code of Conduct, Anti-Fraud, Waste, and Abuse (FWA) Plan, and related Office of Compliance policies and procedures; and

WHEREAS, the Board of Directors reviews the CalOptima Health Compliance Program documents on a periodic basis to ensure the CalOptima Health Compliance Program is consistent with and updated to reflect applicable laws, regulations, and guidelines and to demonstrate the Board of Director's commitment to an effective Compliance Program.

NOW THEREFORE, BE IT RESOLVED:

Section 1. The Board of Directors hereby approves the 2026 CalOptima Health Compliance Plan, 2026 CalOptima Health Code of Conduct, 2026 CalOptima Health Anti-Fraud, Waste and Abuse (FWA) Plan and the 2026 CalOptima Health HIPAA Privacy and Security Program.

Section 2. The Board of Directors hereby approves and adopts the revised Office of Compliance policies and procedures.

Section 3. The Chief Executive Officer or his/her designee is hereby authorized and directed to implement, monitor, and enforce the 2026 CalOptima Health Compliance Plan, 2026 CalOptima Health Code of Conduct, 2026 CalOptima Health Anti-Fraud, Waste and Abuse (FWA) Plan and the 2026 CalOptima Health HIPAA Privacy and Security Program.

Section 4. These actions are effective upon the date of adoption of this Resolution.

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APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, dba CalOptima Health, this 6th day of November 2025.

AYES:
NOES:
ABSENT:
ABSTAIN:

/s/_____
Title: Chair, Board of Directors
Printed Name and Title: Isabel Becerra, Chair, CalOptima Health Board of Directors

Attest:
/s/_____
Sharon Dwiers, Clerk of the Board

Orange County Health Authority
dba CalOptima Health

~~2025~~2026 Compliance Plan

(Revised September ~~2024~~2025)

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Document maintained by: John Tanner
CalOptima Health Chief Compliance Officer

CalOptima Health - A Public Agency
505 City Parkway West | Orange, CA 92868 | www.CalOptimaHealth.org
Main: 714-246-8400 | TTY: 711

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Introduction

At the Orange County Health Authority, dba CalOptima Health, we are committed to conducting our operations in compliance with ethical standards, contractual obligations, and all applicable statutes, regulations, and rules, including those pertaining to Medi-Cal, Medicare Advantage Prescription Drug plan (MAPD), Program of All-Inclusive Care for the Elderly (PACE), and other CalOptima Health Programs.

A key aspect of fulfilling the mission of CalOptima Health is serving our member's health with excellence and dignity, respecting the value and needs of each person in compliance with the rules and regulations applicable to CalOptima Health's programs. We realize health plan compliance can be complicated with its many regulatory requirements. CalOptima Health maintains up to date Policies and Procedures to help staff understand and comply with all required regulations. Additionally, the CalOptima Health Office of Compliance is here to help and support staff in understanding the regulations.

You, the CalOptima Health Board of Directors (hereafter, "Board") Member, Employee, Contractor, or First Tier, Downstream, and Related Entity (FDR), are the most important elements of the Compliance Program. It is important to understand that compliance is everyone's responsibility. If you become aware of a potential non-compliant or unethical matter, we are relying on you to raise your concerns without any fear of intimidation or retaliation. We encourage you to discuss your concerns with your leadership. If for any reason you do not feel comfortable discussing an issue with your leadership, please contact the Office of Compliance by reaching out directly to the Chief Compliance Officer (CCO) or another member of the compliance team.

You also have the option to anonymously report issues to the:

Compliance and Ethics Hotline at 1-855-507-1805

This is a service that is operated by an independent third party. Issues reported to the Hotline will be confidentially routed to the CalOptima Health Office of Compliance for investigation. You can choose to report anonymously and no identifying information will be forwarded to CalOptima Health. **CalOptima Health maintains a non-retaliation policy to protect individuals who report suspected non-compliance or Fraud, Waste, and Abuse (FWA) issues in good faith.** CalOptima Health takes violations of CalOptima Health's non-retaliation policy seriously, and the Chief Compliance Officer will review and enforce disciplinary and/or other appropriate action for violations, as appropriate, with the approval of the Compliance Committee.

This Compliance Plan is a key aspect of our overall Compliance Program. Review the Compliance Plan and consider it as the framework for compliance in your work at or with CalOptima Health.

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THE COMPLIANCE PROGRAM

CalOptima Health has developed a comprehensive Compliance Plan applicable to all of CalOptima Health's programs, including, but not limited to, its Medi-Cal, MAPD, PACE, and other CalOptima Health Programs. The Compliance Plan in conjunction with our Code of Conduct and Policies and Procedures constitutes our Compliance Program and incorporates the seven elements of an effective Compliance Program as recommended by the Department of Health and Human Services (DHHS) Office of Inspector General (OIG) to meet the Medicare and Medi-Cal regulations.

SEVEN ELEMENTS

1. **Code of Conduct, Written Policies and Procedures**
2. **Compliance Officer, Compliance Committee, High-Level Oversight**
3. **Effective Training and Education**
4. **Effective Lines of Communication**
5. **Well-Publicized Disciplinary Standards**
6. **Effective System for Routine Monitoring. Auditing, and Identification of Compliance Risks**
7. **Procedures and Systems for Prompt Response to Compliance Issues**

The Compliance Plan is continually evolving and may be modified and enhanced based on compliance monitoring and identification of new areas of operational, regulatory, or legal risk, but not less than annually. CalOptima Health makes this Compliance Plan available to the Board, employees, contractors, and FDRs. All Board Members, employees, and contractors are required to read the Compliance Plan including the Code of Conduct and conduct themselves in accordance with the requirements of the Compliance Program. FDRs have the option to adopt CalOptima Health's Compliance Plan, Code of Conduct, and Compliance Policies and Procedures, or ~~with the approval of CalOptima Health~~, the FDR may follow their own Compliance Plan, Code of Conduct, and Compliance Policies and Procedures. In those instances, the FDRs must either attest to receipt and review of the CalOptima Health program documents, or equivalent materials. Throughout this document, when referencing these materials and FDRs, it means CalOptima Health materials or the FDR equivalent.

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Compliance Program Seven Elements

I. CODE OF CONDUCT, WRITTEN POLICIES AND PROCEDURES

a. Code of Conduct

The Code of Conduct is CalOptima Health's foundational document detailing fundamental principles, values, and the framework for business practices within and applicable to CalOptima Health. The objective of the Code of Conduct is to provide guiding principles to Board Members, employees, contractors, and FDRs in conducting their business activities in a professional, ethical, and lawful manner.

Reporting Non-Compliance: One of the most fundamental aspects of the Code of Conduct is the **requirement** that all Board Members, employees, contractors, and FDRs **promptly report** any suspected FWA or noncompliance with applicable regulations or CalOptima Health policies. This can be accomplished by reporting directly to your supervisor or management, the Compliance Department, or the CalOptima Health Chief Compliance Officer. If requested, a reported issue will be treated in a confidential manner, to the extent possible. If the individual reporting the issue wants to remain anonymous, they can call the Compliance and Ethics Hotline at **1-855-507-1805**, seven (7) days a week, 24 hours a day**.** This service is managed by an independent third party.

Non-Retaliation: CalOptima Health maintains a strict non-retaliation policy to protect individuals who report suspected non-compliance or FWA issues in good faith. CalOptima Health takes violations of CalOptima Health's non-retaliation policy seriously, and the Chief Compliance Officer will review and enforce disciplinary and/or other appropriate action for violations, as appropriate, with the approval of the Compliance Committee.

The Code of Conduct is a separate document from the Compliance Plan and can be found on ~~the~~ CalOptima Health's InfoNet at *https://caloptima.sharepoint.com/sites/OfficeofCompliance* or on the CalOptima Health website at *https://www.caloptima.org/en/about-us/transparency/compliance*~~*https://www.caloptima.org/en/About/GeneralCompliance/GeneralComplianceResourceLinks*~~. -The Code of Conduct is approved by the Board and distributed to Board Members, employees, contractors, and FDRs upon appointment, hire, or the commencement of the contract, and annually thereafter. New Board Members, employees, contractors, and FDRs are required to sign an attestation acknowledging receipt and review of the Code of Conduct within ninety (90) calendar days of the appointment, hire, or commencement of the contract, and annually thereafter.

b. Compliance Plan

As noted above, this Compliance Plan outlines how contractual and legal standards are reviewed and implemented throughout the organization and communicated to the Board, employees, contractors, and FDRs. This Compliance Plan also includes a comprehensive section articulating

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CalOptima Health's commitment to preventing FWA, and setting forth guidelines and procedures designed to detect, prevent, and remediate FWA in the administration of CalOptima Health Programs. This Compliance Plan allows the Compliance Program to act independently of operational and program areas without fear of repercussions for uncovering deficiencies or noncompliance.

The Compliance Plan is available on CalOptima Health's external website for Board Members and FDRs, as well as on CalOptima Health's intranet site, which is accessible to all employees (InfoNet).

c. Policies and Procedures

CalOptima Health has developed written Policies and Procedures to address specific areas of CalOptima Health's operations, compliance activities, and FWA prevention, detection, and remediation to ensure CalOptima Health can effectively adhere to all applicable laws, regulations, and guidelines. These Policies and Procedures are designed to provide guidance to Board Members, employees, contractors, and FDRs concerning compliance expectations and outline processes on how to identify, report, investigate, and/or resolve suspected, detected, or reported compliance issues. Board Members, employees, contractors, and FDRs are expected to be familiar with the Policies and Procedures pertinent to their respective roles and responsibilities and are expected to perform their responsibilities in compliance with ethical standards, contractual obligations, and applicable law. The Chief Compliance Officer, or his/her designee, will ensure that Board Members, employees, contractors, and FDRs are informed of applicable policy requirements, and that such dissemination of information is documented and retained, in accordance with applicable record retention standards.

CalOptima Health Policies and Procedures are reviewed annually and updated, as needed, depending on state and federal regulatory changes and/or operational improvements to address identified risk factors. Changes to CalOptima Health's Policies and Procedures are reviewed and approved by CalOptima Health's Policy Review Committee. The Policy Review Committee, comprised of executive officers and key management staff, regularly reviews, and approves proposed changes to CalOptima Health's Policies and Procedures. Board Members, employees, contractors, and FDRs receive notice when Policies and Procedures are updated via a monthly memorandum. All CalOptima Health Policies and Procedures are available to Board Members, employees, contractors and FDRs on the InfoNet and the CalOptima Health website.

II. COMPLIANCE OFFICER, COMPLIANCE COMMITTEE, HIGH LEVEL OVERSIGHT

a. Governing Body

The Board, as the Governing authority, is responsible for approving, implementing, and Monitoring the Compliance Program governing CalOptima Health's operations. The Board delegates the Compliance Program oversight and day-to-day compliance activities to the Chief Executive Officer (CEO), who then delegates such oversight and activities to the Chief Compliance Officer. The Chief Compliance Officer is an employee of CalOptima Health, who

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handles compliance oversight and activities full-time. The Chief Compliance Officer, in conjunction with the Compliance Committee, are both accountable for the oversight and reporting roles and responsibilities as set forth in this Compliance Plan. However, the Board remains accountable for ensuring the effectiveness of the Compliance Program within CalOptima Health and Monitoring the status of the Compliance Program to ensure its efficient and successful implementation. The Board reviews and approves the Compliance Plan, Code of Conduct and Compliance Policies and Procedures annually.

b. Compliance Officer

The Chief Compliance Officer is a full-time employee of CalOptima Health and coordinates and communicates all assigned compliance activities and programs. This includes but is not limited to, developing, implementing, and monitoring the day-to-day activities of the Compliance Program. The Chief Compliance Officer reports directly to the CEO and the Compliance Committee and to the Board and is Chair of the Compliance Committee. In this capacity the Chief Compliance officer reports on the activities and status of the Compliance Program. The Chief Compliance Officer has the authority to escalate issues of concern directly to the Board and acts independently of operational and program areas without fear of repercussions for uncovering deficiencies or noncompliance. Furthermore, the Chief Compliance Officer oversees that CalOptima Health meets all state and federal regulatory and contractual requirements. The Chief Compliance Officer, or his or her designee, shall also act as the Fraud Prevention Officer.

The Chief Compliance Officer interacts with the Board, CEO, CalOptima Health's executive staff and departmental management, FDRs, legal counsel, state and federal representatives, and others as required. In addition, the Chief Compliance Officer supervises the Office of Compliance, which includes compliance professionals with expertise and responsibilities for the following areas: Medi-Cal and Medicare Regulatory Affairs & Compliance, FWA, Privacy, Internal Auditing and Monitoring, Policies and Procedures, and training on compliance activities.

c. Compliance Committee

The Compliance Committee, chaired by the Chief Compliance Officer, is composed of CalOptima Health's executive staff including but not limited to the Chief Executive Officer, Chief Operating Officer, Chief Information Officer, Chief Medical Officer, and Chief Financial Officer. The role of the Compliance Committee is to oversee and ensure the implementation of the Compliance Program and to participate in carrying out the provisions of this Compliance Plan. The Compliance Committee meets at least on a quarterly basis, or more frequently as necessary, to ensure reasonable oversight of the Compliance Program.

The Board delegates the following responsibilities to the Compliance Committee:

- Maintain and update the Code of Conduct consistent with regulatory requirements and/or operational changes, subject to the ultimate approval by the Board.
- Maintain and update the Compliance Plan, on an annual basis, consistent with regulatory requirements and/or operational changes, subject to the ultimate approval by the Board

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- ► Maintain written notes, records, correspondence, or minutes (as appropriate) of Compliance Committee meetings reflecting reports made to the Compliance Committee and the Compliance Committee's decisions on the issues raised (subject to all applicable privileges).
- ► Review and monitor the effectiveness of the Compliance Program, including Monitoring key performance reports and metrics, evaluating business and administrative operations, and overseeing the creation, implementation, and development of corrective and preventive action(s) to ensure they are prompt and effective.
- ► Recommend and monitor the development of internal systems and controls to implement CalOptima Health's standards and Policies and Procedures as part of its daily operations.
- ► Determine the appropriate strategy and/or approach to promote compliance and detect potential violations and advise the Chief Compliance Officer accordingly.
- ► Review and address reports of monitoring and auditing of areas in which CalOptima Health is at risk of program non-compliance and/or potential FWA and ensure Corrective Action Plans (CAPs) and Immediate Corrective Action Plans (ICAPs) are implemented and monitored for effectiveness.

III. EFFECTIVE TRAINING AND EDUCATION

Training and education are important elements in CalOptima Health's overall Compliance Program. The following trainings must be completed by Board Members, employees, contractors, and FDRs within ninety (90) calendar days of hire, appointment, or commencement of the contract, as applicable, and annually thereafter:

- **Code of Conduct**
- **General Compliance**
- **FWA**
- **HIPAA Privacy Compliance**

Adherence to the Compliance Program requirements, including training requirements, shall be a condition of employment and a factor in the annual performance evaluation of each Employee.

Specialized education courses are assigned to individuals based on their respective roles or positions within or with CalOptima Health's departments and its programs. Examples include, but are not limited to, the fundamentals of managing Seniors and People with Disabilities (SPD) and cultural competency.

a. Compliance Training for FDRs

All FDRs that provide services to Medi-Cal and Medicare Advantage Part D members, are to complete compliance and FWA training through their own internal compliance program or by using training materials supplied by CalOptima Health.

b. Tracking Required Compliance Training

The Chief Compliance Officer, or his/her designee, is responsible for coordinating compliance education and training programs, and ensuring that records evidencing an individual's/FDR's completion of the training requirements are documented and maintained, such as sign-in sheets,

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attestations, or electronic certifications, as required by law. The Chief Compliance Officer, CalOptima Health executive staff, management, and the Clerk of the Board are responsible for ensuring that Board Members, employees, contractors, and FDRs complete training on an annual basis.

CalOptima Health's Human Resources Department utilizes state of the art web-based training courses that emphasize CalOptima Health's commitment to the Compliance Program, and updates courses regularly to ensure that employees are kept fully informed about any changes in procedures, regulations, and requirements.

IV. EFFECTIVE LINES OF COMMUNICATION – REPORTING NON-COMPLIANCE

CalOptima Health works diligently to foster a culture of compliance throughout the organization by regularly communicating the importance of regulatory requirements and reinforcement of company expectations for ethical and lawful behavior.

CalOptima Health shall maintain and communicate that systems are in place to receive, record, and respond to reports of potential or actual non-compliance from employees, contractors, members, providers, vendors, FDRs, and subcontractors.

a. Compliance and Ethics Hotline, Website and Email

The CalOptima Health's hotline is a confidential, toll-free resource available to employees, contractors, members, providers, vendors, FDRs, and the general public 24 hours a day, seven (7) days a week to report violations of, or raise questions or concerns relating to, non-compliance, unethical behavior, and/or suspected FWA. These reporting mechanisms may be used by all stakeholders of CalOptima Health.

Reporting mechanisms include the following:

Compliance and Ethics Hotline

1-855-507-1805

- Website: caloptima.org
- Email: Compliance@caloptima.org

The hotline and the online "Compliance and Fraud, Waste and Abuse Reporting Form" may be completed anonymously. These communications are never traced. **Anyone can make a report without fear of intimidation or retaliation.**

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b. Report Directly to Management and Executive Staff

CalOptima Health employees are encouraged to contact their immediate management or executive staff when non-compliant activity is suspected or observed. In other words, **if you see something, say something.** A report should be made immediately upon suspecting or identifying the potential or suspected unethical behavior, non-compliance, or violation. Executive staff or management will promptly escalate the report to the Chief Compliance Officer for further investigation and reporting to the CalOptima Health Compliance Committee. If an Employee is concerned that his/her management or executive staff did not adequately address his/her report or complaint, the Employee may go directly to the Chief Compliance Officer, or the Office of the CEO. If for any reason an employee does not feel comfortable discussing an issue with leadership, they may contact Compliance by reaching out directly to the Chief Compliance Officer (CCO) or another member of the compliance team. Employees also always have the **option to anonymously** report issues to the:

Compliance and Ethics Hotline

1-855-507-1805

CalOptima Health educates Board Members, employees and FDRs about CalOptima Health's hotline and online form through:

1) Compliance/FWA training
2) CalOptima Health's intranet (referred to as InfoNet)
3) Posters displayed in common work areas
4) CalOptima Health's Policies and Procedures
5) Newsletters, emails, and other means of communication

c. Confidentiality and Non-Retaliation

CalOptima Health maintains and supports a non-retaliation policy governing good faith reports of suspected, or actual, non-compliance and/or FWA. Every effort will be made to keep reports confidential to the extent permitted by applicable law and circumstances, but there may be some instances where the identity of the individual making the report will have to be disclosed. As a result, CalOptima Health has implemented and enforces a non-retaliation policy to protect individuals who report suspected or actual non-compliance, or FWA, issues in good faith. This non-retaliation policy extends to reports received from FDRs and members. CalOptima Health's non-retaliation policy is communicated along with reporting instructions by posting information on the CalOptima Health InfoNet and website, as well as sending periodic member notifications.

CalOptima Health also takes violations of CalOptima Health's non-retaliation policy seriously, and the Chief Compliance Officer will review and enforce disciplinary and/or other CAPs for violations, as appropriate, with the approval of the Compliance Committee.

V. ENFORCEMENT AND DISCIPLINARY STANDARDS

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a. Conduct Subject to Enforcement and Discipline

Board Members, employees, contractors, and FDRs are subject to appropriate disciplinary and/or corrective actions if they have violated CalOptima Health's standards, requirements, or applicable laws as specified and detailed in the Compliance Program documents and related Policies and Procedures. Board Members, employees, contractors, and FDRs may be disciplined or sanctioned, as applicable, for failing to adhere to CalOptima Health's Compliance Program and/or violating standards, regulatory requirements, and/or applicable laws, including, but not limited to:

- Conduct that leads to the filing of a false or improper claim in violation of federal or state laws and/or contractual requirements.
- Conduct resulting in a violation of any other federal or state laws or contractual requirements relating to participation in Federal and/or State Health Care Programs.
- Failure to perform any required obligation relating to compliance with the Compliance Program, applicable laws, Policies and Procedures, and/or contracts.
- Failure to report violations or suspected violations of the Compliance Program, or applicable laws, or to report suspected or actual FWA issues to an appropriate person through one of the reporting mechanisms.
- Conduct that violates HIPAA and other privacy laws and/or CalOptima Health's HIPAA Privacy and Security Program and policies, including actions that harm the privacy of members, or the CalOptima Health information systems that store member data.

b. Enforcement and Discipline

CalOptima Health maintains a "zero tolerance" policy towards any illegal, or unethical, conduct that impacts the operation, mission, or image of CalOptima Health. The standards established in the Compliance Program shall be enforced consistently through appropriate disciplinary actions. Individuals, or entities, may be disciplined by way of reprimand, suspension, financial penalties, sanctions, and/or termination, depending on the nature and severity of the conduct, or behavior. Board Members may be subject to removal, employees and contractors are subject to discipline, up to and including termination, and FDRs may be Sanctioned, or contracts may be terminated, where permitted. Violations of applicable laws and regulations, even unintentional, could potentially subject individuals, entities, or CalOptima Health to civil, criminal, or administrative sanctions and/or penalties. Further violations could lead to suspension, Preclusion, or Exclusion, from participation in Federal and/or State Health Care Programs.

CalOptima Health employees shall be evaluated annually based on their compliance with CalOptima Health's Compliance Program. Where appropriate, CalOptima Health shall promptly initiate education and training to correct identified problems, or behaviors.

VI. EFFECTIVE SYSTEM FOR ROUTINE MONITORING, AUDITING, AND IDENTIFICATION OF COMPLIANCE RISKS

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Monitoring and Auditing can help prevent, detect, and correct non-compliance with applicable federal and/or state requirements. A risk assessment serves as a tool for determining levels of risk and serves as a guide for which monitoring and auditing activities are performed to assess ongoing levels of compliance.

Routine Monitoring and Auditing of CalOptima Health Operations

The routine monitoring and auditing of CalOptima Health's operations is conducted by the Internal Audit Department under the Office of Compliance.

a. Risk Assessment

A Compliance Risk Assessment will be performed no less than annually to evaluate the current status of CalOptima Health's operational areas.

Operations and processes will be evaluated based on:

1) Deficiencies found by regulatory agencies
2) Deficiencies found by internal and external audit and monitoring reports
3) Institution of new or updated Policies and Procedures and/or regulations/guidance.
4) Cross departmental interdependencies
5) Significant management or organizational changes and/or significant systems changes
6) The OIG Work Plan
7) Monitoring dashboard trends

The Director of the Internal Audit Department, or his/her designee, will work with the operational areas, to identify and assess compliance risks. The risk assessment process will be managed by the Director of the Internal Audit Department-, or his/her designee, and presented to the Compliance Committee, for review and approval. The risk assessment shall also be updated as processes change or are identified as being deficient.

b. Monitoring and Auditing

The Audit Work Plan (AWP) is developed based on the results of the risk assessment. Internal auditing and monitoring activities are employed to test and verify compliance with all applicable regulations, guidance, contractual agreements, and federal and state laws, as well as CalOptima Health Policies and Procedures. The AWP includes:

1. Audits to be performed including estimated time frames
2. Audit methodologies
3. Necessary resources
4. Person(s) responsible
5. Final audit reports
6. Follow-up activities from findings including CAPs (when applicable)

The Internal Audit Department -manages a dashboard of key compliance metrics that serves as a monitoring tool to track performance compliance for such items as coverage determinations,

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complaints, appeals, grievances, regulatory communications, credentialing, customer service, transition of coverage (TOC), and claims. The Internal Audit Department performs audits based on the AWP. The monitoring and auditing results are communicated to executive staff, the Compliance Committee, and the Board.

In addition, an Audit of the Compliance Program and its effectiveness is conducted by an independent third party annually, and the results are reported to the Compliance Committee~~,~~ and the Board.

Routine Monitoring and Auditing of First-tier, Downstream, and Related party entities (FDRs)

c. FDR Annual Risk Assessment

The Director~~,~~ of the Delegation Oversight Department, or his/her designee will conduct an annual comprehensive risk assessment to determine an FDR's vulnerabilities and high-risk areas. High-risk FDRs are those that are continually non-compliant or at risk of non-compliance based on identified gaps in processes with regulatory and CalOptima Health requirements. Any previously identified issues, which include any corrective actions, low service level performance, reported detected offenses, and/or complaints and appeals from the previous year will be factors that are included in the risk assessment. Any FDR deemed a high risk or vulnerable, is presented to the Chief Compliance Officer to collaborate in determining appropriate follow-up. FDRs determined to be high-risk may be subjected to a more frequent monitoring and auditing schedule, as well as additional reporting requirements. The risk assessment process, along with reports from FDRs, will be managed by the Director, Delegation Oversight, or his/her designee, and presented to the Compliance Committee for review and discussion.

d. FDR Monitoring and Auditing

An FDR AWP is developed based on the results of the FDR risk assessment. Auditing and Monitoring Activities are employed to test and verify compliance with all applicable regulations, guidance, contractual agreements, and federal and state laws, as well as applicable CalOptima Health Policies and Procedures or equivalent. The FDR AWP includes:

1. Audits to be performed including estimated time frames
2. Audit methodologies
3. Necessary resources
4. Person(s) responsible
5. Final audit reports
6. Follow-up activities from findings including CAPs (when applicable)

The Delegation Oversight Department manages a dashboard of key compliance metrics that serves as a monitoring tool to track compliant performance of FDRs' case management, credentialing, claims, and utilization management. Delegation Oversight performs audits as per the FDR AWP. The monitoring and auditing results are communicated to executive staff, the Compliance Committee, and the Board.

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e. Regular Exclusion and Preclusion Screening

CalOptima Health performs Participation Status Reviews by searching the OIG–LEIE, the GSA–SAM, the DHCS Medi-Cal Suspended & Ineligible Provider Lists, Medi-Cal Restricted Provider Database (RPD), Medi-Cal Procedure/Drug Code Limitation List, and the CMS Preclusion List upon appointment, hire, or commencement of a contract, as applicable, and monthly thereafter, to ensure Board Members, employees, contractors, Providers and/or FDRs are not suspended, excluded, or do not become excluded or precluded from participating in Federal and/or State Health Care Programs. Board Members, employees, contractors, Providers, and FDRs are required to disclose their participation status as part of their initial appointment, employment, commencement of the contract and registration/application processes and if they receive a notice of a suspension, Preclusion, Exclusion, or debarment during the period of appointment, employment, or contract term. CalOptima Health also requires that its First Tier Entities comply with Participation Status Review requirements with respect to their relationships with Downstream Entities, including without limitation, the delegated credentialing and re-credentialing processes.

VII. PROCEDURES AND SYSTEMS FOR PROMPT REPONSE TO COMPLIANCE ISSUES

CalOptima Health takes corrective actions when there is a confirmed incident of non-compliance. CalOptima Health may identify the incident of non-compliance through a variety of sources, such as self-reporting, governmental audits, internal audits, hotline calls, external audits, or member complaints, either directly to CalOptima Health or through governmental units. Whenever CalOptima Health identifies an issue of non-compliance or potential FWA, it is investigated and resolved.

The Chief Compliance Officer and/or Director of FWA, in conjunction with the Office of Compliance, FWA Department and other key staff, are responsible for reviewing cases of non-compliance and suspected activity, and for disclosing such issues to the appropriate authority, when applicable. Because of the complex nature of some issues that may be reported or identified, the investigation may be delegated to the appropriate internal expert.

When a material issue of non-compliance is discovered or a department's process or system results in non-compliance with regulatory requirements, the business area may be required to implement a formal CAP which is overseen by the Office of Compliance. The CAP promotes the correction of the identified issue in a timely manner. Corrective actions may include revising processes, updating policies or procedures, retraining staff, reviewing systems edits and/or addressing other root causes. The CAP must achieve sustained compliance with the overall requirements for that specific operational department.

The status of open CAPs is reviewed by the Office of Compliance on a monthly basis, or at a frequency determined by the Chief Compliance Officer. The Office of Compliance monitors CAP implementation and requires that business departments regularly report the completion of all interim actions. The Office of Compliance tracks the duration of open CAPs and

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intervenes as appropriate to promote timely completion. Once a CAP is ~~complete~~completed, the Office of Compliance may validate the corrective actions by auditing individual action items over a period of time to confirm compliance and the effectiveness of the implemented corrective actions. A summary of CAP activity is periodically reported to executive staff and the Compliance Committee.

CalOptima Health's oversight of FDRs includes a requirement that FDRs submit a CAP when material deficiencies are identified through Delegation Oversight audits, ongoing monitoring and/or self-reporting. CalOptima Health takes appropriate action against any contracted organization that does not comply with a CAP or does not meet its regulatory obligations, up to and including termination of its agreement. FDRs are bound contractually through written agreements with CalOptima Health that stipulate compliance with governmental requirements and include provisions for termination for failure to cure performance deficiencies.

CalOptima Health's Compliance Plan is effective in promoting compliance and controlling FWA at both the sponsor and FDR/Subcontractor levels in managing the Medi-Cal and Medicare programs. Policies and procedures associated with this Compliance Plan further expand the activities and oversight of the program.

a. Referral to Enforcement Agencies

In appropriate circumstances, CalOptima Health shall report violations of Medi-Cal Program requirements to DHCS Audits and Investigations, violations of Medicare Program requirements to the Medicare Drug Integrity Contractor (MEDIC), and violations of other state and federal laws to the appropriate law enforcement agencies, in accordance with the applicable reporting procedures adopted by such enforcement agencies.

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FRAUD, WASTE, AND ABUSE (FWA) PREVENTION AND DETECTION

The detection, prevention, and remediation of FWA are components of CalOptima Health's Compliance Program. FWA activities are implemented and overseen by CalOptima Health's Chief Compliance Officer in conjunction with the Director, FWA or his/her designee, in conjunction with other compliance activities. Investigations are performed, or overseen, by the Special Investigations Unit (SIU), an internal investigative unit within CalOptima Health's Office of Compliance, responsible for FWA investigations. The Chief Compliance Officer, and/or his/her designee, shall attend the quarterly DHCS Program Integrity meetings, as scheduled. The Chief Compliance Officer, or his/her designee, reports FWA activities to the CalOptima Health Compliance Committee, the Office of the CEO, the Board, and Regulatory Agencies.

CalOptima Health utilizes various resources to detect, prevent, and remediate FWA. In addition, CalOptima Health promptly investigates suspected FWA issues and may implement disciplinary or corrective action to avoid recurrence of FWA issues. The objective of the Anti-Fraud, Waste, Abuse (FWA) Plan is to ensure that the scope of benefits covered by CalOptima Health Programs are appropriately delivered to members and resources are effectively utilized in accordance with federal and state guidelines. CalOptima Health incorporates a system of internal assessments which are organized to identify FWA and promptly respond appropriately to such incidents of FWA. See the CalOptima Health Anti-Fraud, Waste and Abuse (FWA) Plan for further details.

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Orange County Health Authority
dba CalOptima Health

2026 Compliance Plan

(Revised September 2025)

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Document maintained by: John Tanner
CalOptima Health Chief Compliance Officer

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Introduction

At the Orange County Health Authority, dba CalOptima Health, we are committed to conducting our operations in compliance with ethical standards, contractual obligations, and all applicable statutes, regulations, and rules, including those pertaining to Medi-Cal, Medicare Advantage Prescription Drug plan (MAPD), Program of All-Inclusive Care for the Elderly (PACE), and other CalOptima Health Programs.

A key aspect of fulfilling the mission of CalOptima Health is serving our member's health with excellence and dignity, respecting the value and needs of each person in compliance with the rules and regulations applicable to CalOptima Health's programs. We realize health plan compliance can be complicated with its many regulatory requirements. CalOptima Health maintains up to date Policies and Procedures to help staff understand and comply with all required regulations. Additionally, the CalOptima Health Office of Compliance is here to help and support staff in understanding the regulations.

You, the CalOptima Health Board of Directors (hereafter, "Board") Member, Employee, Contractor, or First Tier, Downstream, and Related Entity (FDR), are the most important elements of the Compliance Program. It is important to understand that compliance is everyone's responsibility. If you become aware of a potential non-compliant or unethical matter, we are relying on you to raise your concerns without any fear of intimidation or retaliation. We encourage you to discuss your concerns with your leadership. If for any reason you do not feel comfortable discussing an issue with your leadership, please contact the Office of Compliance by reaching out directly to the Chief Compliance Officer (CCO) or another member of the compliance team.

You also have the option to anonymously report issues to the:

Compliance and Ethics Hotline at 1-855-507-1805

This is a service that is operated by an independent third party. Issues reported to the Hotline will be confidentially routed to the CalOptima Health Office of Compliance for investigation. You can choose to report anonymously and no identifying information will be forwarded to CalOptima Health. **CalOptima Health maintains a non-retaliation policy to protect individuals who report suspected non-compliance or Fraud, Waste, and Abuse (FWA) issues in good faith.** CalOptima Health takes violations of CalOptima Health's non-retaliation policy seriously, and the Chief Compliance Officer will review and enforce disciplinary and/or other appropriate action for violations, as appropriate, with the approval of the Compliance Committee.

This Compliance Plan is a key aspect of our overall Compliance Program. Review the Compliance Plan and consider it as the framework for compliance in your work at or with CalOptima Health.

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THE COMPLIANCE PROGRAM

CalOptima Health has developed a comprehensive Compliance Plan applicable to all of CalOptima Health's programs, including, but not limited to, its Medi-Cal, MAPD, PACE, and other CalOptima Health Programs. The Compliance Plan in conjunction with our Code of Conduct and Policies and Procedures constitutes our Compliance Program and incorporates the seven elements of an effective Compliance Program as recommended by the Department of Health and Human Services (DHHS) Office of Inspector General (OIG) to meet the Medicare and Medi-Cal regulations.

SEVEN ELEMENTS

1. **Code of Conduct, Written Policies and Procedures**
2. **Compliance Officer, Compliance Committee, High-Level Oversight**
3. **Effective Training and Education**
4. **Effective Lines of Communication**
5. **Well-Publicized Disciplinary Standards**
6. **Effective System for Routine Monitoring. Auditing and Identification of Compliance Risks**
7. **Procedures and Systems for Prompt Response to Compliance Issues**

The Compliance Plan is continually evolving and may be modified and enhanced based on compliance monitoring and identification of new areas of operational, regulatory, or legal risk, but not less than annually. CalOptima Health makes this Compliance Plan available to the Board, employees, contractors, and FDRs. All Board Members, employees, and contractors are required to read the Compliance Plan including the Code of Conduct and conduct themselves in accordance with the requirements of the Compliance Program. FDRs have the option to adopt CalOptima Health's Compliance Plan, Code of Conduct, and Compliance Policies and Procedures, or, the FDR may follow their own Compliance Plan, Code of Conduct, and Compliance Policies and Procedures. In those instances, the FDRs must either attest to receipt and review of the CalOptima Health program documents, or equivalent materials. Throughout this document, when referencing these materials and FDRs, it means CalOptima Health materials or the FDR equivalent.

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Compliance Program Seven Elements

I. CODE OF CONDUCT, WRITTEN POLICIES AND PROCEDURES

a. Code of Conduct

The Code of Conduct is CalOptima Health's foundational document detailing fundamental principles, values, and the framework for business practices within and applicable to CalOptima Health. The objective of the Code of Conduct is to provide guiding principles to Board Members, employees, contractors, and FDRs in conducting their business activities in a professional, ethical, and lawful manner.

Reporting Non-Compliance: One of the most fundamental aspects of the Code of Conduct is the **requirement** that all Board Members, employees, contractors, and FDRs **promptly report** any suspected FWA or noncompliance with applicable regulations or CalOptima Health policies. This can be accomplished by reporting directly to your supervisor or management, the Compliance Department, or the CalOptima Health Chief Compliance Officer. If requested, a reported issue will be treated in a confidential manner, to the extent possible. If the individual reporting the issue wants to remain anonymous, they can call the Compliance and Ethics Hotline at **1-855-507-1805**, seven (7) days a week, 24 hours a day**.** This service is managed by an independent third party.

Non-Retaliation: CalOptima Health maintains a strict non-retaliation policy to protect individuals who report suspected non-compliance or FWA issues in good faith. CalOptima Health takes violations of CalOptima Health's non-retaliation policy seriously, and the Chief Compliance Officer will review and enforce disciplinary and/or other appropriate action for violations, as appropriate, with the approval of the Compliance Committee.

The Code of Conduct is a separate document from the Compliance Plan and can be found on CalOptima Health's InfoNet at *https://caloptima.sharepoint.com/sites/OfficeofCompliance* or on the CalOptima Health website at *https://www.caloptima.org/en/about-us/transparency/compliance*. The Code of Conduct is approved by the Board and distributed to Board Members, employees, contractors, and FDRs upon appointment, hire, or the commencement of the contract, and annually thereafter. New Board Members, employees, contractors, and FDRs are required to sign an attestation acknowledging receipt and review of the Code of Conduct within ninety (90) calendar days of the appointment, hire, or commencement of the contract, and annually thereafter.

b. Compliance Plan

As noted above, this Compliance Plan outlines how contractual and legal standards are reviewed and implemented throughout the organization and communicated to the Board, employees, contractors, and FDRs. This Compliance Plan also includes a comprehensive section articulating CalOptima Health's commitment to preventing FWA, and setting forth guidelines and

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procedures designed to detect, prevent, and remediate FWA in the administration of CalOptima Health Programs. This Compliance Plan allows the Compliance Program to act independently of operational and program areas without fear of repercussions for uncovering deficiencies or noncompliance.

The Compliance Plan is available on CalOptima Health's external website for Board Members and FDRs, as well as on CalOptima Health's intranet site, which is accessible to all employees (InfoNet).

c. Policies and Procedures

CalOptima Health has developed written Policies and Procedures to address specific areas of CalOptima Health's operations, compliance activities, and FWA prevention, detection, and remediation to ensure CalOptima Health can effectively adhere to all applicable laws, regulations, and guidelines. These Policies and Procedures are designed to provide guidance to Board Members, employees, contractors, and FDRs concerning compliance expectations and outline processes on how to identify, report, investigate, and/or resolve suspected, detected, or reported compliance issues. Board Members, employees, contractors, and FDRs are expected to be familiar with the Policies and Procedures pertinent to their respective roles and responsibilities and are expected to perform their responsibilities in compliance with ethical standards, contractual obligations, and applicable law. The Chief Compliance Officer, or his/her designee, will ensure that Board Members, employees, contractors, and FDRs are informed of applicable policy requirements, and that such dissemination of information is documented and retained, in accordance with applicable record retention standards.

CalOptima Health Policies and Procedures are reviewed annually and updated, as needed, depending on state and federal regulatory changes and/or operational improvements to address identified risk factors. Changes to CalOptima Health's Policies and Procedures are reviewed and approved by CalOptima Health's Policy Review Committee. The Policy Review Committee, comprised of executive officers and key management staff, regularly reviews, and approves proposed changes to CalOptima Health's Policies and Procedures. Board Members, employees, contractors, and FDRs receive notice when Policies and Procedures are updated via a monthly memorandum. All CalOptima Health Policies and Procedures are available to Board Members, employees, contractors and FDRs on the InfoNet and the CalOptima Health website.

II. COMPLIANCE OFFICER, COMPLIANCE COMMITTEE, HIGH LEVEL OVERSIGHT

a. Governing Body

The Board, as the Governing authority, is responsible for approving, implementing, and Monitoring the Compliance Program governing CalOptima Health's operations. The Board delegates the Compliance Program oversight and day-to-day compliance activities to the Chief Executive Officer (CEO), who then delegates such oversight and activities to the Chief Compliance Officer. The Chief Compliance Officer is an employee of CalOptima Health, who handles compliance oversight and activities full-time. The Chief Compliance Officer, in

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conjunction with the Compliance Committee, are both accountable for the oversight and reporting roles and responsibilities as set forth in this Compliance Plan. However, the Board remains accountable for ensuring the effectiveness of the Compliance Program within CalOptima Health and Monitoring the status of the Compliance Program to ensure its efficient and successful implementation. The Board reviews and approves the Compliance Plan, Code of Conduct and Compliance Policies and Procedures annually.

b. Compliance Officer

The Chief Compliance Officer is a full-time employee of CalOptima Health and coordinates and communicates all assigned compliance activities and programs. This includes but is not limited to, developing, implementing, and monitoring the day-to-day activities of the Compliance Program. The Chief Compliance Officer reports directly to the CEO and the Compliance Committee and to the Board and is Chair of the Compliance Committee. In this capacity the Chief Compliance officer reports on the activities and status of the Compliance Program. The Chief Compliance Officer has the authority to escalate issues of concern directly to the Board and acts independently of operational and program areas without fear of repercussions for uncovering deficiencies or noncompliance. Furthermore, the Chief Compliance Officer oversees that CalOptima Health meets all state and federal regulatory and contractual requirements. The Chief Compliance Officer, or his or her designee, shall also act as the Fraud Prevention Officer.

The Chief Compliance Officer interacts with the Board, CEO, CalOptima Health's executive staff and departmental management, FDRs, legal counsel, state and federal representatives, and others as required. In addition, the Chief Compliance Officer supervises the Office of Compliance, which includes compliance professionals with expertise and responsibilities for the following areas: Medi-Cal and Medicare Regulatory Affairs & Compliance, FWA, Privacy, Internal Auditing and Monitoring, Policies and Procedures, and training on compliance activities.

c. Compliance Committee

The Compliance Committee, chaired by the Chief Compliance Officer, is composed of CalOptima Health's executive staff including but not limited to the Chief Executive Officer, Chief Operating Officer, Chief Information Officer, Chief Medical Officer, and Chief Financial Officer. The role of the Compliance Committee is to oversee and ensure the implementation of the Compliance Program and to participate in carrying out the provisions of this Compliance Plan. The Compliance Committee meets at least on a quarterly basis, or more frequently as necessary, to ensure reasonable oversight of the Compliance Program.

The Board delegates the following responsibilities to the Compliance Committee:

- Maintain and update the Code of Conduct consistent with regulatory requirements and/or operational changes, subject to the ultimate approval by the Board.
- Maintain and update the Compliance Plan, on an annual basis, consistent with regulatory requirements and/or operational changes, subject to the ultimate approval by the Board
- Maintain written notes, records, correspondence, or minutes (as appropriate) of Compliance Committee meetings reflecting reports made to the Compliance Committee and the Compliance Committee's decisions on the issues raised (subject to all applicable privileges).

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- ► Review and monitor the effectiveness of the Compliance Program, including Monitoring key performance reports and metrics, evaluating business and administrative operations, and overseeing the creation, implementation, and development of corrective and preventive action(s) to ensure they are prompt and effective.
- ► Recommend and monitor the development of internal systems and controls to implement CalOptima Health's standards and Policies and Procedures as part of its daily operations.
- ► Determine the appropriate strategy and/or approach to promote compliance and detect potential violations and advise the Chief Compliance Officer accordingly.
- ► Review and address reports of monitoring and auditing of areas in which CalOptima Health is at risk of program non-compliance and/or potential FWA and ensure Corrective Action Plans (CAPs) and Immediate Corrective Action Plans (ICAPs) are implemented and monitored for effectiveness.

III. EFFECTIVE TRAINING AND EDUCATION

Training and education are important elements in CalOptima Health's overall Compliance Program. The following trainings must be completed by Board Members, employees, contractors, and FDRs within ninety (90) calendar days of hire, appointment, or commencement of the contract, as applicable, and annually thereafter:

- **Code of Conduct**
- **General Compliance**
- **FWA**
- **HIPAA Privacy Compliance**

Adherence to the Compliance Program requirements, including training requirements, shall be a condition of employment and a factor in the annual performance evaluation of each Employee.

Specialized education courses are assigned to individuals based on their respective roles or positions within or with CalOptima Health's departments and its programs. Examples include, but are not limited to, the fundamentals of managing Seniors and People with Disabilities (SPD) and cultural competency.

a. Compliance Training for FDRs

All FDRs that provide services to Medi-Cal and Medicare Advantage Part D members, are to complete compliance and FWA training through their own internal compliance program or by using training materials supplied by CalOptima Health.

b. Tracking Required Compliance Training

The Chief Compliance Officer, or his/her designee, is responsible for coordinating compliance education and training programs, and ensuring that records evidencing an individual's/FDR's completion of the training requirements are documented and maintained, such as sign-in sheets, attestations, or electronic certifications, as required by law. The Chief Compliance Officer, CalOptima Health executive staff, management, and the Clerk of the Board are responsible for ensuring that Board Members, employees, contractors, and FDRs complete training on an annual

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basis.

CalOptima Health's Human Resources Department utilizes state of the art web-based training courses that emphasize CalOptima Health's commitment to the Compliance Program, and updates courses regularly to ensure that employees are kept fully informed about any changes in procedures, regulations, and requirements.

IV. EFFECTIVE LINES OF COMMUNICATION – REPORTING NON-COMPLIANCE

CalOptima Health works diligently to foster a culture of compliance throughout the organization by regularly communicating the importance of regulatory requirements and reinforcement of company expectations for ethical and lawful behavior.

CalOptima Health shall maintain and communicate that systems are in place to receive, record, and respond to reports of potential or actual non-compliance from employees, contractors, members, providers, vendors, FDRs, and subcontractors.

a. Compliance and Ethics Hotline, Website and Email

The CalOptima Health's hotline is a confidential, toll-free resource available to employees, contractors, members, providers, vendors, FDRs, and the general public 24 hours a day, seven (7) days a week to report violations of, or raise questions or concerns relating to, non-compliance, unethical behavior, and/or suspected FWA. These reporting mechanisms may be used by all stakeholders of CalOptima Health.

Reporting mechanisms include the following:

Compliance and Ethics Hotline

1-855-507-1805

- Website: caloptima.org
- Email: Compliance@caloptima.org

The hotline and the online "Compliance and Fraud, Waste and Abuse Reporting Form" may be completed anonymously. These communications are never traced. **Anyone can make a report without fear of intimidation or retaliation.**

b. Report Directly to Management and Executive Staff

CalOptima Health employees are encouraged to contact their immediate management or

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executive staff when non-compliant activity is suspected or observed. In other words, **if you see something, say something.** A report should be made immediately upon suspecting or identifying the potential or suspected unethical behavior, non-compliance, or violation. Executive staff or management will promptly escalate the report to the Chief Compliance Officer for further investigation and reporting to the CalOptima Health Compliance Committee. If an Employee is concerned that his/her management or executive staff did not adequately address his/her report or complaint, the Employee may go directly to the Chief Compliance Officer, or the Office of the CEO. If for any reason an employee does not feel comfortable discussing an issue with leadership, they may contact Compliance by reaching out directly to the Chief Compliance Officer (CCO) or another member of the compliance team. Employees also always have the **option to anonymously** report issues to the:

Compliance and Ethics Hotline

1-855-507-1805

CalOptima Health educates Board Members, employees and FDRs about CalOptima Health's hotline and online form through:

1) Compliance/FWA training
2) CalOptima Health's intranet (referred to as InfoNet)
3) Posters displayed in common work areas
4) CalOptima Health's Policies and Procedures
5) Newsletters, emails, and other means of communication

c. Confidentiality and Non-Retaliation

CalOptima Health maintains and supports a non-retaliation policy governing good faith reports of suspected, or actual, non-compliance and/or FWA. Every effort will be made to keep reports confidential to the extent permitted by applicable law and circumstances, but there may be some instances where the identity of the individual making the report will have to be disclosed. As a result, CalOptima Health has implemented and enforces a non-retaliation policy to protect individuals who report suspected or actual non-compliance, or FWA, issues in good faith. This non-retaliation policy extends to reports received from FDRs and members. CalOptima Health's non-retaliation policy is communicated along with reporting instructions by posting information on the CalOptima Health InfoNet and website, as well as sending periodic member notifications.

CalOptima Health also takes violations of CalOptima Health's non-retaliation policy seriously, and the Chief Compliance Officer will review and enforce disciplinary and/or other CAPs for violations, as appropriate, with the approval of the Compliance Committee.

V. ENFORCEMENT AND DISCIPLINARY STANDARDS

a. Conduct Subject to Enforcement and Discipline

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Board Members, employees, contractors, and FDRs are subject to appropriate disciplinary and/or corrective actions if they have violated CalOptima Health's standards, requirements, or applicable laws as specified and detailed in the Compliance Program documents and related Policies and Procedures. Board Members, employees, contractors, and FDRs may be disciplined or sanctioned, as applicable, for failing to adhere to CalOptima Health's Compliance Program and/or violating standards, regulatory requirements, and/or applicable laws, including, but not limited to:

- Conduct that leads to the filing of a false or improper claim in violation of federal or state laws and/or contractual requirements.
- Conduct resulting in a violation of any other federal or state laws or contractual requirements relating to participation in Federal and/or State Health Care Programs.
- Failure to perform any required obligation relating to compliance with the Compliance Program, applicable laws, Policies and Procedures, and/or contracts.
- Failure to report violations or suspected violations of the Compliance Program, or applicable laws, or to report suspected or actual FWA issues to an appropriate person through one of the reporting mechanisms.
- Conduct that violates HIPAA and other privacy laws and/or CalOptima Health's HIPAA Privacy and Security Program and policies, including actions that harm the privacy of members, or the CalOptima Health information systems that store member data.

b. Enforcement and Discipline

CalOptima Health maintains a "zero tolerance" policy towards any illegal, or unethical, conduct that impacts the operation, mission, or image of CalOptima Health. The standards established in the Compliance Program shall be enforced consistently through appropriate disciplinary actions. Individuals, or entities, may be disciplined by way of reprimand, suspension, financial penalties, sanctions, and/or termination, depending on the nature and severity of the conduct, or behavior. Board Members may be subject to removal, employees and contractors are subject to discipline, up to and including termination, and FDRs may be Sanctioned, or contracts may be terminated, where permitted. Violations of applicable laws and regulations, even unintentional, could potentially subject individuals, entities, or CalOptima Health to civil, criminal, or administrative sanctions and/or penalties. Further violations could lead to suspension, Preclusion, or Exclusion, from participation in Federal and/or State Health Care Programs.

CalOptima Health employees shall be evaluated annually based on their compliance with CalOptima Health's Compliance Program. Where appropriate, CalOptima Health shall promptly initiate education and training to correct identified problems, or behaviors.

VI. EFFECTIVE SYSTEM FOR ROUTINE MONITORING, AUDITING, AND IDENTIFICATION OF COMPLIANCE RISKS

Monitoring and Auditing can help prevent, detect, and correct non-compliance with applicable federal and/or state requirements. A risk assessment serves as a tool for determining levels of risk and serves as a guide for which monitoring and auditing activities are performed to assess ongoing levels of compliance.

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Routine Monitoring and Auditing of CalOptima Health Operations

The routine monitoring and auditing of CalOptima Health's operations is conducted by the Internal Audit Department under the Office of Compliance.

a. Risk Assessment

A Compliance Risk Assessment will be performed no less than annually to evaluate the current status of CalOptima Health's operational areas.

Operations and processes will be evaluated based on:

1) Deficiencies found by regulatory agencies
2) Deficiencies found by internal and external audit and monitoring reports
3) Institution of new or updated Policies and Procedures and/or regulations/guidance.
4) Cross departmental interdependencies
5) Significant management or organizational changes and/or significant systems changes
6) The OIG Work Plan
7) Monitoring dashboard trends

The Director of the Internal Audit Department, or his/her designee, will work with the operational areas, to identify and assess compliance risks. The risk assessment process will be managed by the Director of the Internal Audit Department, or his/her designee, and presented to the Compliance Committee for review and approval. The risk assessment shall also be updated as processes change or are identified as being deficient.

b. Monitoring and Auditing

The Audit Work Plan (AWP) is developed based on the results of the risk assessment. Internal auditing and monitoring activities are employed to test and verify compliance with all applicable regulations, guidance, contractual agreements, and federal and state laws, as well as CalOptima Health Policies and Procedures. The AWP includes:

1. Audits to be performed including estimated time frames
2. Audit methodologies
3. Necessary resources
4. Person(s) responsible
5. Final audit reports
6. Follow-up activities from findings including CAPs (when applicable)

The Internal Audit Department manages a dashboard of key compliance metrics that serves as a monitoring tool to track performance compliance for such items as coverage determinations, complaints, appeals, grievances, regulatory communications, credentialing, customer service, transition of coverage (TOC), and claims. The Internal Audit Department performs audits based on the AWP. The monitoring and auditing results are communicated to executive staff, the Compliance Committee, and the Board.

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In addition, an Audit of the Compliance Program and its effectiveness is conducted by an independent third party annually, and the results are reported to the Compliance Committee and the Board.

Routine Monitoring and Auditing of First-tier, Downstream, and Related party entities (FDRs)

c. FDR Annual Risk Assessment

The Director of the Delegation Oversight Department, or his/her designee will conduct an annual comprehensive risk assessment to determine an FDR's vulnerabilities and high-risk areas. High-risk FDRs are those that are continually non-compliant or at risk of non-compliance based on identified gaps in processes with regulatory and CalOptima Health requirements. Any previously identified issues, which include any corrective actions, low service level performance, reported detected offenses, and/or complaints and appeals from the previous year will be factors that are included in the risk assessment. Any FDR deemed a high risk or vulnerable, is presented to the Chief Compliance Officer to collaborate in determining appropriate follow-up. FDRs determined to be high-risk may be subjected to a more frequent monitoring and auditing schedule, as well as additional reporting requirements. The risk assessment process, along with reports from FDRs, will be managed by the Director, Delegation Oversight, or his/her designee, and presented to the Compliance Committee for review and discussion.

d. FDR Monitoring and Auditing

An FDR AWP is developed based on the results of the FDR risk assessment. Auditing and Monitoring Activities are employed to test and verify compliance with all applicable regulations, guidance, contractual agreements, and federal and state laws, as well as applicable CalOptima Health Policies and Procedures or equivalent. The FDR AWP includes:

1. Audits to be performed including estimated time frames
2. Audit methodologies
3. Necessary resources
4. Person(s) responsible
5. Final audit reports
6. Follow-up activities from findings including CAPs (when applicable)

The Delegation Oversight Department manages a dashboard of key compliance metrics that serves as a monitoring tool to track compliant performance of FDRs' case management, credentialing, claims, and utilization management. Delegation Oversight performs audits as per the FDR AWP. The monitoring and auditing results are communicated to executive staff, the Compliance Committee, and the Board.

e. Regular Exclusion and Preclusion Screening

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CalOptima Health performs Participation Status Reviews by searching the OIG–LEIE, the GSA–SAM, the DHCS Medi-Cal Suspended & Ineligible Provider Lists, Medi-Cal Restricted Provider Database (RPD), Medi-Cal Procedure/Drug Code Limitation List, and the CMS Preclusion List upon appointment, hire, or commencement of a contract, as applicable, and monthly thereafter, to ensure Board Members, employees, contractors, Providers and/or FDRs are not suspended, excluded, or do not become excluded or precluded from participating in Federal and/or State Health Care Programs. Board Members, employees, contractors, Providers, and FDRs are required to disclose their participation status as part of their initial appointment, employment, commencement of the contract and registration/application processes and if they receive a notice of a suspension, Preclusion, Exclusion, or debarment during the period of appointment, employment, or contract term. CalOptima Health also requires that its First Tier Entities comply with Participation Status Review requirements with respect to their relationships with Downstream Entities, including without limitation, the delegated credentialing and re-credentialing processes.

VII. PROCEDURES AND SYSTEMS FOR PROMPT REPONSE TO COMPLIANCE ISSUES

CalOptima Health takes corrective actions when there is a confirmed incident of non-compliance. CalOptima Health may identify the incident of non-compliance through a variety of sources, such as self-reporting, governmental audits, internal audits, hotline calls, external audits, or member complaints, either directly to CalOptima Health or through governmental units. Whenever CalOptima Health identifies an issue of non-compliance or potential FWA, it is investigated and resolved.

The Chief Compliance Officer and/or Director of FWA, in conjunction with the Office of Compliance, FWA Department and other key staff, are responsible for reviewing cases of non-compliance and suspected activity, and for disclosing such issues to the appropriate authority, when applicable. Because of the complex nature of some issues that may be reported or identified, the investigation may be delegated to the appropriate internal expert.

When a material issue of non-compliance is discovered or a department's process or system results in non-compliance with regulatory requirements, the business area may be required to implement a formal CAP which is overseen by the Office of Compliance. The CAP promotes the correction of the identified issue in a timely manner. Corrective actions may include revising processes, updating policies or procedures, retraining staff, reviewing systems edits and/or addressing other root causes. The CAP must achieve sustained compliance with the overall requirements for that specific operational department.

The status of open CAPs is reviewed by the Office of Compliance on a monthly basis, or at a frequency determined by the Chief Compliance Officer. The Office of Compliance monitors CAP implementation and requires that business departments regularly report the completion of all interim actions. The Office of Compliance tracks the duration of open CAPs and intervenes as appropriate to promote timely completion. Once a CAP is completed, the Office of Compliance may validate the corrective actions by auditing individual action items over a period of time to confirm compliance and the effectiveness of the implemented corrective actions. A summary of CAP activity is periodically reported to executive staff and

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the Compliance Committee.

CalOptima Health's oversight of FDRs includes a requirement that FDRs submit a CAP when material deficiencies are identified through Delegation Oversight audits, ongoing monitoring and/or self-reporting. CalOptima Health takes appropriate action against any contracted organization that does not comply with a CAP or does not meet its regulatory obligations, up to and including termination of its agreement. FDRs are bound contractually through written agreements with CalOptima Health that stipulate compliance with governmental requirements and include provisions for termination for failure to cure performance deficiencies.

CalOptima Health's Compliance Plan is effective in promoting compliance and controlling FWA at both the sponsor and FDR/Subcontractor levels in managing the Medi-Cal and Medicare programs. Policies and procedures associated with this Compliance Plan further expand the activities and oversight of the program.

a. Referral to Enforcement Agencies

In appropriate circumstances, CalOptima Health shall report violations of Medi-Cal Program requirements to DHCS Audits and Investigations, violations of Medicare Program requirements to the Medicare Drug Integrity Contractor (MEDIC), and violations of other state and federal laws to the appropriate law enforcement agencies, in accordance with the applicable reporting procedures adopted by such enforcement agencies.

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FRAUD, WASTE, AND ABUSE (FWA) PREVENTION AND DETECTION

The detection, prevention, and remediation of FWA are components of CalOptima Health's Compliance Program. FWA activities are implemented and overseen by CalOptima Health's Chief Compliance Officer in conjunction with the Director, FWA or his/her designee, in conjunction with other compliance activities. Investigations are performed, or overseen, by the Special Investigations Unit (SIU), an internal investigative unit within CalOptima Health's Office of Compliance, responsible for FWA investigations. The Chief Compliance Officer, and/or his/her designee, shall attend the quarterly DHCS Program Integrity meetings, as scheduled. The Chief Compliance Officer, or his/her designee, reports FWA activities to the CalOptima Health Compliance Committee, the Office of the CEO, the Board, and Regulatory Agencies.

CalOptima Health utilizes various resources to detect, prevent, and remediate FWA. In addition, CalOptima Health promptly investigates suspected FWA issues and may implement disciplinary or corrective action to avoid recurrence of FWA issues. The objective of the Anti-Fraud, Waste, Abuse (FWA) Plan is to ensure that the scope of benefits covered by CalOptima Health Programs are appropriately delivered to members and resources are effectively utilized in accordance with federal and state guidelines. CalOptima Health incorporates a system of internal assessments which are organized to identify FWA and promptly respond appropriately to such incidents of FWA. See the CalOptima Health Anti-Fraud, Waste and Abuse (FWA) Plan for further details.

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CalOptima Health

2026

CALOPTIMA HEALTH

CODE OF CONDUCT

Revised September 2025

Document maintained by: John Tanner
CalOptima Health Chief Compliance Officer



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Message from Chief Compliance Officer



John Tanner
CCO

CalOptima Health is committed to its mission "to serve member health with excellence and dignity, respecting the value and needs of each person." Foundational to fulfilling this commitment is conducting ourselves in an ethical and compliant manner in the course of our daily activities and interactions. CalOptima Health expects all employees, contractors, officers, board members, network providers, subcontractors and downstream contractors act ethically and have a responsibility in ensuring compliance.

This document is a guide with 11 principles and related standards to provide a framework for CalOptima Health's Code of Conduct and how we are to conduct ourselves in serving our members. Please review this Code of Conduct and reach out to the Chief Compliance Officer or a representative from the Office of Compliance if you have any questions regarding this information.

It is incumbent upon all Board members, employees, providers and contractors to report any potential issues of non-compliance or misconduct. Reporting can be done online via the InfoNet or the CalOptima Health website, email, or phone.

You also have the option to anonymously report issues to the:

Compliance and Ethics Hotline at
1-855-507-1805

If you are unsure of a particular matter or situation, talk to your supervisor or a representative from the Office of Compliance to discuss your concerns and get guidance. Conducting our business compliantly and ethically is key to sustaining our business and maintaining our focus in serving our members.

Thank you for your dedication to serving our members and to following this Code of Conduct.

Code of Conduct 11 Principles

1. Mission, Vision, and Values
2. Member Rights
3. Compliance with the Law and Applicable Program Requirements
4. Business Ethics
5. Conflicts of Interests
6. Public Integrity
7. Confidentiality
8. Compliance Program Reporting
9. Discrimination
10. Participation Status
11. Government Inquiries/Legal Disputes

Principles and Standards

1 Mission, Vision, and Values

CalOptima Health is committed to its Mission, Vision, and Values

Our Mission

To serve member health with excellence and dignity, respecting the value and needs of each person.

Our Vision

Provide all members with access to care and supports to achieve optimal health and well-being through an equitable and high-quality health care system.

Values

CARES — Collaboration, Accountability, Respect, Excellence, Stewardship

2 Member Rights

CalOptima Health is committed to meeting the health care needs of its members by providing access to quality health care services.

- **Access & Continuity of Care:** Follow policies ensuring member choice and coordination of services.
- **Health Equity:** Prioritize equity in all programs.
- **Cultural & Linguistic Services:** Provide appropriate communication support.
- **Disabled Member Access:** Comply with ADA Title III.
- **Emergency Treatment:** Follow EMTALA and anti-dumping laws.
- **Grievance & Appeals:** Inform members of rights and resolve complaints promptly.

Member Choice, Access to Health Care Services, Continuity of Care

Employees and contractors must follow CalOptima Health policies, procedures, and laws regarding member choice, access to healthcare, and continuity of care. They must also coordinate medical and support services for individuals with special needs.

Health Equity

Employees and contractors shall endeavor to address and prioritize health equity in the design and implementation of CalOptima Health strategies and programs.

Cultural and Linguistic Services

CalOptima Health and contractors must deliver culturally, linguistically, and sensory appropriate services to ensure members understand their diagnosis, medical history, treatment, and health education.

Disabled Member Access

CalOptima Health›s facilities must comply with Title III of the Americans with Disabilities Act of 1990, ensuring access for disabled members.

Emergency Treatment

Employees and contractors must follow all guidelines, policies, procedures, and laws related to CalOptima Health member access and emergency service payments, including EMTALA and state anti-dumping laws, prior authorization limits, and payment standards.

Grievance and Appeals Processes

CalOptima Health, its physician groups, Health Networks, and third-party administrators (TPA) must inform members of their grievance and appeal rights, including the state fair hearing process, through member handbooks and other communications according to policies and laws. Employees and contractors must promptly and fairly address, investigate, and resolve member complaints and grievances per CalOptima Health policies and applicable laws.

3 Compliance with the Law and Applicable Program Requirements

CalOptima Health is committed to conducting all activities and operations in compliance with applicable law and program requirements.

- **Transparent Conduct:** Operate with integrity and fairness.
- **Obeying the Law:** No lying, stealing, or cheating.
- **Fraud, Waste & Abuse (FWA):** Prevent, detect, and report FWA. Training is mandatory.
- **Political Activities:** No use of CalOptima resources for political purposes.
- **Antitrust Compliance:** Avoid price-fixing, bid rigging, and unfair trade practices.

Business Conduct Policies

CalOptima Health follows all federal and state laws, regulations, and DHCS contract standards. Employees, contractors, officers, board members, network providers, subcontractors, and downstream contractors are expected to act ethically and ensure compliance.

Obeying the Law

Board members, employees, and contractors (including First Tier and Downstream Entities included in the term "FDRs") shall not lie, steal, cheat, or violate any law in connection with their employment and/or engagement with CalOptima Health.

Fraud, Waste, & Abuse (FWA)

CalOptima Health is committed to preventing, detecting, and reporting Fraud, Waste, and Abuse (FWA). The organization ensures Board members, employees, contractors, and FDRs receive necessary FWA training as per regulations. The Compliance Plan outlines examples of potential FWA and details employee and contractor obligations, as well as possible sanctions under federal and state laws. CalOptima Health requires that all parties avoid any conduct violating FWA laws, including anti-kickback statutes, false claims acts, and civil monetary penalty laws.

Political Activities

CalOptima Health is legally restricted in political participation. Its funds, property, and resources cannot be used for political campaigns or parties. Board members, employees, and contractors may engage in politics on their own time and expense but must not imply representation of CalOptima Health.

Anti-Trust

All Board members, employees, and contractors must comply with applicable antitrust, unfair competition, and similar laws which regulate competition. Such persons shall seek advice from legal counsel if they encounter any business decisions involving a risk of violation of antitrust laws. The types of activities that potentially implicate antitrust laws include, without limitation, agreements to fix prices, bid rigging, and related activities; boycotts, certain exclusive dealings, and price discrimination agreements; unfair trade practices; sales or purchases conditioned on reciprocal purchases or sales; and discussion of factors determinative of prices at trade association meetings.

4 Business Ethics

In furtherance of CalOptima Health's commitment to the highest standards of business ethics, employees and contractors shall accurately and honestly represent CalOptima Health and shall not engage in any activity or scheme intended to defraud anyone of money, property, or honest services.

- **Candor & Honesty:** Be truthful in all communications.
- **Financial & Data Reporting:** Ensure accuracy in all records and submissions.
- Regulatory Agenc**ies:** Engage openly and honestly.

Candor & Honesty

CalOptima Health requires candor and honesty from everyone in their duties and communications, including with the Board of Directors, supervisors, attorneys, and auditors. No one shall make false or misleading statements about CalOptima Health's products or services to any members or business partners.

Financial and Data Reporting

All financial reports, accounting records, research reports, expense accounts, data submissions, attestations, timesheets, and other documents must accurately represent the relevant facts and true nature of a transaction. CalOptima Health ensures all transactions are authorized by Management and recorded properly to maintain asset accountability. Fraudulent accounting or false reporting is against CalOptima Health's policy and may violate laws and regulations.

Regulatory Agencies and Accrediting Bodies

CalOptima Health will deal with all Regulatory Agencies and accrediting bodies in a direct, open, and honest manner. Employees and contractors shall not take action with Regulatory Agencies and accrediting bodies that is false or misleading.

5 Conflicts of Interest

Board members, employees, and contractors owe a duty of undivided and unqualified loyalty to CalOptima Health.

- **Disclosure Required:** Report any personal or family ties to vendors, providers, grantees or any other individual or organization with whom CalOptima Health has or is considering a business relationship.

  Example: If a family member, i.e. your brother works for a vendor under consideration, disclose it to HR.
- **Policy References:** GA.8012 (Conflicts of Interest), AA.1204 (Gifts), AA.1216 (Solicitations)

Conflicts of Interest

Designated employees and contractors shall comply with the requirements of CalOptima Health Policy GA.8012: Conflicts of Interest, and applicable laws. Board members, employees, and contractors are expected to conduct their activities to avoid impropriety and/or the appearance of impropriety, which might arise from the influence of those activities on business decisions of CalOptima Health, or from disclosure of CalOptima Health's business operations.

In addition to these provisions, designated employees are also subject to the provisions of the Conflict of Interest Code adopted by the CalOptima Health Board of Directors in compliance with the California Government Code. Designated employees must complete a Form 700 Statement of Economic Interests and a CalOptima Health Supplement to Form 700 upon hire, annually, and upon separation of employment. The HR department coordinates this activity with the CalOptima Health Clerk of the Board.

CalOptima Health Policy GA.8012: Conflicts of Interest describes in detail prohibited conflicts of interest relative to your employment with CalOptima Health.

One aspect of particular interest is any conflict related to family members. As noted in CalOptima Health Policy GA.8012: Conflicts of Interest:

- If an employee or an employee's immediate family member, as defined in the Political Reform Act, has a financial or employment relationship with a current or potential provider, supplier, vendor, consultant or member, the employee must disclose this fact in writing to HR.
  - » For example, if CalOptima Health is considering contracting with a vendor for which your spouse is an employee, you must disclose this in writing to HR.
- CalOptima Health Employees shall not handle member or provider issues, applications, requests, or cases on behalf of CalOptima Health for member(s) of the employee's own family or for personal friends.

For further specific information on Conflicts of Interest; Gifts, Honoraria, and Travel Payments; and Solicitation and Receipts of Gifts see CalOptima Health Policies GA.8012: Conflicts of Interest, AA.1204: Gifts, Honoraria, and Travel Payments, and AA.1216: Solicitation and Receipt of Gifts to CalOptima Health. If you have any questions regarding these policies, you may reach out to the Chief Human Resources Officer or the Chief Compliance Officer.

6 Public Integrity

CalOptima Health and its Board members, employees, and contractors shall comply with laws and regulations governing public agencies.

- **Public Records:** Comply with the California Public Records Act.
- **Use of Funds:** No gifts of public funds unless legally justified.
- **Public Meetings:** Follow the Ralph M. Brown Act.

Public Records

CalOptima Health shall provide access to CalOptima Health Public Records to any person, corporation, partnership, firm, or association requesting to inspect and copy them in accordance with the California Public Records Act, California Government Code Sections 6250 et seq. and CalOptima Health policies.

Public Funds

CalOptima Health, its Board members, employees, and contractors shall not make gifts of public funds or assets or lend credit to private persons without adequate consideration unless such actions clearly serve a public purpose within the authority of the agency and are otherwise approved by legal counsel. CalOptima Health, its Board members, employees, and contractors shall comply with applicable law and CalOptima Health policies governing the investment of public funds and expenditure limitations.

Public Meetings

CalOptima Health, its Board members, employees, and contractors shall comply with requirements relating to the notice and operation of public meetings in accordance with the Ralph M. Brown Act, California Government Code Sections 54950 et seq.

7 Confidentiality

Board members, employees, and contractors shall maintain the confidentiality of all confidential information in accordance with applicable law and shall not disclose such confidential information except as specifically authorized by CalOptima Health policies, procedures, and applicable laws.

- **No Personal Benefit:** Do not use confidential info for personal gain.
- **Safeguard Member Info:** Comply with HIPAA, HITECH, and state laws.
- **Personnel Files:** Maintain confidentiality.
- **Proprietary Info:** Protect contractor data and provider IDs.

No Personal Benefit

Board members, employees, and contractors must not use CalOptima Health's confidential or proprietary information for personal gain or to benefit others, during or after their time with CalOptima Health.

Duty to Safeguard Member Confidential Information

CalOptima Health is committed to protecting its members' confidentiality. Board members, employees, and contractors must secure member identity, eligibility, social security, medical details, and other confidential information per applicable laws, including Health Insurance Portability and Accountability Act (HIPAA), Health Information Technology for Economic and Clinical Health Act

(HITECH Act), California Security Breach Notification Law, California Confidentiality of Medical Information Act, and CalOptima Health policies and procedures.

Personnel Files

Personal information contained in employee personnel files shall be maintained in a manner designed to ensure confidentiality in accordance with applicable laws.

Proprietary Information

Subject to its obligations under the Public Records Act, CalOptima Health shall safeguard confidential proprietary information including, without limitation, contractor information and proprietary computer software, in accordance with and, to the extent required by contract or law. CalOptima Health shall safeguard provider identification numbers including, without limitation, Medi-Cal license, Medicare numbers, social security numbers, and other identifying numbers.

8 Compliance Program Reporting

Board members, employees, and contractors have a duty to comply with CalOptima Health's Compliance Program and such duty shall be a condition of their respective appointment, employment, or engagement.

- **Reporting Requirements:** Promptly report violations to supervisors or the hotline.
- **Hotline:** 1-855-507-1805 (anonymous option available)
- **Disciplinary Action:** Non-compliance may lead to termination or legal penalties.
- **Training:** Mandatory for all employees and contractors.
- **Non-Retaliation:** Retaliation is prohibited. Retaliation can result in disciplinary action including termination.
- **FWA Referrals:** Coordinate with regulators as required.
- **Certification:** All personnel must certify understanding and compliance.

Reporting Requirements

In alignment with CalOptima Health's reporting policies, all Board members, employees and contractors are expected and required to promptly report suspected violations of any statute, regulation, or guideline applicable to Federal and/or State health care programs or

of CalOptima Health's policies and Compliance Plan.. Such reports may be made to a Supervisor, the Chief Compliance Officer or may also be made to CalOptima Health's Compliance and Ethics Hotline number below. Persons making reports to the hotline can do so on an anonymous basis.

Compliance and Ethics Hotline: 1-855-507-1805

No Personal Benefit

Failure to comply with the Compliance Program, including the Code of Conduct, policies, and/or applicable statutes, regulations and guidelines may lead to disciplinary action. Discipline for failure to abide by the Code of Conduct may, in CalOptima Health's discretion, range from oral correction to termination in accordance with CalOptima Health's policies. In addition, failure to comply may result in the imposition of civil, criminal, or administrative fines on the individual, or entity, and CalOptima Health or Exclusion or Preclusion from participation in Federal and/or State health care programs.

Training and Education

CalOptima Health provides training and education to Board members, employees, contractors, and FDRs. Timely completion of compliance and HIPAA training is mandatory for all CalOptima Health employees and contractors.

Non-Retaliation Policy

CalOptima Health prohibits retaliation against any individual who reports discrimination, harassment, or compliance concerns, or participates in an investigation of such reports, in good faith. Employees and contractors involved in any retaliatory acts may be subject to discipline, up to and including termination of employment.

Referrals of FWA to Government Agencies

CalOptima Health is obligated to coordinate compliance activities with federal and state regulators. Employees and contractors shall comply with CalOptima Health policies related to FWA referral requirements to federal and state regulators, delegated program integrity contractors, and law enforcement agencies.

Certification

All Board members, employees, and contractors are required to certify, in writing, that they have received, read, understand, and will abide by the Code of Conduct and applicable policies.

9 Discrimination

CalOptima Health acknowledges that fair and equitable treatment of employees, contractors, members, providers, and other persons is fundamental to fulfilling its mission and goals.

- **No Discrimination:** Prohibited on the basis of race, gender, disability, etc..
- **Reassignment:** Must not be based on health status.

No Discrimination

CalOptima Health is committed to compliance with applicable anti-discrimination laws including Title VI of the Civil Right Act of 1964. Board members, employees and contractors shall not unlawfully discriminate on the basis of race, color, national origin, creed, ancestry, religion, language, age, marital status, gender (which includes sex, gender identity, gender transition status and gender expression), sexual orientation, health status, pregnancy, physical or mental disability, military status or any other classification protected by law. CalOptima Health is committed to providing a work environment free from discrimination and harassment based on any classification noted above.

Reassignment

CalOptima Health, physician groups, and Health Networks shall not reassign members in a discriminatory manner, including based on the enrollee's health status.

10 Participation Status

CalOptima Health requires that employees, contractors, providers, and suppliers meet Government requirements for participation in CalOptima Health's programs.

- **Eligibility:** Must not be excluded from federal/state programs.
- **Screening:** Regular exclusion checks are conducted.
- **Disclosure:** Report any investigations or disciplinary actions.
- **Licensure:** Maintain valid credentials.

Federal and State Health Care Program Participation Status

Board members, employees, and contractors shall not be currently suspended, terminated, debarred, or otherwise ineligible to participate in any Federal or State health care program, including the Medi-Cal program and Medicare programs.

CalOptima Health Screening

CalOptima Health will Monitor the participation status of employees, individuals and entities doing business with CalOptima Health by conducting regular Exclusion and Preclusion screening reviews in accordance with CalOptima Health policies.

Disclosure of Participation Status

Board members, employees and contractors shall disclose to CalOptima Health whether they are currently suspended, terminated, debarred, or otherwise ineligible to participate in any Federal and/or State health care program. Employees, individuals, and entities that do business with CalOptima Health shall disclose to CalOptima Health any pending investigation, disciplinary action, or other matter that could potentially result in their exclusion or preclusion from participation in any Federal or State health care program.

Delegated Third Party Administrator Review

CalOptima Health requires that its Health Networks, physician groups, and third-party administrators review participating providers and suppliers for licensure and participation status as part of the delegated credentialing and recredentialing processes when such obligations have been delegated to them.

Licensure

CalOptima Health requires that all employees, contractors, Health Networks, participating providers, and suppliers who are required to be licensed, credentialed, certified, and/or registered in order to furnish items or services to CalOptima Health and its members have valid and current licensure, credentials, certification and/or registration, as applicable.

11 Government Inquiries / Legal Disputes

Employees and contractors shall notify CalOptima Health upon receipt of government inquiries and shall not destroy or alter documents in response to a government request for documents or information.

- **Notification:** Inform Compliance immediately upon receiving inquiries.
- **No Destruction:** Do not alter or destroy documents.
- **Preservation:** Follow legal instructions for data retention.

Notification of Government Inquiry

Employees and contractors shall notify the Chief Compliance Officer and/or their supervisor immediately upon the receipt (at work or at home) of an inquiry, subpoena, or other agency or government requests for information regarding CalOptima Health.

No Destruction of Documents

Employees and contractors shall not destroy or alter CalOptima Health information or documents in anticipation of, or in response to, a request for documents by any governmental agency or from a court of competent jurisdiction.

Preservation of Documents Including Electronically Stored Information

Board members, employees, and contractors shall comply with all obligations to preserve documents, data, and records including, electronically stored information in accordance with CalOptima Health policies and shall comply with instructions on preservation of information and prohibitions and destruction of information issued by legal counsel.

Frequently Asked Questions

What constitutes an unfair competitive advantage for an employee's outside business activity?

An unfair competitive advantage occurs when an employee's outside employment, consulting, or business activity influences decisions made by CalOptima Health, thereby giving an unfair advantage to the employee's outside business.

Can CalOptima Health employees use privileged or official information for personal gain?

No, the use of privileged or official information for personal financial gain is prohibited. This applies to both current employees and those who have separated from employment. Privileged information includes, but is not limited to, personal health information (PHI), provider rates, personnel records, and proprietary information not available to the public.

Are employees allowed to use information obtained from CalOptima Health in their outside consulting work?

No, employees acting as independent consultants or as employees of another organization cannot use proprietary information, skills, or knowledge obtained from CalOptima Health, especially if it pertains to current, in-progress, or proposed projects that are not yet public.

Is outside employment or consulting activity allowed if it competes with CalOptima Health?

No, an employee's outside employment or consulting activity must not compete with current or proposed CalOptima Health projects, programs, or initiatives.

Can CalOptima Health employees handle issues for family or personal friends?

No, employees are prohibited from handling member or provider issues, applications, requests, or cases on behalf of CalOptima Health for their own family members or personal friends.

What should an employee do if the employee or an employee's immediate family member, as defined in the Political Reform Act, has a financial or employment relationship with a current or potential provider, supplier, vendor, consultant or member?

The employee must disclose this fact in writing to HR. For example, if CalOptima Health is considering contracting with a vendor for which your spouse is an employee, you must disclose this in writing to HR.

Are CalOptima Health employees allowed to perform a second job?

Employees are prohibited from performing a second job that creates a conflict of interest. They must report any non-CalOptima Health job positions that might create such a conflict and complete an Employee Report of Outside Interest and/or Other Employment form for HR approval.

What activities require prior written approval from the Chief Executive Officer or the Chair of the CalOptima Health Board of Directors?

The following activities require prior written approval:

- Performing work or rendering services for any contractor/vendor/provider or related association that does or seeks to do business with CalOptima Health.
- Performing work or holding a position with a job-related non-profit/charitable business or organization.
- Being a director, officer, or consultant of any contractor/vendor/provider or related association that does or seeks to do business with CalOptima Health.
- Allowing your name to be used in a manner that indicates a business connection with any contractor/vendor/provider or related association that does or seeks to do business with CalOptima Health.



CalOptima Health

CalOptima Health, A Public Agency
505 City Parkway West, Orange, CA 92868

caloptima.org

~~2025~~ 2026 Code of Conduct

(Revised September ~~2024~~2025)

For 20251106 BOD Review Only

Document maintained by: John Tanner
CalOptima Health Chief Compliance Officer

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Message from Chief Compliance Officer (CCO)

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You also have the option to anonymously report issues to the:

Compliance and Ethics Hotline at 1-855-507-1805

If you are unsure of a particular matter or situation, talk to your supervisor or a representative from the Office of Compliance to discuss your concerns and get guidance. Conducting our business compliantly and ethically is key to sustaining our business and maintaining our focus in serving our members.

Thank you for your dedication to serving our members and to following this Code of Conduct.

For 20251106 BOD Review Only

Code of Conduct 11 Principles

1. **Mission, Vision, and Values:**
   ~~CalOptima Health is committed to its Mission, Vision, and Values.~~

2. **Member Rights:**
   ~~CalOptima Health is committed to meeting the health care needs of its members by providing access to quality health care services.~~

3. **Compliance with the Law and Applicable Program Requirements:**
   ~~CalOptima Health is committed to conducting all activities and operations in compliance with all applicable requirements and standards under its contract with DHCS and all and federal and state requirements including CMS requirements.~~

~~4.~~ **Business Ethics:**

~~5.~~4. ~~In furtherance of CalOptima Health's commitment to the highest standards of business ethics, employees and contractors shall accurately and honestly represent CalOptima Health and shall not engage in any activity or scheme intended to defraud anyone of money, property, or honest services.~~

~~6.~~ **Conflicts of Interests:**

~~7.~~5. ~~Board members, employees, and contractors owe a duty of undivided and unqualified loyalty to CalOptima Health.~~

~~8.~~6. **Public Integrity:**
   ~~CalOptima Health and its Board members, employees, and contractors shall comply with laws and regulations governing public agencies.~~

~~9.~~7. **Confidentiality:**
   ~~Board members, employees, and contractors shall maintain the confidentiality of all confidential information in accordance with applicable law and shall not disclose such confidential information except as specifically authorized by CalOptima Health policies, procedures, and applicable laws.~~

~~10.~~8. **Compliance Program Reporting:**
   ~~Board members, employees, and contractors have a duty to comply with CalOptima Health's Compliance Program and such duty shall be a condition of their respective appointment, employment, or engagement.~~

~~11.~~9. **Discrimination:**
   ~~CalOptima Health acknowledges that fair and equitable treatment of employees, contractors, members, providers, and other persons is fundamental to fulfilling its mission and goals.~~

~~12.~~10. **Participation Status:**
   ~~CalOptima Health requires that employees, contractors, providers, and suppliers meet Government requirements for participation in CalOptima Health's programs.~~

~~13.~~11. **Government Inquiries/Legal Disputes:**
   ~~Employees and contractors shall notify CalOptima Health upon receipt of Government inquiries and shall not destroy or alter documents in response to a government request for documents or information.~~

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Principles and Standards (Detailed)

1. Mission, Vision, and Values

CalOptima Health is committed to its Mission, Vision, and Values

- **Mission:** Serve member health with excellence and dignity.
- **Vision (by 2027):**
  - Same-day treatment authorizations
  - Real-time claims payments
  - Annual assessments of members' social determinants of health
- **Values:** CARES — Collaboration, Accountability, Respect, Excellence, Stewardship

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2. Member Rights

CalOptima Health is committed to meeting the health care needs of its members by providing access to quality health care services.

- **Access & Continuity of Care:** Follow policies ensuring member choice and coordination of services.
- **Health Equity:** Prioritize equity in all programs.
- **Cultural & Linguistic Services:** Provide appropriate communication support.
- **Disabled Member Access:** Comply with ADA Title III.
- **Emergency Treatment:** Follow EMTALA and anti-dumping laws.
- **Grievance & Appeals:** Inform members of rights and resolve complaints promptly.

Member Choice, Access to Health Care Services, Continuity of Care

Employees and contractors must follow CalOptima Health policies, procedures, and laws regarding member choice, access to healthcare, and continuity of care. They must also coordinate medical and support services for individuals with special needs.

Health Equity

Employees and contractors shall endeavor to address and prioritize health equity in the design and implementation of CalOptima Health strategies and programs.

Cultural and Linguistic Services

CalOptima Health and contractors must deliver culturally, linguistically, and sensory appropriate services to ensure members understand their diagnosis, medical history, treatment, and health education.

Disabled Member Access

CalOptima Health's facilities must comply with Title III of the Americans with Disabilities Act of 1990, ensuring access for disabled members.

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Emergency Treatment

Employees and contractors must follow all guidelines, policies, procedures, and laws related to CalOptima Health member access and emergency service payments, including EMTALA and state anti-dumping laws, prior authorization limits, and payment standards.

Grievance and Appeals Processes

CalOptima Health, its physician groups, Health Networks, and third-party administrators (TPA) must inform members of their grievance and appeal rights, including the state fair hearing process, through member handbooks and other communications according to policies and laws. Employees and contractors must promptly and fairly address, investigate, and resolve member complaints and grievances per CalOptima Health policies and applicable laws.

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3. Compliance with the Law and Applicable Program Requirements

CalOptima Health is committed to conducting all activities and operations in compliance with applicable law and program requirements.

- **Transparent Conduct:** Operate with integrity and fairness.
- **Obeying the Law:** No lying, stealing, or cheating.
- **Fraud, Waste & Abuse (FWA):** Prevent, detect, and report FWA. Training is mandatory.
- **Political Activities:** No use of CalOptima resources for political purposes.
- **Antitrust Compliance:** Avoid price-fixing, bid rigging, and unfair trade practices.

Business Conduct Policies

CalOptima Health follows all federal and state laws, regulations, and DHCS contract standards. Employees, contractors, officers, board members, network providers, subcontractors, and downstream contractors are expected to act ethically and ensure compliance.

Obeying the Law

Board members, employees, and contractors (including First Tier and Downstream Entities included in the term "FDRs") shall not lie, steal, cheat, or violate any law in connection with their employment and/or engagement with CalOptima Health.

Fraud, Waste, & Abuse (FWA)

CalOptima Health is committed to preventing, detecting, and reporting Fraud, Waste, and Abuse (FWA). The organization ensures Board members, employees, contractors, and FDRs receive necessary FWA training as per regulations. The Compliance Plan outlines examples of potential FWA and details employee and contractor obligations, as well as possible sanctions under federal and state laws. CalOptima Health requires that all parties avoid any conduct violating FWA laws, including anti-kickback statutes, false claims acts, and civil monetary penalty laws.

Political Activities

CalOptima Health is legally restricted in political participation. Its funds, property, and resources cannot be

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used for political campaigns or parties. Board members, employees, and contractors may engage in politics on their own time and expense but must not imply representation of CalOptima Health.

Anti-Trust

All Board members, employees, and contractors must comply with applicable antitrust, unfair competition, and similar laws which regulate competition. Such persons shall seek advice from legal counsel if they encounter any business decisions involving a risk of violation of antitrust laws. The types of activities that potentially implicate antitrust laws include, without limitation, agreements to fix prices, bid rigging, and related activities; boycotts, certain exclusive dealings, and price discrimination agreements; unfair trade practices; sales or purchases conditioned on reciprocal purchases or sales; and discussion of factors determinative of prices at trade association meetings.

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4. Business Ethics

In furtherance of CalOptima Health's commitment to the highest standards of business ethics, employees and contractors shall accurately and honestly represent CalOptima Health and shall not engage in any activity or scheme intended to defraud anyone of money, property, or honest services.

- **Candor & Honesty:** Be truthful in all communications.
- **Financial & Data Reporting:** Ensure accuracy in all records and submissions.
- **Regulatory Agencies:** Engage openly and honestly.

Candor & Honesty

CalOptima Health requires candor and honesty from everyone in their duties and communications, including with the Board of Directors, supervisors, attorneys, and auditors. No one shall make false or misleading statements about CalOptima Health's products or services to any members or business partners.

Financial and Data Reporting

All financial reports, accounting records, research reports, expense accounts, data submissions, attestations, timesheets, and other documents must accurately represent the relevant facts and true nature of a transaction. CalOptima Health ensures all transactions are authorized by Management and recorded properly to maintain asset accountability. Fraudulent accounting or false reporting is against CalOptima Health's policy and may violate laws and regulations.

Regulatory Agencies and Accrediting Bodies

CalOptima Health will deal with all Regulatory Agencies and accrediting bodies in a direct, open, and honest manner. Employees and contractors shall not take action with Regulatory Agencies and accrediting bodies that is false or misleading.

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5. Conflicts of Interest

Board members, employees, and contractors owe a duty of undivided and unqualified loyalty to CalOptima Health.

- **Disclosure Required:** Report any personal or family ties to vendors, providers, grantees or any other individual or organization with whom CalOptima Health has or is considering a business relationship.
- **Example:** If a family member, i.e. your brother works for a vendor under consideration, disclose it to HR.
- **Policy References:** GA.8012 (Conflicts of Interest), AA.1204 (Gifts), AA.1216 (Solicitations)

Conflicts of Interest

Designated employees and contractors shall comply with the requirements of CalOptima Health Policy GA.8012: Conflicts of Interest, and applicable laws. Board members, employees, and contractors are expected to conduct their activities to avoid impropriety and/or the appearance of impropriety, which might arise from the influence of those activities on business decisions of CalOptima Health, or from disclosure of CalOptima Health's business operations.

In addition to these provisions, designated employees are also subject to the provisions of the Conflict of Interest Code adopted by the CalOptima Health Board of Directors in compliance with the California Government Code. Designated employees must complete a Form 700 Statement of Economic Interests and a CalOptima Health Supplement to Form 700 upon hire, annually, and upon separation of employment. The HR department coordinates this activity with the CalOptima Health Clerk of the Board.

CalOptima Health Policy GA.8012: Conflicts of Interest describes in detail prohibited conflicts of interest relative to your employment with CalOptima Health.

One aspect of particular interest is any conflict related to family members. As noted in CalOptima Health Policy GA.8012: Conflicts of Interest:

- If an employee or an employee's immediate family member, as defined in the Political Reform Act, has a financial or employment relationship with a current or potential provider, supplier, vendor, consultant or member, the employee must disclose this fact in writing to HR.
    - For example, if CalOptima Health is considering contracting with a vendor for which your spouse is an employee, you must disclose this in writing to HR.
- CalOptima Health Employees shall not handle member or provider issues, applications, requests, or cases on behalf of CalOptima Health for member(s) of the employee's own family or for personal friends.

For further specific information on Conflicts of Interest; Gifts, Honoraria, and Travel Payments; and Solicitation and Receipts of Gifts see CalOptima Health Policies GA.8012: Conflicts of Interest, AA.1204: Gifts, Honoraria, and Travel Payments, and AA.1216: Solicitation and Receipt of Gifts to CalOptima Health. If you have any questions regarding these policies, you may reach out to the Chief Human Resources Officer or the Chief Compliance Officer.

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6. Public Integrity

CalOptima Health and its Board members, employees, and contractors shall comply with laws and regulations governing public agencies.

- **Public Records:** Comply with the California Public Records Act.
- **Use of Funds:** No gifts of public funds unless legally justified.
- **Public Meetings:** Follow the Ralph M. Brown Act.

Public Records

CalOptima Health shall provide access to CalOptima Health Public Records to any person, corporation, partnership, firm, or association requesting to inspect and copy them in accordance with the California Public Records Act, California Government Code Sections 6250 et seq. and CalOptima Health policies.

Public Funds

CalOptima Health, its Board members, employees, and contractors shall not make gifts of public funds or assets or lend credit to private persons without adequate consideration unless such actions clearly serve a public purpose within the authority of the agency and are otherwise approved by legal counsel. CalOptima Health, its Board members, employees, and contractors shall comply with applicable law and CalOptima Health policies governing the investment of public funds and expenditure limitations.

Public Meetings

CalOptima Health, its Board members, employees, and contractors shall comply with requirements relating to the notice and operation of public meetings in accordance with the Ralph M. Brown Act, California Government Code Sections 54950 et seq.

7. Confidentiality

Board members, employees, and contractors shall maintain the confidentiality of all confidential information in accordance with applicable law and shall not disclose such confidential information except as specifically authorized by CalOptima Health policies, procedures, and applicable laws.

- **No Personal Benefit:** Do not use confidential info for personal gain.
- **Safeguard Member Info:** Comply with HIPAA, HITECH, and state laws.
- **Personnel Files:** Maintain confidentiality.
- **Proprietary Info:** Protect contractor data and provider IDs.

No Personal Benefit

Board members, employees, and contractors must not use CalOptima Health's confidential or proprietary information for personal gain or to benefit others, during or after their time with CalOptima Health.

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Duty to Safeguard Member Confidential Information

CalOptima Health is committed to protecting its members' confidentiality. Board members, employees, and contractors must secure member identity, eligibility, social security, medical details, and other confidential information per applicable laws, including Health Insurance Portability and Accountability Act (HIPAA), Health Information Technology for Economic and Clinical Health Act (HITECH Act), California Security Breach Notification Law, California Confidentiality of Medical Information Act, and CalOptima Health policies and procedures.

Personnel Files

Personal information contained in employee personnel files shall be maintained in a manner designed to ensure confidentiality in accordance with applicable laws.

Proprietary Information

Subject to its obligations under the Public Records Act, CalOptima Health shall safeguard confidential proprietary information including, without limitation, contractor information and proprietary computer software, in accordance with and, to the extent required by contract or law. CalOptima Health shall safeguard provider identification numbers including, without limitation, Medi-Cal license, Medicare numbers, social security numbers, and other identifying numbers.

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8. Compliance Program Reporting

Board members, employees, and contractors have a duty to comply with CalOptima Health's Compliance Program and such duty shall be a condition of their respective appointment, employment, or engagement.

- **Reporting Requirements:** Promptly report violations to supervisors or the hotline.
- **Hotline:** 1-855-507-1805 (anonymous option available)
- **Disciplinary Action:** Non-compliance may lead to termination or legal penalties.
- **Training:** Mandatory for all employees and contractors.
- **Non-Retaliation:** Retaliation is prohibited. Retaliation can result in disciplinary action including termination.
- **FWA Referrals:** Coordinate with regulators as required.
- **Certification:** All personnel must certify understanding and compliance.

Reporting Requirements

In alignment with CalOptima Health's reporting policies, all Board members, employees and contractors are expected and required to promptly report suspected violations of any statute, regulation, or guideline applicable to Federal and/or State health care programs or of CalOptima Health's policies and Compliance Plan.. Such reports may be made to a Supervisor, the Chief Compliance Officer or may also be made to

CalOptima Health's Compliance and Ethics Hotline number below. Persons making reports to the hotline can do so on an anonymous basis.

Compliance and Ethics Hotline: 1-855-507-1805

Disciplinary Action

Failure to comply with the Compliance Program, including the Code of Conduct, policies, and/or applicable statutes, regulations and guidelines may lead to disciplinary action. Discipline for failure to abide by the Code of Conduct may, in CalOptima Health's discretion, range from oral correction to termination in accordance with CalOptima Health's policies. In addition, failure to comply may result in the imposition of civil, criminal, or administrative fines on the individual, or entity, and CalOptima Health or Exclusion or Preclusion from participation in Federal and/or State health care programs.

Training and Education

CalOptima Health provides training and education to Board members, employees, contractors, and FDRs. Timely completion of compliance and HIPAA training is mandatory for all CalOptima Health employees and contractors.

Non-Retaliation Policy

CalOptima Health prohibits retaliation against any individual who reports discrimination, harassment, or compliance concerns, or participates in an investigation of such reports, in good faith. Employees and contractors involved in any retaliatory acts may be subject to discipline, up to and including termination of employment.

Referrals of FWA to Government Agencies

CalOptima Health is obligated to coordinate compliance activities with federal and state regulators. Employees and contractors shall comply with CalOptima Health policies related to FWA referral requirements to federal and state regulators, delegated program integrity contractors, and law enforcement agencies.

Certification

All Board members, employees, and contractors are required to certify, in writing, that they have received, read, understand, and will abide by the Code of Conduct and applicable policies.

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9. Discrimination

CalOptima Health acknowledges that fair and equitable treatment of employees, contractors, members, providers, and other persons is fundamental to fulfilling its mission and goals.

- **No Discrimination:** Prohibited on the basis of race, gender, disability, etc.
- **Reassignment:** Must not be based on health status.

No Discrimination

CalOptima Health is committed to compliance with applicable anti-discrimination laws including Title VI of the Civil Right Act of 1964. Board members, employees and contractors shall not unlawfully discriminate on the basis of race, color, national origin, creed, ancestry, religion, language, age, marital status, gender (which includes sex, gender identity, gender transition status and gender expression), sexual orientation, health status, pregnancy, physical or mental disability, military status or any other classification protected by law. CalOptima Health is committed to providing a work environment free from discrimination and harassment based on any classification noted above.

Reassignment

CalOptima Health, physician groups, and Health Networks shall not reassign members in a discriminatory manner, including based on the enrollee's health status.

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10. Participation Status

CalOptima Health requires that employees, contractors, providers, and suppliers meet Government requirements for participation in CalOptima Health's programs.

- **Eligibility:** Must not be excluded from federal/state programs.
- **Screening:** Regular exclusion checks are conducted.
- **Disclosure:** Report any investigations or disciplinary actions.
- **Licensure:** Maintain valid credentials.

Federal and State Health Care Program Participation Status

Board members, employees, and contractors shall not be currently suspended, terminated, debarred, or otherwise ineligible to participate in any Federal or State health care program, including the Medi-Cal program and Medicare programs.

CalOptima Health Screening

CalOptima Health will Monitor the participation status of employees, individuals and entities doing business with CalOptima Health by conducting regular Exclusion and Preclusion screening reviews in accordance with CalOptima Health policies.

Disclosure of Participation Status

Board members, employees and contractors shall disclose to CalOptima Health whether they are currently suspended, terminated, debarred, or otherwise ineligible to participate in any Federal and/or State health care program. Employees, individuals, and entities that do business with CalOptima Health shall disclose to CalOptima Health any pending investigation, disciplinary action, or other matter that could potentially result in their exclusion or preclusion from participation in any Federal or State health care program.

Delegated Third Party Administrator Review

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CalOptima Health requires that its Health Networks, physician groups, and third-party administrators review participating providers and suppliers for licensure and participation status as part of the delegated credentialing and recredentialing processes when such obligations have been delegated to them.

Licensure

CalOptima Health requires that all employees, contractors, Health Networks, participating providers, and suppliers who are required to be licensed, credentialed, certified, and/or registered in order to furnish items or services to CalOptima Health and its members have valid and current licensure, credentials, certification and/or registration, as applicable.

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11. Government Inquiries / Legal Disputes

Employees and contractors shall notify CalOptima Health upon receipt of government inquiries and shall not destroy or alter documents in response to a government request for documents or information.

- **Notification:** Inform Compliance immediately upon receiving inquiries.
- **No Destruction:** Do not alter or destroy documents.
- **Preservation:** Follow legal instructions for data retention.

Notification of Government Inquiry

Employees and contractors shall notify the Chief Compliance Officer and/or their supervisor immediately upon the receipt (at work or at home) of an inquiry, subpoena, or other agency or government requests for information regarding CalOptima Health.

No Destruction of Documents

Employees and contractors shall not destroy or alter CalOptima Health information or documents in anticipation of, or in response to, a request for documents by any governmental agency or from a court of competent jurisdiction.

Preservation of Documents Including Electronically Stored Information

Board members, employees, and contractors shall comply with all obligations to preserve documents, data, and records including, electronically stored information in accordance with CalOptima Health policies and shall comply with instructions on preservation of information and prohibitions and destruction of information issued by legal counsel.

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~~Code of Conduct Principles and Standards~~

~~Principle~~	~~Standard~~
~~1. Mission, Vision, and Values~~	~~Mission~~ ~~To serve member health with excellence and dignity, respecting the value and needs of each person.~~

Principle	Standard
CalOptima Health is committed to its Mission, Vision, and Values	**Vision by 2027** • CalOptima Health Same-Day Treatment Authorizations • Real-Time Claims Payments • Annual Assessments of Member's Social Determinants of Health. **Values = CalOptima Health CARES** **C**ollaboration; **A**ccountability; **R**espect; **E**xcellence; **S**tewardship
2. Member Rights CalOptima Health is committed to meeting the health care needs of its members by providing access to quality health care services.	**Member Choice, Access to Health Care Services, Continuity of Care** Employees and contractors shall comply with CalOptima Health policies and procedures and applicable law governing member choice, access to health care services, and continuity of member care. Employees and contractors shall comply with all requirements for coordination of medical and support services for persons with special needs. Health Equity Employees and contractors shall endeavor to address and prioritize health equity in the design and implementation of CalOptima Health strategies and programs. **Cultural and Linguistic Services** CalOptima Health and contractors shall provide culturally, linguistically, and sensory appropriate services to CalOptima Health members to ensure effective communication regarding diagnosis, medical history, and treatment, and health education. **Disabled Member Access** CalOptima Health's facilities shall adhere to the requirements of Title III of the Americans with Disabilities Act of 1990 by providing access for disabled members. **Emergency Treatment** Employees and contractors shall comply with all applicable guidelines, policies and procedures, and laws governing CalOptima Health member access and payment of emergency services including, without limitation, the Emergency Medical Treatment and Active Labor Act ("EMTALA") and state patient "anti-dumping" laws, prior authorization limitations, and payment standards.

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Principle	Standard
	Grievance and Appeals Processes CalOptima Health, its physician groups, its Health Networks, and third-party administrators (TPA) shall ensure that CalOptima Health members are informed of their grievance and appeal rights including, the state hearing process, through member handbooks and other communications in accordance with CalOptima Health policies and procedures and applicable laws. Employees and contractors shall address, investigate, and resolve CalOptima Health member complaints and grievances in a prompt and nondiscriminatory manner in accordance with CalOptima Health policies and applicable laws.
3. Compliance with the Law and Applicable Program Requirements CalOptima Health is committed to conducting all activities and operations in compliance with applicable law and program requirements.	**Transparent, Legal, and Ethical Business Conduct** CalOptima Health is committed to conducting its business with integrity, honesty, and fairness and in compliance with all federal and state laws and regulations, and applicable requirements and standards under its Contract with DHCS. CalOptima Health expects all employees, contractors, officers, board of directors members, network providers, subcontractors, and downstream contractors to act ethically and are responsible for ensuring CalOptima Health compliance. **Obeying the Law** Board members, employees, and contractors (including First Tier and Downstream Entities included in the term "FDRs") shall not lie, steal, cheat, or violate any law in connection with their employment and/or engagement with CalOptima Health. **Fraud, Waste, & Abuse (FWA)** CalOptima Health shall refrain from conduct which would violate the Fraud, Waste, and Abuse laws. CalOptima Health is committed to the detection, prevention, and reporting of Fraud, Waste, and Abuse. CalOptima Health is also responsible for ensuring that Board members, employees, contractors, and FDRs receive appropriate FWA training as described in regulatory guidance. CalOptima Health's Compliance Plan, Anti-Fraud, Waste, and Abuse Plan and policies describe examples of Potential Fraud, Waste, and Abuse and discuss employee and contractor FWA obligations and potential Sanctions arising from relevant federal and state FWA laws. CalOptima Health expects and requires that its Board members, employees, and contractors do not participate in any conduct that may violate the FWA laws including federal and state anti-kickback laws, false claims acts, and civil monetary penalty laws.

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Principle	Standard
	Political Activities CalOptima Health's political participation is limited by law. CalOptima Health funds, property, and resources are not to be used to contribute to political campaigns, political parties, and/or organizations. Board members, employees and contractors may participate in the political process on their own time and at their own expense but shall not give the impression that they are speaking on behalf of or representing CalOptima Health in these activities. **Anti-Trust** All Board members, employees, and contractors must comply with applicable antitrust, unfair competition, and similar laws which regulate competition. Such persons shall seek advice from legal counsel if they encounter any business decisions involving a risk of violation of antitrust laws. The types of activities that potentially implicate antitrust laws include, without limitation, agreements to fix prices, bid rigging, and related activities; boycotts, certain exclusive dealings, and price discrimination agreements; unfair trade practices; sales or purchases conditioned on reciprocal purchases or sales; and discussion of factors determinative of prices at trade association meetings.
4. Business Ethics In furtherance of CalOptima Health's commitment to the highest standards of business ethics, employees and contractors shall accurately and honestly represent CalOptima Health and shall not engage in any activity or scheme intended to defraud anyone of money, property, or honest services.	**Candor & Honesty** CalOptima Health requires candor and honesty from individuals in the performance of their responsibilities and in communications including, communications with CalOptima Health's Board of Directors, supervisory employees, attorneys, and auditors. No Board member, employee, or contractor shall make false or misleading statements to any members and/or persons, or entities, doing business with CalOptima Health about products or services of CalOptima Health. **Financial and Data Reporting** All financial reports, accounting records, research reports, expense accounts, data submissions, attestations, timesheets, and other documents must accurately and clearly represent the relevant facts and the true nature of a transaction. CalOptima Health maintains a system of internal controls to ensure that all transactions are executed in accordance with Management's authorization and recorded in a proper manner to maintain accountability of the agency's assets. Improper or fraudulent accounting documentation or financial reporting or false or misleading encounter, claims, cost, or other

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Principle	Standard
	required regulatory data submissions is contrary to the policy of CalOptima Health and may be in violation of applicable laws and regulatory obligations. **Regulatory Agencies and Accrediting Bodies** CalOptima Health will deal with all Regulatory Agencies and accrediting bodies in a direct, open, and honest manner. Employees and contractors shall not take action with Regulatory Agencies and accrediting bodies that is false or misleading.
5. Conflicts of Interests Board members, employees, and contractors owe a duty of undivided and unqualified loyalty to CalOptima Health.	**Conflicts of Interest** Designated employees and contractors shall comply with the requirements of CalOptima Health Policy GA.8012: Conflicts of Interest, and applicable laws. Board members, employees, and contractors are expected to conduct their activities to avoid impropriety and/or the appearance of impropriety, which might arise from the influence of those activities on business decisions of CalOptima Health, or from disclosure of CalOptima Health's business operations. In addition to these provisions, designated employees are also subject to the provisions of the Conflict of Interest Code adopted by the CalOptima Health Board of Directors in compliance with the California Government Code. Designated employees must complete a Form 700 Statement of Economic Interests and a CalOptima Health Supplement to Form 700 upon hire, annually, and upon separation of employment. The HR department coordinates this activity with the CalOptima Health Clerk of the Board. CalOptima Health Policy GA.8012: Conflicts of Interest describes in detail prohibited conflicts of interest relative to your employment with CalOptima Health. One aspect of particular interest are conflicts related to family members. As noted in CalOptima Health Policy GA.8012: Conflicts of Interest: • If an employee or an employee's immediate family member, as defined in the Political Reform Act, has a financial or employment relationship with a current or potential provider, supplier, vendor, consultant or member, the employee must disclose this fact in writing to HR.

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Principle	Standard
	○ For example, if CalOptima Health is considering contracting with a vendor for which your brother is an employee, you must disclose this in writing to HR. • CalOptima Health Employees shall not handle member or provider issues, applications, requests, or cases on behalf of CalOptima Health for member(s) of the employee's own family or for personal friends. For further specific information on Conflicts of Interest; Gifts, Honoraria, and Travel Payments; and Solicitation and Receipts of Gifts see CalOptima Health Policies GA.8012: Conflicts of Interest, AA.1204: Gifts, Honoraria, and Travel Payments, and AA.1216: Solicitation and Receipt of Gifts to CalOptima Health. If you have any questions regarding these policies, you may reach out to the Chief Human Resources Officer or the Chief Compliance Officer.
6. Public Integrity CalOptima Health and its Board members, employees, and contractors shall comply with laws and regulations governing public agencies.	**Public Records** CalOptima Health shall provide access to CalOptima Health Public Records to any person, corporation, partnership, firm, or association requesting to inspect and copy them in accordance with the California Public Records Act, California Government Code Sections 6250 et seq. and CalOptima Health policies. **Public Funds** CalOptima Health, its Board members, employees, and contractors shall not make gifts of public funds or assets or lend credit to private persons without adequate consideration unless such actions clearly serve a public purpose within the authority of the agency and are otherwise approved by legal counsel. CalOptima Health, its Board members, employees, and contractors shall comply with applicable law and CalOptima Health policies governing the investment of public funds and expenditure limitations. **Public Meetings** CalOptima Health, its Board members, employees, and contractors shall comply with requirements relating to the notice and operation of public meetings in accordance with the Ralph M. Brown Act, California Government Code Sections 54950 et seq.
7. Confidentiality Board members, employees, and contractors shall maintain	**No Personal Benefit** Board members, employees and contractors shall not use confidential or proprietary CalOptima Health information for their own personal

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Principle	Standard
the confidentiality of all confidential information in accordance with applicable law and shall not disclose such confidential information except as specifically authorized by CalOptima Health policies, procedures, and applicable laws.	benefit or for the benefit of any other person or entity, while employed at, or engaged by, CalOptima Health, or at any time thereafter. **Duty to Safeguard Member Confidential Information** CalOptima Health recognizes the importance of its members' right to confidentiality and implements policies and procedures to ensure its members' confidentiality rights and the protection of medical and other confidential information. Board members, employees and contractors shall safeguard CalOptima Health member identity, eligibility, social security, medical information and other confidential information in accordance with applicable laws including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health Act (HITECH Act) and implementing regulations, the California Security Breach Notification Law, the California Confidentiality of Medical Information Act, other applicable federal and state privacy laws, and CalOptima Health's policies and procedures. **Personnel Files** Personal information contained in employee personnel files shall be maintained in a manner designed to ensure confidentiality in accordance with applicable laws. **Proprietary Information** Subject to its obligations under the Public Records Act, CalOptima Health shall safeguard confidential proprietary information including, without limitation, contractor information and proprietary computer software, in accordance with and, to the extent required by contract or law. CalOptima Health shall safeguard provider identification numbers including, without limitation, Medi-Cal license, Medicare numbers, social security numbers, and other identifying numbers.
8. Compliance Program Reporting Board members, employees, and contractors have a duty to comply with CalOptima Health's Compliance Program and such duty shall be a condition of their respective	**Reporting Requirements** In alignment with CalOptima Health's reporting policies, all Board members, employees and contractors are expected and required to promptly report suspected violations of any statute, regulation, or guideline applicable to Federal and/or State health care programs or of CalOptima Health's policies and Compliance Plan.. Such reports may be made to a Supervisor, the Chief Compliance Officer or may also be made to CalOptima Health's Compliance and Ethics Hotline

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Principle	Standard
appointment, employment, or engagement.	number below. Persons making reports to the hotline can do so on an anonymous basis. **Compliance and Ethics Hotline: 1-855-507-1805** **Disciplinary Action** Failure to comply with the Compliance Program, including the Code of Conduct, policies, and/or applicable statutes, regulations and guidelines may lead to disciplinary action. Discipline for failure to abide by the Code of Conduct may, in CalOptima Health's discretion, range from oral correction to termination in accordance with CalOptima Health's policies. In addition, failure to comply may result in the imposition of civil, criminal, or administrative fines on the individual, or entity, and CalOptima Health or Exclusion or Preclusion from participation in Federal and/or State health care programs. **Training and Education** CalOptima Health provides training and education to Board members, employees, contractors, and FDRs. Timely completion of compliance and HIPAA training is mandatory for all CalOptima Health employees and contractors. **Non-Retaliation Policy** CalOptima Health prohibits retaliation against any individual who reports discrimination, harassment, or compliance concerns, or participates in an investigation of such reports, in good faith. Employees and contractors involved in any retaliatory acts may be subject to discipline, up to and including termination of employment. **Referrals of FWA to Government Agencies** CalOptima Health is obligated to coordinate compliance activities with federal and state regulators. Employees and contractors shall comply with CalOptima Health policies related to FWA referral requirements to federal and state regulators, delegated program integrity contractors, and law enforcement agencies. **Certification** All Board members, employees, and contractors are required to certify, in writing, that they have received, read, understand, and will abide by the Code of Conduct and applicable policies.

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Principle	Standard
9. Discrimination CalOptima Health acknowledges that fair and equitable treatment of employees, contractors, members, providers, and other persons is fundamental to fulfilling its mission and goals.	**No Discrimination** CalOptima Health is committed to compliance with applicable anti-discrimination laws including Title VI of the Civil Right Act of 1964. Board members, employees and contractors shall not unlawfully discriminate on the basis of race, color, national origin, creed, ancestry, religion, language, age, marital status, gender (which includes sex, gender identity, gender transition status and gender expression), sexual orientation, health status, pregnancy, physical or mental disability, military status or any other classification protected by law. CalOptima Health is committed to providing a work environment free from discrimination and harassment based on any classification noted above. **Reassignment** CalOptima Health, physician groups, and Health Networks shall not reassign members in a discriminatory manner, including based on the enrollee's health status.
10. Participation Status CalOptima Health requires that employees, contractors, providers, and suppliers meet Government requirements for participation in CalOptima Health's programs.	**Federal and State Health Care Program Participation Status** Board members, employees, and contractors shall not be currently suspended, terminated, debarred, or otherwise ineligible to participate in any Federal or State health care program, including the Medi-Cal program and Medicare programs. **CalOptima Health Screening** CalOptima Health will Monitor the participation status of employees, individuals and entities doing business with CalOptima Health by conducting regular Exclusion and Preclusion screening reviews in accordance with CalOptima Health policies. **Disclosure of Participation Status** Board members, employees and contractors shall disclose to CalOptima Health whether they are currently suspended, terminated, debarred, or otherwise ineligible to participate in any Federal and/or State health care program. Employees, individuals, and entities that do business with CalOptima Health shall disclose to CalOptima Health any pending investigation, disciplinary action, or other matter that could potentially result in their exclusion or preclusion from participation in any Federal or State health care program. **Delegated Third Party Administrator Review**

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Principle	Standard
	CalOptima Health requires that its Health Networks, physician groups, and third-party administrators review participating providers and suppliers for licensure and participation status as part of the delegated credentialing and recredentialing processes when such obligations have been delegated to them. **Licensure** CalOptima Health requires that all employees, contractors, Health Networks, participating providers, and suppliers who are required to be licensed, credentialed, certified, and/or registered in order to furnish items or services to CalOptima Health and its members have valid and current licensure, credentials, certification and/or registration, as applicable.
11. Government Inquiries/Legal Disputes Employees and contractors shall notify CalOptima Health upon receipt of government inquiries and shall not destroy or alter documents in response to a government request for documents or information.	**Notification of Government Inquiry** Employees and contractors shall notify the Chief Compliance Officer and/or their supervisor immediately upon the receipt (at work or at home) of an inquiry, subpoena, or other agency or government requests for information regarding CalOptima Health. **No Destruction of Documents** Employees and contractors shall not destroy or alter CalOptima Health information or documents in anticipation of, or in response to, a request for documents by any governmental agency or from a court of competent jurisdiction. **Preservation of Documents Including Electronically Stored Information** Board members, employees, and contractors shall comply with all obligations to preserve documents, data, and records including, electronically stored information in accordance with CalOptima Health policies and shall comply with instructions on preservation of information and prohibitions and destruction of information issued by legal counsel.

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Orange County Health Authority
dba CalOptima Health

~~2025~~ 2026 Anti-Fraud, Waste, and Abuse (FWA) Plan

(Revised September ~~2024~~2025)

For 20251106 BOD Review Only

Document maintained by: Fay Ho
CalOptima Health Director FWA

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I. FRAUD, WASTE, AND ABUSE (FWA) PREVENTION AND DETECTION

The detection, prevention, and remediation of FWA are components of CalOptima Health's Compliance Program. FWA activities are implemented and overseen by CalOptima Health's Chief Compliance Officer, or his/her Designee. The Chief Compliance Officer, or his or her designee, shall also act as the Fraud Prevention Officer. Investigations are performed, or overseen, in conjunction with other compliance activities by the Special Investigations Unit (SIU), an internal investigative unit within CalOptima Health's Office of Compliance, responsible for FWA investigations.

The Chief Compliance Officer, or his/her Designee, reports FWA activities to the CalOptima Health Compliance Committee, Chief Executive Officer, the CalOptima Health Board, and Regulatory Agencies.

Inquiries regarding the Fraud, Waste, and Abuse Plan may be directed to the CalOptima Health Fraud, Waste, and Abuse Director, Fay Ho, who may be reached at (714) 246-8892.

CalOptima Health will submit its anti-fraud plan to the Department of Managed Health Care (DMHC). Any changes will be filed with DMHC pursuant to Health and Safety Code (HSC) § 1352. The submission will describe the manner in which the plan is complying with HSC § 1348(a), and the name and telephone number of the contact person to whom inquiries concerning the anti-fraud plan may be directed.

CalOptima Health will provide to the DMHC director an annual written report describing CalOptima Health's efforts to deter, detect, and investigate fraud, and to report cases of fraud to a law enforcement agency. For those cases that are reported to law enforcement agencies by CalOptima Health, this report will include the number of cases prosecuted to the extent known by CalOptima Health. The report may also include recommendations by CalOptima Health to improve efforts to combat health care fraud.

The Anti-Fraud, Waste, and Abuse (FWA) Plan has been developed in accordance with the following federal and state statutes, regulations, and guidelines:

- ~~Applicable state laws and contractual requirements~~
- ~~Civil False Claims Act, 31 U.S.C. §§3729-3733~~
- ~~Criminal False Claims Act, 18 U.S.C. §287~~
- Anti-Kickback Statute, 42 U.S.C. §1320a-7b
- ~~42 C.F.R. 422 and 423~~
- ~~42 C.F.R. 438.608~~
- Applicable regulatory guidance
- Applicable state laws and contractual requirements
- Civil False Claims Act, 31 U.S. Code §§3729-3733
- Criminal False Claims Act, 18 U.S.C. §287
- Health and Safety Codes (HSC) §§ 1348(a), and 1352
- Title 42, Code of Federal Regulations (CFR) 422 and 423
- Title 42, Code of Federal Regulations (CFR) 438.608

CalOptima Health utilizes various resources to detect, prevent, and remediate FWA. In

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addition, CalOptima Health promptly investigates suspected FWA issues and may implement disciplinary, or corrective, action to avoid recurrence of FWA issues. The objective of the FWA program is to ensure that the scope of benefits covered by the CalOptima Health Programs is appropriately delivered to members and resources are effectively utilized in accordance with federal and state guidelines. CalOptima Health incorporates a system of internal assessments which are organized to identify FWA and promptly respond appropriately to such incidents of FWA.

Covered California:
In accordance with Covered California contractual requirements, the purpose of CalOptima Health's anti-fraud plan shall be to organize and implement an anti-fraud strategy to identify and reduce costs to CalOptima Health, providers, subscribers, members, and others caused by fraudulent activities, and to protect consumers in the delivery of health care services through the timely detection, investigation, and prosecution of suspected fraud.

II. DEFINITIONS

Medi-Cal:
Abuse ("Abuse") means practices that are inconsistent with sound fiscal and business practices or medical standards, and result in an unnecessary cost to a CalOptima Health Program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes member practices that result in unnecessary cost to the CalOptima Health Programs.

Fraud ("Fraud") means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law, in accordance with Title 42 Code of Federal Regulations section 455.2, Welfare and Institutions Code section 14043.1(i).

Waste ("Waste") means the overutilization or inappropriate utilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Health Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

Covered California:
Abuse - Excessive, or improper use of something, or the use of something in a manner contrary to the natural or legal rules for its use; the intentional destruction, diversion, manipulation, misapplication, maltreatment, or misuse of resources; or extravagant or excessive use to abuse one's position or authority. Often, the terms fraud and abuse are used simultaneously with the primary distinction is the intent. Inappropriate practices that begin as abuse can quickly evolve into fraud. Abuse can occur in financial or non-financial settings. Examples of abuse include excessive charges, improper billing practices, payment for services that do not meet recognized standards of care and payment for medically unnecessary services.

Fraud - Consists of an intentional misrepresentation, deceit, or concealment of a material fact known to the defendant with the intention on the part of the defendant of thereby depriving a

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person of property or legal rights or otherwise causing injury. (California (CA) Civil Code §3294 (c)(3), CA Penal Code §§470-483.5). Prevention and early detection of fraudulent activities is crucial to ensuring affordable healthcare for all individuals. Examples of fraud include false applications to obtain payment, false information to obtain insurance, billing for services that were not rendered.

Waste - Intentional or unintentional, extravagant careless or needless expenditures, consumption, mismanagement, use, or squandering of resources, to the detriment or potential detriment of entities, but without an intent to deceive or misrepresent. Waste includes incurring unnecessary costs because of inefficient or ineffective practices, systems, decisions, or controls.

III. FWA TRAINING

FWA training is provided to all CalOptima Health Board ~~Members,~~members, employees, and contractors~~, and employees~~ as part of the overall compliance training courses in order to help detect, prevent, and remediate FWA in accordance with CalOptima Health Policy HH.2023: Compliance Training. First-tier, downstream and related entities (FDRs) are also required to complete FWA training.

CalOptima Health's FWA training provides guidance to Board members, employees, contractors, and FDRs on how to identify activities and behaviors that would constitute FWA and how to report suspected, or actual, FWA activities. Training materials are retained for a period of at least ten (10) years, and such training includes, but is not limited to:

- The process for detection, prevention, and reporting of suspected or actual FWA;
- Common types of member FWA and FDR FWA as well as common local and national schemes relevant to managed care organization operations;
- Information on how to identify FWA in CalOptima Health Programs (e.g., suspicious activities suggesting CalOptima Health members, or their family members, may be engaged in improper drug utilization or drug-seeking behavior, conduct suggesting improper utilization, persons offering kickbacks for referring, etc.);
- Information on how to identify potential prescription drug FWA (e.g., identification of significant outliers whose drug utilization patterns far exceed those of the average member in terms of cost or quantity, disproportionate utilization of controlled substances, use of prescription medications for excessive periods of time, misrepresenting the type of drug that was actually dispensed, excessive prescriptions by a particular physician, etc.);
- How to report potential FWA using CalOptima Health's reporting options, including CalOptima Health's Compliance and Ethics Hotline;
- CalOptima Health's policy of non-retaliation and non-retribution toward individuals who make such reports in good faith; and
- Information on the False Claims Act and CalOptima Health's requirement to train employees and FDRs on the False Claims Act and other applicable FWA laws.

CalOptima Health shall provide Board members, employees, contractors, FDRs, and members with reminders and additional training and educational materials through print and electronic communications, including, but not limited to, newsletters, alerts, and/or applicable meetings.

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IV. DETECTION OF FWA

a. Data Sources

In partnership with CalOptima Health internal departments, CalOptima Health's SIU utilizes different sources and analyzes various data in an effort to detect patterns of FWA. Members, FDRs, employees, contractors, law enforcement and Regulatory Agencies, and others may contact CalOptima Health by phone, mail, and email if they suspect any individual, or entity, is engaged in inappropriate practices. Furthermore, the sources identified below can be used to identify problem areas within CalOptima Health, such as enrollment, finance, or other relevant data.

Sources used to detect FWA include, but are not limited to:

- CalOptima Health's Compliance and Ethics Hotline or other reporting mechanisms;
- Claims data history;
- Encounter data;
- Medical record audits;
- Member and provider complaints, appeals, and grievance reviews;
- Utilization Management reports;
- Provider utilization profiles;
- Pharmacy data;
- Auditing and monitoring activities;
- Monitoring external health care FWA cases and determining if CalOptima Health's FWA Program can be strengthened with information gleaned from the case activity; and/or
- Internal and external surveys, reviews, and audits.

b. Data Analytics

CalOptima Health uses technology and data analyses to reduce FWA externally. Using a combination of industry standard edits and CalOptima Health-specific edits, CalOptima Health identifies claims for which procedures have been unbundled or upcoded. CalOptima Health also identifies suspect FDRs based on billing patterns.

CalOptima Health also uses the services of an external Medicare Secondary Payer (MSP) Vendor to reduce costs associated with its Medicare-Medicaid programs, such as the OneCare, and/or PACE programs, by ensuring that federal and state funds are not used where certain health insurance, or coverage, is primarily responsible.

c. Analysis and Identification of Risk Areas Using Claims Data

Claims data are analyzed in numerous ways to uncover fraudulent billing schemes. Routine review of claims data will be conducted in order to identify unusual patterns, outliers in billing and utilization, and identify the population of providers and pharmacies that will be further investigated and/or audited. Any medical claim can be pended and reviewed, in accordance with applicable state or federal law if they meet certain criteria that warrant additional review. Payments for pharmacy claims may also be pended and reviewed in accordance with applicable

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state or federal law based on criteria focused on the types of drugs (e.g., narcotics), provider patterns, and suspicious activities reported pertaining to pharmacies. CalOptima Health along with the Pharmacy Benefit Manager (PBM) will conduct data mining activities in order to identify potential issues of prescription or pharmacy FWA.

The following trends are reviewed and flagged for potential FWA, including:

- Overutilized services;
- Aberrant provider billing practices;
- Abnormal billing in relation to peers;
- Manipulation of modifiers;
- Unusual coding practices such as excessive procedures per day, or excessive surgeries per patient;
- Unbundling of services;
- Unusual Durable Medical Equipment (DME) billing; and/or
- Unusual utilization patterns by members and providers.

The following claims data may be utilized to evaluate and uncover fraudulent billing schemes:

- Average dollars paid per medical procedure;
- Average medical procedures per office visit;
- Average visits per member;
- Average distance a member travels to see a provider/pharmacy;
- Excessive patient levels of high-risk diagnoses;
- Peer to peer comparisons within specialties;
- Analysis of provider medical billing activity within their own peer group;
- Analysis of pharmacy billing and provider prescribing practices;
- Controlled drug prescribing exceeds two (2) standard deviations of the provider's peer group; and/or
- Number of times a provider bills a CPT code in relation to all providers, or within their own peer group.

The claims data from the PBM go through the same risk assessment process. The analysis may be focused on the following characteristics:

- Prescription drug shorting, which occurs when pharmacy staff provides less than the prescribed quantity and intentionally does not inform the member or arranges to provide the balance but bills for the prescribed amount.
- Bait and switch pricing, which occurs when a member is led to believe that a drug will cost one (1) price, but at the point of sale, they are charged a higher amount. An example of this type of scheme is when the pharmacy switches the prescribed medication to a form that increases the pharmacy's reimbursement.
- Prescription forging, or altering, which occurs when existing prescriptions are altered to increase the quantity or the number of refills, without the prescriber's authorization. Usually, the medications are diverted after being billed to the Medicare Part D program.
- Dispensing expired, or adulterated, prescription drugs, which occurs when pharmacies dispense drugs after the expiration date on the package. This also includes drugs that are intended as samples not for sale or have not been stored or handled in accordance with

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manufacturer and FDA requirements.

- Prescription refill errors, which occur when pharmacy staff deliberately provides several refills different from the number prescribed by the provider.
- Failure to offer negotiated prices, which occurs when a pharmacy charges a member the wrong amount.

d. Sample Indicators

No single indicator is evidence of FWA. The presence of several indicators may suggest FWA, but further investigation is needed to determine if a suspicion of FWA exists. The following list below highlights common industry indicators and red flags that are used to determine whether to investigate an FDR or their claim disposition:

- Claims that show any altered information (dates, codes, names).
- Photocopies of claim forms and bills, or handwritten claims and bills.
- Provider's last name is the same as the member/patient's last name.
- The insured's address is the same as the servicing provider.
- Same provider submits multiple claims for the same treatment for multiple family members or group members of provider's practice.
- Provider resubmitting claim with changed diagnosis code for a date of service already denied.

Cases identified through these data sources and risk assessments are entered into the FWA case management system and a reports are routinely generated and shared with the Chief Compliance Officer and Compliance Committee. In addition, the Chief Compliance Officer, and/or his/her Designee, shall attend the quarterly DHCS Program Integrity meetings, as scheduled.

V. FWA INVESTIGATIVE PROCESS

Once the SIU receives an allegation of suspected FWA or detects FWA through an evaluation of the data sources identified above, the SIU utilizes the following steps as a guide to investigate and document the case:

- The allegation is logged into the case management system;
- The allegation is assigned an investigation number (sequentially by year of receipt) and an electronic file is assigned on the internal drive by investigation number and name;
- SIU develops an investigative plan;
- SIU obtains a legal opinion from legal counsel on specific cases or issues, as necessary;
- Quality of care issues are referred to CalOptima Health's Quality Improvement Department;
- Where appropriate, SIU will submit a Request for Information (RFI) directly to an FDR to obtain relevant information;
- SIU interviews the individual who reported the FWA, affected members and/or FDRs, or any other potential witnesses, as appropriate;
- SIU conducts a data analytics review of the allegation for overall patterns, trends, and errors using applicable data sources and reports;
- Review of FDR enrollment applications, history, and ownership

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- ► Review of member enrollment applications and other documents, as necessary;
- ► Review of applicable contracts and/or All Plan Letters (APLs);
- ► Discuss allegation and evidence collected with subject matter experts;
- ► All supporting documentation is scanned and saved in the assigned electronic file. Any pertinent information, gathered during the SIU review/investigation, is placed into the electronic file;
- ► After an allegation is logged into the case management system, the investigation is tracked to its ultimate conclusion;
- ► The FWA case report shall reflect all information gathered and documentation received to ensure timely receipt, review, and resolution, and report may be made to applicable state or federal agencies within mandated/required time periods;
- ► If a referral to another investigative agency is warranted, the information is collected, and a referral is made to the appropriate agency; and/or
- ► If the investigation results in recommendations for disciplinary or corrective actions, the results of the investigation may be reported to the Chief Compliance Officer, CEO, and Compliance Committee. If a CalOptima Health internal department or FDR has ~~repeat~~repeated disciplinary or corrective actions, SIU may report the issue(s) to the Compliance Committee for further action.

a. Referral to Enforcement Agencies

CalOptima Health's SIU shall coordinate timely referrals of potential FWA to appropriate Regulatory Agencies, or their designated program integrity contractors, including the CMS MEDIC, DHCS Audits and Investigations, DMHC, Covered California, and/or other enforcement agencies, in accordance with the applicable reporting procedures adopted by such enforcement agencies. FDRs shall report FWA to CalOptima Health within the time frames required by the applicable contract and in sufficient time for CalOptima Health to timely report to applicable enforcement agencies. Significant program non-compliance, or suspected FWA, should be reported to CMS, Covered California, DMHC, and/or DHCS, as soon as possible after discovery, but no later than ten (10) business days to DHCS after CalOptima Health first becomes aware of and is on notice of such activity, and within thirty (30) calendar days to CMS MEDIC after a potential fraudulent or abusive activity is identified for a case impacting the OneCare ~~or PACE programs.~~ program.

For the purposes of reporting FWA to Covered California:

- ► CalOptima Health shall communicate within ten (10) days to Covered California any material concerns identified by CalOptima Health or material concerns, including any enforcement actions resulting in monetary penalties equal to or exceeding $100,000, identified by State and Federal Regulators related to regulatory compliance that may impact performance under the contract with Covered California following CalOptima Health's knowledge of such occurrence; provided, however, such notification shall be provided immediately if such occurrence may reasonably be deemed to adversely affect the quality of care or safety of Covered California members. All notifications shall be made according to the "Contract Reporting Requirements" table posted on CalOptima Health's extranet website provided by Covered California.
- ► If CalOptima Health receives any preliminary or final reports, findings, or orders related to material concerns identified by State and Federal Regulators that may impact performance

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under the contract with Covered California pursuant to Section 1.15 of the 6.5. Qualified Health Plans (QHP) contract, CalOptima Health shall provide Covered California with copies of them within 48 hours of receiving them from State and Federal Regulators.

- CalOptima Health shall provide Covered California with a description of its FWA detection and prevention programs and report total monies recovered by CalOptima Health in the most recent 12-month period for CalOptima Health's total book of business as well as, total monies recovered for Covered California business only. This description shall be updated during each year that the contract with Covered California is in effect and shall include an overview of fraud and abuse detection and prevention program activities conducted by CalOptima Health, Participating Providers, other Subcontractors and their authorized Agents, including a summary of key findings, relevant data analytics and fraud risk assessments to circumvent fraud, waste, and abuse, and the development, implementation, and enforcement of any corrective action plans for changing, upgrading, or improving these programs.
- CalOptima Health maintains and enforces a written Code of Conduct publicly available on CalOptima Health's website.
- CalOptima Health shall refer potential fraud activities identified through fraud detection and response measures to Covered California. CalOptima Health shall follow the established Carrier Referral Process posted on the Contractor's extranet website provided by Covered California.

Potential cases that should be referred include, but are not limited to:

- Suspected, detected, or reported criminal, civil, or administrative law violations;
- Allegations that extend beyond CalOptima Health and involve multiple health plans, multiple states, or widespread schemes;
- Allegations involving known patterns of FWA;
- Patterns of FWA threatening the life, or well-being, of CalOptima Health members; and/or
- Schemes with large financial risk to CalOptima Health, or its members.

b. Findings, Response, and Remediation

Outcomes and findings of the investigation may include, but are not limited to, confirmation of violations, insufficient evidence of FWA, need for contract amendment, education and training requirement, recommendation of focused audits, additional investigation, continued monitoring, prepayment claim review, new policy implementation, and/or criminal or civil action. As appropriate, claims will be denied or reversed, chargebacks against future claims will be employed, and other payment recovery actions will be taken. The SIU will track and trend the FWA allegation and investigation, including, the data analysis performed, which shall be reported to the Compliance Committee on a quarterly basis. Investigation findings can be used to determine whether disciplinary, or corrective, action is appropriate, whether there is a need for a change in CalOptima Health's Policies and Procedures.

In accordance with applicable CalOptima Health Policies and Procedures, CalOptima Health shall take appropriate disciplinary, or corrective, action against Board members, employees, and/or FDRs related to validated instances of FWA. CalOptima Health will also assess FDRs for potential overpayments when reviewing and undertaking corrective actions. Corrective actions will be monitored by the Compliance Committee, and progressive discipline will be

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monitored by the Department of Human Resources, as appropriate. Corrective actions may include, but are not limited to, financial sanctions, regulatory reporting, CAPs, or termination of the delegation agreement, when permitted by the contract terms. Should such disciplinary, or corrective, action need to be issued, CalOptima Health's Office of Compliance will initiate review and discussion at the first Compliance Committee following the date of identification of the suspected FWA, the date of report to DHCS, or the date of FWA substantiation by DHCS subsequent to the report. If vulnerability is identified through a single FWA incident, the corrective action may be applied universally.

CalOptima Health will not terminate Covered California member coverage for fraud without prior review and approval from Covered California.

c. Cooperation with regulatory investigations or prosecutions

Should there be any investigation or prosecution conducted by the Office of the Attorney General, Division of Medi-Cal Fraud and Elder Abuse (DMFEA), or the U.S. DOJ, CalOptima Health shall cooperate with the investigation, which may include, but is not limited to, providing information and access to records upon request.

VI. ANNUAL FWA EVALUATION

CalOptima Health's Compliance Committee shall periodically review and evaluate the FWA work plan, FWA activities, and its effectiveness as part of the overall Compliance Program Audit and Monitoring Activities. Revisions should be made based on industry changes, trends in FWA activities (locally and nationally), the OIG Work Plan, the CalOptima Health Compliance Plan, and other input from applicable sources.

VII. POLICIES AND PROCEDURES (P&Ps)

The CalOptima Health Policies and Procedures listed below are the primary means by which the Anti-Fraud, Waste and Abuse Plan is effectuated at CalOptima Health.

- GA.8022: Performance and Behavior Standards
- GG.1428: Pharmacy Management Medi-Cal Rx Responsibilities
- GG.1615: Corrective Action Plan for Practitioners and Organizational Providers
- HH.1105: Fraud, Waste, and Abuse Detection
- HH.1107: Fraud, Waste, and Abuse Investigation and Reporting
- HH.2002: Sanctions
- HH.2005: Corrective Action Plan
- HH.2007: Compliance Committee
- HH.2014: Compliance Program
- HH.2018: Compliance and Ethics Hotline
- HH.2019: Reporting Suspected or Actual Fraud, Waste, or Abuse (FWA~~,~~), Violations of Applicable Laws and Regulations, and/or CalOptima Health Policies
- HH.2020: Conducting Compliance Investigations
- HH.2023: Compliance ~~and FWA~~ Training ~~Programs~~
- HH.2028: Code of Conduct
- HH.3012: Non-~~retaliation~~Retaliation for Reporting Violations

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- HH.5000: Provider Overpayment Investigation and Determination
- HH.5004: False Claims Act Education
- MA.5013: Pharmacy Audits and Reviews
- MA.6104: Opioid Medication Utilization Management

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Orange County Health Authority
dba CalOptima Health

2026 Anti-Fraud, Waste, and Abuse (FWA) Plan

(Revised September 2025)

For 20251106 BOD Review Only

Document maintained by: Fay Ho
CalOptima Health Director FWA

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The Chief Compliance Officer, or his/her Designee, reports FWA activities to the CalOptima Health Compliance Committee, Chief Executive Officer, the CalOptima Health Board, and Regulatory Agencies.

Inquiries regarding the Fraud, Waste, and Abuse Plan may be directed to the CalOptima Health Fraud, Waste, and Abuse Director, Fay Ho, who may be reached at (714) 246-8892.

CalOptima Health will submit its anti-fraud plan to the Department of Managed Health Care (DMHC). Any changes will be filed with DMHC pursuant to Health and Safety Code (HSC) § 1352. The submission will describe the manner in which the plan is complying with HSC § 1348(a), and the name and telephone number of the contact person to whom inquiries concerning the anti-fraud plan may be directed.

CalOptima Health will provide to the DMHC director an annual written report describing CalOptima Health's efforts to deter, detect, and investigate fraud, and to report cases of fraud to a law enforcement agency. For those cases that are reported to law enforcement agencies by CalOptima Health, this report will include the number of cases prosecuted to the extent known by CalOptima Health. The report may also include recommendations by CalOptima Health to improve efforts to combat health care fraud.

The Anti-Fraud, Waste, and Abuse (FWA) Plan has been developed in accordance with the following federal and state statutes, regulations, and guidelines:

- Anti-Kickback Statute, 42 U.S.C. §1320a-7b
- Applicable regulatory guidance
- Applicable state laws and contractual requirements
- Civil False Claims Act, 31 U.S. Code §§3729-3733
- Criminal False Claims Act, 18 U.S.C. §287
- Health and Safety Codes (HSC) §§ 1348(a), and 1352
- Title 42, Code of Federal Regulations (CFR) 422, 423 and 438.608

CalOptima Health utilizes various resources to detect, prevent, and remediate FWA. In addition, CalOptima Health promptly investigates suspected FWA issues and may implement disciplinary, or corrective, action to avoid recurrence of FWA issues. The objective of the FWA program is to ensure that the scope of benefits covered by the CalOptima Health Programs is appropriately delivered to members and resources are effectively utilized in accordance with federal and state guidelines. CalOptima Health incorporates a system of internal assessments which are organized to identify FWA and promptly respond appropriately

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to such incidents of FWA.

Covered California:
In accordance with Covered California contractual requirements, the purpose of CalOptima Health's anti-fraud plan shall be to organize and implement an anti-fraud strategy to identify and reduce costs to CalOptima Health, providers, subscribers, members, and others caused by fraudulent activities, and to protect consumers in the delivery of health care services through the timely detection, investigation, and prosecution of suspected fraud.

II. DEFINITIONS

Medi-Cal:
Abuse ("Abuse") means practices that are inconsistent with sound fiscal and business practices or medical standards, and result in an unnecessary cost to a CalOptima Health Program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes member practices that result in unnecessary cost to the CalOptima Health Programs.

Fraud ("Fraud") means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law, in accordance with Title 42 Code of Federal Regulations section 455.2, Welfare and Institutions Code section 14043.1(i).

Waste ("Waste") means the overutilization or inappropriate utilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Health Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

Covered California:
Abuse - Excessive, or improper use of something, or the use of something in a manner contrary to the natural or legal rules for its use; the intentional destruction, diversion, manipulation, misapplication, maltreatment, or misuse of resources; or extravagant or excessive use to abuse one's position or authority. Often, the terms fraud and abuse are used simultaneously with the primary distinction is the intent. Inappropriate practices that begin as abuse can quickly evolve into fraud. Abuse can occur in financial or non-financial settings. Examples of abuse include excessive charges, improper billing practices, payment for services that do not meet recognized standards of care and payment for medically unnecessary services.

Fraud - Consists of an intentional misrepresentation, deceit, or concealment of a material fact known to the defendant with the intention on the part of the defendant of thereby depriving a person of property or legal rights or otherwise causing injury. (California (CA) Civil Code §3294 (c)(3), CA Penal Code §§470-483.5). Prevention and early detection of fraudulent activities is crucial to ensuring affordable healthcare for all individuals. Examples of fraud include false applications to obtain payment, false information to obtain insurance, billing for services that were not rendered.

Waste - Intentional or unintentional, extravagant careless or needless expenditures,

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consumption, mismanagement, use, or squandering of resources, to the detriment or potential detriment of entities, but without an intent to deceive or misrepresent. Waste includes incurring unnecessary costs because of inefficient or ineffective practices, systems, decisions, or controls.

III. FWA TRAINING

FWA training is provided to all CalOptima Health Board members, employees, and contractors as part of the overall compliance training courses in order to help detect, prevent, and remediate FWA in accordance with CalOptima Health Policy HH.2023: Compliance Training. First-tier, downstream and related entities (FDRs) are also required to complete FWA training.

CalOptima Health's FWA training provides guidance to Board members, employees, contractors, and FDRs on how to identify activities and behaviors that would constitute FWA and how to report suspected, or actual, FWA activities. Training materials are retained for a period of at least ten (10) years, and such training includes, but is not limited to:

- The process for detection, prevention, and reporting of suspected or actual FWA;
- Common types of member FWA and FDR FWA as well as common local and national schemes relevant to managed care organization operations;
- Information on how to identify FWA in CalOptima Health Programs (e.g., suspicious activities suggesting CalOptima Health members, or their family members, may be engaged in improper drug utilization or drug-seeking behavior, conduct suggesting improper utilization, persons offering kickbacks for referring, etc.);
- Information on how to identify potential prescription drug FWA (e.g., identification of significant outliers whose drug utilization patterns far exceed those of the average member in terms of cost or quantity, disproportionate utilization of controlled substances, use of prescription medications for excessive periods of time, misrepresenting the type of drug that was actually dispensed, excessive prescriptions by a particular physician, etc.);
- How to report potential FWA using CalOptima Health's reporting options, including CalOptima Health's Compliance and Ethics Hotline;
- CalOptima Health's policy of non-retaliation and non-retribution toward individuals who make such reports in good faith; and
- Information on the False Claims Act and CalOptima Health's requirement to train employees and FDRs on the False Claims Act and other applicable FWA laws.

CalOptima Health shall provide Board members, employees, contractors, FDRs, and members with reminders and additional training and educational materials through print and electronic communications, including, but not limited to, newsletters, alerts, and/or applicable meetings.

IV. DETECTION OF FWA

a. Data Sources

In partnership with CalOptima Health internal departments, CalOptima Health's SIU utilizes different sources and analyzes various data in an effort to detect patterns of FWA. Members, FDRs, employees, contractors, law enforcement and Regulatory Agencies, and others may contact CalOptima Health by phone, mail, and email if they suspect any individual, or entity, is

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engaged in inappropriate practices. Furthermore, the sources identified below can be used to identify problem areas within CalOptima Health, such as enrollment, finance, or other relevant data.

Sources used to detect FWA include, but are not limited to:

- CalOptima Health's Compliance and Ethics Hotline or other reporting mechanisms;
- Claims data history;
- Encounter data;
- Medical record audits;
- Member and provider complaints, appeals, and grievance reviews;
- Utilization Management reports;
- Provider utilization profiles;
- Pharmacy data;
- Auditing and monitoring activities;
- Monitoring external health care FWA cases and determining if CalOptima Health's FWA Program can be strengthened with information gleaned from the case activity; and/or
- Internal and external surveys, reviews, and audits.

b. Data Analytics

CalOptima Health uses technology and data analyses to reduce FWA externally. Using a combination of industry standard edits and CalOptima Health-specific edits, CalOptima Health identifies claims for which procedures have been unbundled or upcoded. CalOptima Health also identifies suspect FDRs based on billing patterns.

CalOptima Health also uses the services of an external Medicare Secondary Payer (MSP) Vendor to reduce costs associated with its Medicare-Medicaid programs, such as the OneCare, and/or PACE programs, by ensuring that federal and state funds are not used where certain health insurance, or coverage, is primarily responsible.

c. Analysis and Identification of Risk Areas Using Claims Data

Claims data are analyzed in numerous ways to uncover fraudulent billing schemes. Routine review of claims data will be conducted in order to identify unusual patterns, outliers in billing and utilization, and identify the population of providers and pharmacies that will be further investigated and/or audited. Any medical claim can be pended and reviewed, in accordance with applicable state or federal law if they meet certain criteria that warrant additional review. Payments for pharmacy claims may also be pended and reviewed in accordance with applicable state or federal law based on criteria focused on the types of drugs (e.g., narcotics), provider patterns, and suspicious activities reported pertaining to pharmacies. CalOptima Health along with the Pharmacy Benefit Manager (PBM) will conduct data mining activities in order to identify potential issues of prescription or pharmacy FWA.

The following trends are reviewed and flagged for potential FWA, including:

- Overutilized services;
- Aberrant provider billing practices;

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- Abnormal billing in relation to peers;
- Manipulation of modifiers;
- Unusual coding practices such as excessive procedures per day, or excessive surgeries per patient;
- Unbundling of services;
- Unusual Durable Medical Equipment (DME) billing; and/or
- Unusual utilization patterns by members and providers.

The following claims data may be utilized to evaluate and uncover fraudulent billing schemes:

- Average dollars paid per medical procedure;
- Average medical procedures per office visit;
- Average visits per member;
- Average distance a member travels to see a provider/pharmacy;
- Excessive patient levels of high-risk diagnoses;
- Peer to peer comparisons within specialties;
- Analysis of provider medical billing activity within their own peer group;
- Analysis of pharmacy billing and provider prescribing practices;
- Controlled drug prescribing exceeds two (2) standard deviations of the provider's peer group; and/or
- Number of times a provider bills a CPT code in relation to all providers, or within their own peer group.

The claims data from the PBM go through the same risk assessment process. The analysis may be focused on the following characteristics:

- Prescription drug shorting, which occurs when pharmacy staff provides less than the prescribed quantity and intentionally does not inform the member or arranges to provide the balance but bills for the prescribed amount.
- Bait and switch pricing, which occurs when a member is led to believe that a drug will cost one (1) price, but at the point of sale, they are charged a higher amount. An example of this type of scheme is when the pharmacy switches the prescribed medication to a form that increases the pharmacy's reimbursement.
- Prescription forging, or altering, which occurs when existing prescriptions are altered to increase the quantity or the number of refills, without the prescriber's authorization. Usually, the medications are diverted after being billed to the Medicare Part D program.
- Dispensing expired, or adulterated, prescription drugs, which occurs when pharmacies dispense drugs after the expiration date on the package. This also includes drugs that are intended as samples not for sale or have not been stored or handled in accordance with manufacturer and FDA requirements.
- Prescription refill errors, which occur when pharmacy staff deliberately provides several refills different from the number prescribed by the provider.
- Failure to offer negotiated prices, which occurs when a pharmacy charges a member the wrong amount.

d. Sample Indicators

No single indicator is evidence of FWA. The presence of several indicators may suggest FWA,

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but further investigation is needed to determine if a suspicion of FWA exists. The following list below highlights common industry indicators and red flags that are used to determine whether to investigate an FDR or their claim disposition:

- Claims that show any altered information (dates, codes, names).
- Photocopies of claim forms and bills, or handwritten claims and bills.
- Provider's last name is the same as the member/patient's last name.
- The insured's address is the same as the servicing provider.
- Same provider submits multiple claims for the same treatment for multiple family members or group members of provider's practice.
- Provider resubmitting claim with changed diagnosis code for a date of service already denied.

Cases identified through these data sources and risk assessments are entered into the FWA case management system and a reports are routinely generated and shared with the Chief Compliance Officer and Compliance Committee. In addition, the Chief Compliance Officer, and/or his/her Designee, shall attend the quarterly DHCS Program Integrity meetings, as scheduled.

V. FWA INVESTIGATIVE PROCESS

Once the SIU receives an allegation of suspected FWA or detects FWA through an evaluation of the data sources identified above, the SIU utilizes the following steps as a guide to investigate and document the case:

- The allegation is logged into the case management system;
- The allegation is assigned an investigation number (sequentially by year of receipt) and an electronic file is assigned on the internal drive by investigation number and name;
- SIU develops an investigative plan;
- SIU obtains a legal opinion from legal counsel on specific cases or issues, as necessary;
- Quality of care issues are referred to CalOptima Health's Quality Improvement Department;
- Where appropriate, SIU will submit a Request for Information (RFI) directly to an FDR to obtain relevant information;
- SIU interviews the individual who reported the FWA, affected members and/or FDRs, or any other potential witnesses, as appropriate;
- SIU conducts a data analytics review of the allegation for overall patterns, trends, and errors using applicable data sources and reports;
- Review of FDR enrollment applications, history, and ownership
- Review of member enrollment applications and other documents, as necessary;
- Review of applicable contracts and/or All Plan Letters (APLs);
- Discuss allegation and evidence collected with subject matter experts;
- All supporting documentation is scanned and saved in the assigned electronic file. Any pertinent information, gathered during the SIU review/investigation, is placed into the electronic file;
- After an allegation is logged into the case management system, the investigation is tracked to its ultimate conclusion;
- The FWA case report shall reflect all information gathered and documentation received to

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ensure timely receipt, review, and resolution, and report may be made to applicable state or federal agencies within mandated/required time periods;

- If a referral to another investigative agency is warranted, the information is collected, and a referral is made to the appropriate agency; and/or
- If the investigation results in recommendations for disciplinary or corrective actions, the results of the investigation may be reported to the Chief Compliance Officer, CEO, and Compliance Committee. If a CalOptima Health internal department or FDR has repeated disciplinary or corrective actions, SIU may report the issue(s) to the Compliance Committee for further action.

a. Referral to Enforcement Agencies

CalOptima Health's SIU shall coordinate timely referrals of potential FWA to appropriate Regulatory Agencies, or their designated program integrity contractors, including the CMS MEDIC, DHCS Audits and Investigations, DMHC, Covered California, and/or other enforcement agencies, in accordance with the applicable reporting procedures adopted by such enforcement agencies. FDRs shall report FWA to CalOptima Health within the time frames required by the applicable contract and in sufficient time for CalOptima Health to timely report to applicable enforcement agencies. Significant program non-compliance, or suspected FWA, should be reported to CMS, Covered California, DMHC, and/or DHCS, as soon as possible after discovery, but no later than ten (10) business days to DHCS after CalOptima Health first becomes aware of and is on notice of such activity, and within thirty (30) calendar days to CMS MEDIC after a potential fraudulent or abusive activity is identified for a case impacting the OneCare program.

For the purposes of reporting FWA to Covered California:

- CalOptima Health shall communicate within ten (10) days to Covered California any material concerns identified by CalOptima Health or material concerns, including any enforcement actions resulting in monetary penalties equal to or exceeding $100,000, identified by State and Federal Regulators related to regulatory compliance that may impact performance under the contract with Covered California following CalOptima Health's knowledge of such occurrence; provided, however, such notification shall be provided immediately if such occurrence may reasonably be deemed to adversely affect the quality of care or safety of Covered California members. All notifications shall be made according to the "Contract Reporting Requirements" table posted on CalOptima Health's extranet website provided by Covered California.
- If CalOptima Health receives any preliminary or final reports, findings, or orders related to material concerns identified by State and Federal Regulators that may impact performance under the contract with Covered California pursuant to Section 1.15 of the 6.5. Qualified Health Plans (QHP) contract, CalOptima Health shall provide Covered California with copies of them within 48 hours of receiving them from State and Federal Regulators.
- CalOptima Health shall provide Covered California with a description of its FWA detection and prevention programs and report total monies recovered by CalOptima Health in the most recent 12-month period for CalOptima Health's total book of business as well as, total monies recovered for Covered California business only. This description shall be updated during each year that the contract with Covered California is in effect and shall include an overview of fraud and abuse detection and prevention program activities

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conducted by CalOptima Health, Participating Providers, other Subcontractors and their authorized Agents, including a summary of key findings, relevant data analytics and fraud risk assessments to circumvent fraud, waste, and abuse, and the development, implementation, and enforcement of any corrective action plans for changing, upgrading, or improving these programs.

- ► CalOptima Health maintains and enforces a written Code of Conduct publicly available on CalOptima Health's website.
- ► CalOptima Health shall refer potential fraud activities identified through fraud detection and response measures to Covered California. CalOptima Health shall follow the established Carrier Referral Process posted on the Contractor's extranet website provided by Covered California.

Potential cases that should be referred include, but are not limited to:

- ► Suspected, detected, or reported criminal, civil, or administrative law violations;
- ► Allegations that extend beyond CalOptima Health and involve multiple health plans, multiple states, or widespread schemes;
- ► Allegations involving known patterns of FWA;
- ► Patterns of FWA threatening the life, or well-being, of CalOptima Health members; and/or
- ► Schemes with large financial risk to CalOptima Health, or its members.

b. Findings, Response, and Remediation

Outcomes and findings of the investigation may include, but are not limited to, confirmation of violations, insufficient evidence of FWA, need for contract amendment, education and training requirement, recommendation of focused audits, additional investigation, continued monitoring, prepayment claim review, new policy implementation, and/or criminal or civil action. As appropriate, claims will be denied or reversed, chargebacks against future claims will be employed, and other payment recovery actions will be taken. The SIU will track and trend the FWA allegation and investigation, including, the data analysis performed, which shall be reported to the Compliance Committee on a quarterly basis. Investigation findings can be used to determine whether disciplinary, or corrective, action is appropriate, whether there is a need for a change in CalOptima Health's Policies and Procedures.

In accordance with applicable CalOptima Health Policies and Procedures, CalOptima Health shall take appropriate disciplinary, or corrective, action against Board members, employees, and/or FDRs related to validated instances of FWA. CalOptima Health will also assess FDRs for potential overpayments when reviewing and undertaking corrective actions. Corrective actions will be monitored by the Compliance Committee, and progressive discipline will be monitored by the Department of Human Resources, as appropriate. Corrective actions may include, but are not limited to, financial sanctions, regulatory reporting, CAPs, or termination of the delegation agreement, when permitted by the contract terms. Should such disciplinary, or corrective, action need to be issued, CalOptima Health's Office of Compliance will initiate review and discussion at the first Compliance Committee following the date of identification of the suspected FWA, the date of report to DHCS, or the date of FWA substantiation by DHCS subsequent to the report. If vulnerability is identified through a single FWA incident, the corrective action may be applied universally.

CalOptima Health will not terminate Covered California member coverage for fraud without

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prior review and approval from Covered California.

c. Cooperation with regulatory investigations or prosecutions
Should there be any investigation or prosecution conducted by the Office of the Attorney General, Division of Medi-Cal Fraud and Elder Abuse (DMFEA), or the U.S. DOJ, CalOptima Health shall cooperate with the investigation, which may include, but is not limited to, providing information and access to records upon request.

VI. ANNUAL FWA EVALUATION

CalOptima Health's Compliance Committee shall periodically review and evaluate the FWA work plan, FWA activities, and its effectiveness as part of the overall Compliance Program Audit and Monitoring Activities. Revisions should be made based on industry changes, trends in FWA activities (locally and nationally), the OIG Work Plan, the CalOptima Health Compliance Plan, and other input from applicable sources.

VII. POLICIES AND PROCEDURES (P&Ps)

The CalOptima Health Policies and Procedures listed below are the primary means by which the Anti-Fraud, Waste and Abuse Plan is effectuated at CalOptima Health.

- GA.8022: Performance and Behavior Standards
- GG.1428: Pharmacy Management Medi-Cal Rx Responsibilities
- GG.1615: Corrective Action Plan for Practitioners and Organizational Providers
- HH.1105: Fraud, Waste, and Abuse Detection
- HH.1107: Fraud, Waste, and Abuse Investigation and Reporting
- HH.2002: Sanctions
- HH.2005: Corrective Action Plan
- HH.2007: Compliance Committee
- HH.2014: Compliance Program
- HH.2018: Compliance and Ethics Hotline
- HH.2019: Reporting Suspected or Actual Fraud, Waste, or Abuse (FWA), Violations of Applicable Laws and Regulations, and/or CalOptima Health Policies
- HH.2020: Conducting Compliance Investigations
- HH.2023: Compliance Training
- HH.2028: Code of Conduct
- HH.3012: Non-Retaliation for Reporting Violations
- HH.5000: Provider Overpayment Investigation and Determination
- HH.5004: False Claims Act Education
- MA.5013: Pharmacy Audits and Reviews
- MA.6104: Opioid Medication Utilization Management

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~~2025~~2026 HIPAA Privacy and Security Program

Protection of Member Health Information

(Revised September ~~2024~~2025)

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Document maintained by: John Tanner
CalOptima Health Chief Compliance Officer

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I. OBJECTIVES

This program description is a general introduction for all CalOptima Health employees to the privacy and security regulations dictated by the federal Health Insurance Portability and Accountability Act (HIPAA), the Health Information Technology for Economic and Clinical Health Act (HITECH), other federal and California privacy laws, as well as CalOptima HIPAA security and privacy policies and procedures. This program description will be updated as needed and reviewed on an annual basis.

It is expected that all CalOptima Health employees understand that it is their legal and ethical responsibility to preserve and protect the privacy, confidentiality and security of all confidential information in accordance with these laws, policies, and procedures.

All employees are expected to access, use, and disclose confidential information only in the performance of their duties or when required or permitted by law. Additionally, all employees must disclose information only to persons who have the right to receive that information.

II. HIPAA PRIVACY AND CONFIDENTIALITY OVERVIEW

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law which, in part, protects the privacy of individually identifiable member information, provides for the electronic and physical security of health and member medical information, and simplifies billing and other electronic transactions through the use of standard transactions and code sets (billing codes). HIPAA applies to all "covered entities" such as hospitals, physicians and other providers, health plans, their employees and other members of the covered entities' workforce. HIPAA privacy and security standards were updated in 2009 by the Health Information Technology for Economic and Clinical Health (HITECH) Act and in 2013 by the HIPAA Final Omnibus Rule.

Privacy and security are addressed separately in HIPAA under two distinct rules, the Privacy Rule and the Security Rule. The Privacy Rule sets the standards for how all protected health information (PHI) should be controlled. Privacy standards define what information must be protected, who is authorized to access, use or disclose information, what processes must be in place to control the access, use, and disclosure of information, and member rights.

The Security Rule defines the standards for covered entities' basic security safeguards to protect electronic protected health information (ePHI). Security is the ability to control access to electronic information, and to protect it from accidental or intentional disclosure to unauthorized persons and from alteration, destruction, or loss. The standards include

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administrative, technical, and physical safeguards designed to protect the confidentiality, integrity, and availability of ePHI.

III. DEFINITION OF PROTECTED HEALTH INFORMATION (PHI)

The HIPAA privacy regulations apply to "protected health information" (PHI). This term is used throughout this HIPAA Privacy and Security Program as well as in the policies and procedures.

Protected Health Information (PHI) has the meaning in 45 Code of Federal Regulations ~~Section~~(CFR) § 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media (ePHI), or transmitted or maintained in any other form or medium. This information identifies the individual, or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima Health or its Business Associate(s) 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.

PHI excludes:

1. Education records covered by the Family Educational Rights and Privacy Act;
2. Health records held by post-secondary educational institutions; and
3. Employment records held by a covered entity in its role as employer.

Electronic Protected Health Information (EPHI) is individually identifiable health information that is transmitted by electronic media or maintained in electronic media.

What is not considered PHI?

Health information is not PHI if it is de-identified. De-identified information may be used without restriction and without member authorization. The de-identification standard provides a method for which health information can be designated as de-identified. This method requires the removal of all 18 identifying data elements listed in the regulations. To ensure that PHI is de-identified, two methods can be used to satisfy the Privacy Rule's de-identification standard as specific in 45 CFR §164.514(b)(1) Expert Determination, and 45 CFR §164.514(b)(2) Safe Harbor.

The identifiers of an individual or of relatives, employers, or household members of the individual, which must be removed, are:

1. Names;
2. Geographic subdivisions smaller than a State (addresses);

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3. Elements of dates (except year) for dates directly related to an individual (birthdates);
4. Telephone numbers;
5. Fax numbers;
6. Electronic mail addresses;
7. Social security numbers;
8. Medical records numbers;
9. Health plan beneficiary numbers;
10. Account numbers;
11. Certificate or license numbers;
12. Vehicle identifiers and serial numbers (license plate numbers);
13. Device identifiers and serial numbers;
14. Web Universal Resource Locators (URLs);
15. Internet Protocol (IP) address numbers;
16. Biometric identifiers (finger, eye, and voice prints);
17. Full face photographic images and any comparable images; and
18. Any other unique identifying number, characteristic, or code, except as permitted by paragraph c of 45 CFR §164.514(b)(2).

What member information must we protect?

We must protect all PHI including, but not limited to medical/clinical records, prescriptions, billing records, claim data, referral authorizations, member notifications such as explanation of benefits and other member materials including marketing materials that contain PHI.

We have implemented controls, as well as policies and procedures, for protecting member information pertaining to race, ethnicity, language, gender identity[1], and sexual orientation[2].

IV. THE PRIVACY RULE AND THE SECURITY RULE

Purpose of Privacy Rule

The purpose of the Privacy Rule is to protect and enhance the rights of members by providing them access to their health information and controlling the inappropriate use of that information.

Highlights of Privacy Rule

[1] **Gender identity** is defined as an individual's innermost concept of self and experience of gender (how individuals perceive themselves and what they call themselves). An individual's gender identity may be the same or different from the sex assigned at birth.

[2] **Sexual orientation**, which is separate from gender identity, is defined as an inherent or immutable and enduring emotional, romantic or sexual attraction or nonattraction to individuals of the same and/or other genders.

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The Privacy Rule requires that access to PHI, including ePHI, by CalOptima Health employees is based on the general principles of "need to know" and "minimum necessary," wherein access is limited only to the member information needed to perform a job function.

The Privacy Rule also affords certain rights to members, such as the right to request copies of their health records in paper or electronic format, or to request an amendment of information in their records.

Potential Consequences of Violating the Privacy Rule

The Privacy Rule imposes penalties for non-compliance and for breaches of privacy. These penalties range from $~~137~~141 per violation to $2,~~067,813~~134,831 per violation (with an annual penalty limit of $2,~~067,813~~134,831), in addition to costs and attorneys' fees and costs, depending on the type of violation. In addition to civil monetary penalties, other consequences may include civil lawsuits, misdemeanor and felony charges, the reporting of individual violators to licensing boards for violations, and imprisonment.

Purpose of Security Rule

The Security Rule encompasses physical, administrative, and technical security, including computer systems and transmissions of ePHI. The rule's purpose is to:

- Ensure the confidentiality, integrity, and availability of all ePHI that is created, received, maintained, or transmitted by the covered entity.
- Protect against any reasonably anticipated threats or hazards to the security or integrity of ePHI.
- Protect against unauthorized uses or disclosures of ePHI.
- Ensure compliance of the covered entity's workforce.

Definition of Security

"**Security**" is defined as having controls, countermeasures, and procedures in place to ensure the appropriate protection of information assets, and to control access to valued resources. The purpose of security is to minimize the vulnerability of assets and resources.

Requirements and Responsibility for Security

CalOptima Health's Information Cybersecurity Department is responsible for maintaining, monitoring, storing and securing transmission of ePHI data along with oversight of all policies and procedures regarding the security of CalOptima Health information assets.

CalOptima Health employees are responsible for protecting all of CalOptima Health's electronic information resources under their control by employing appropriate and applicable security controls.

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Protection of CalOptima Health electronic information resources encompasses:

- Safeguarding ePHI from accidental or intentional disclosure to unauthorized persons.
- Safeguarding ePHI from accidental or intentional alteration, destruction, or loss.
- Safeguarding systems from viruses and malware.
- Taking precautions that will minimize the potential for theft, destruction, or any type of loss.
- Protecting workstations and mobile devices from unauthorized access and theft (e.g., via encryption, password authenticated access and physical lockdown) to ensure that ePHI is accessed, used, and/or disclosed only by authorized persons.
- Protecting other electronic assets and storage media (e.g., USB thumb drives, external hard drives, CD--ROM/DVD disks, floppy disks, magnetic tapes, videotapes, SD memory cards, etc.) from unauthorized access and theft, to ensure that ePHI contained within is accessed, used, and/or disclosed only by authorized persons.

V. WRITTEN POLICIES AND PROCEDURES FOR HIPAA PRIVACY PROGRAM

CalOptima Health's policies and procedures for the HIPAA Privacy and Security Program are located on CalOptima Health's intranet, InfoNet, which is accessible to all employees. Policies and procedures are available to CalOptima providers and health networks on CalOptima Health's website.

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- Recommending and monitoring, in conjunction with the relevant business units or departments, the development of internal systems to carry out the privacy policies and procedures as part of daily operations;

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- Determining the appropriate strategy/approach to promote compliance with the Privacy Program and Security Program and detection of any potential violations, such as through hotlines and other reporting mechanisms;
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- Reviewing and tracking of possible confidentiality breaches that may be identified through incident reports, security incident reports, referrals for privacy investigations, etc.;
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Responsibility to Report

CalOptima Health is committed to compliance with the HIPAA and state privacy laws and to correcting violations wherever they may occur in the organization. Every employee is responsible for reporting any activity they suspect violates applicable privacy and security laws, rules, regulations or the HIPAA Privacy and Security Program. CalOptima Health must notify the Department of Health Care Services (DHCS) of any suspected or actual security incident and breaches of unsecure (unencrypted) protected information or other unauthorized use or disclosure of our members' PHI and provide a written report of the investigation. On an as needed basis, CalOptima Health shall notify the Centers for Medicare & Medicaid Services (CMS), and/or the Department of Health and Human Services, Office of Civil Rights (OCR), and/or the California Attorney General of actual privacy and security breaches. The Office of Compliance will maintain documentation of incidents, including the nature of any investigation, mitigation and corrective action. In addition, employees and members have the right to report violations to the California DHCS Privacy Officer or the Secretary of the Department of Health and Human Services (DHHS). Contact information is below:

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~~C/O: Office of HIPAA Compliance~~
Department of Health Care Services
~~C/O~~Attention: Office of HIPAA Compliance
P.O. Box 997413, MS ~~47224~~4721
Sacramento, CA 95899-7413
Phone: ~~(1-~~916~~)-~~ 552-9444~~445-4646~~
Fax: ~~(1-~~916~~)-~~440-7680
Email: hipaateam@dhcs.ca.gov

OR

U.S. Department of Health and Human Services
Office for Civil Rights
Attention: Regional Manager
90 7th Street, Suite 4-100
San Francisco, CA 94103
Phone: (800) 368-1019~~ or~~
~~FAX~~ Fax: (202) 619-3818~~(415) 437-8329 or~~
TDD: (800) 537-7697 ~~TDD~~
Email: ocrmail~~OCRComplaint~~@hhs.gov

In addition, employees who have observed a security incident or HIPAA breach (e.g., unsecured transmission of PHI, etc.) may contact the Compliance Hotline anonymously at: 1-855-507-1805, CalOptima Health's Privacy Officer at Privacy@caloptima.org, or CISO.

Confidentiality and No Retaliation

CalOptima Health will not threaten, intimidate, discriminate, or take other retaliatory action against any individual for filing HIPAA complaints, assisting in HIPAA investigations or compliance reviews, or raising concerns with any act or practice that they suspect is in violation of HIPAA and/or state privacy laws when the individual has a good faith belief that the act may be unlawful.

X. ENFORCING STANDARDS THROUGH DISCIPLINARY GUIDELINES

All violators of the HIPAA Privacy and Security Program or of the policies and procedures will be subject to disciplinary action. The precise discipline will depend on the nature and severity of the violation.

Disciplinary Guidelines

Any employee who fails to comply with CalOptima Health's HIPAA Privacy and Security Program or its policies and procedures is subject to focused and/or additional training or discipline. In coordination with ~~Human Resource policy~~CalOptima Health Policy GA.8022 ~~Progressive Discipline~~: Performance and Behavior Standards, such discipline

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may include: 1) a verbal warning; 2) written warning; 3) suspension; or 4) termination. The type of discipline rendered will depend on the degree of wrongdoing, whether there have been past violations and the individual's cooperation in promptly reporting the incident to the appropriate manager or to the Privacy Officer. Intentional or reckless non-compliance will not be tolerated and will subject the employee to discipline up to and including termination of employment.

CalOptima Health's Office of Compliance may require that an internal department or FDR develop a Corrective Action Plan based on the identified area(s) of non-compliance identified from the HIPAA and/or state privacy laws violation.

Consistent Enforcement of Policies

The range of disciplinary standards for improper conduct will be consistently applied and enforced. All personnel will be treated equally, and disciplinary action will be taken on a fair and equitable basis. CalOptima Health management must comply with and take action to ensure that their direct reports comply with the applicable policies and procedures.

Education on Disciplinary Guidelines

In the training sessions, all employees will be advised of the policy regarding disciplinary actions for non-compliance.

XI. RESPONSE TO DETECTED OFFENSES AND CORRECTIVE ACTION PLANS

Investigation and Corrective Action

If there is a report of non-compliance, or if the Privacy Officer, CISO, a member of the Compliance Committee, or a manager discovers credible evidence of a violation, an investigation will immediately ensue. When CalOptima Health substantiates a reported violation, it is the policy to institute corrective action.

Initiating Systemic Changes to Correct Problems

After a problem has been identified and corrected, the Privacy Officer, CISO, and the Compliance Committee will review the circumstances to determine: 1) whether similar problems have been uncovered elsewhere, and 2) whether modifications of the privacy policies and procedures are necessary to prevent and detect other inappropriate conduct or violations. The Privacy Officer and CISO will work with the Compliance Committee to initiate systemic changes throughout the company to avoid future problems of a similar nature.

Mitigation

If a suspected or actual use or disclosure occurs by CalOptima Health or a business associate that violates the HIPAA regulations and/or state privacy laws, CalOptima

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Health will take prompt corrective action to mitigate any damaging effects that the potential disclosure could have on the affected members as well as cure any system deficiencies to prevent future unauthorized uses or disclosures. CalOptima Health employees and FDRs are required to report any suspected or actual violation that they observe or learn about to his/her supervisor, or the Privacy Officer, CCO, or CISO immediately so that action to mitigate the damage can commence promptly.

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CalOptima Health

2026 HIPAA Privacy and Security Program

Protection of Member Health Information

(Revised September 2025)

For 20251106 BOD Review Only

Document maintained by: John Tanner
CalOptima Health Chief Compliance Officer

CalOptima Health - A Public Agency
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Main: 714-246-8400 | TTY: 711

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I. OBJECTIVES

This program description is a general introduction for all CalOptima Health employees to the privacy and security regulations dictated by the federal Health Insurance Portability and Accountability Act (HIPAA), the Health Information Technology for Economic and Clinical Health Act (HITECH), other federal and California privacy laws, as well as CalOptima HIPAA security and privacy policies and procedures. This program description will be updated as needed and reviewed on an annual basis.

It is expected that all CalOptima Health employees understand that it is their legal and ethical responsibility to preserve and protect the privacy, confidentiality and security of all confidential information in accordance with these laws, policies, and procedures.

All employees are expected to access, use, and disclose confidential information only in the performance of their duties or when required or permitted by law. Additionally, all employees must disclose information only to persons who have the right to receive that information.

II. HIPAA PRIVACY AND CONFIDENTIALITY OVERVIEW

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law which, in part, protects the privacy of individually identifiable member information, provides for the electronic and physical security of health and member medical information, and simplifies billing and other electronic transactions through the use of standard transactions and code sets (billing codes). HIPAA applies to all "covered entities" such as hospitals, physicians and other providers, health plans, their employees and other members of the covered entities' workforce. HIPAA privacy and security standards were updated in 2009 by the Health Information Technology for Economic and Clinical Health (HITECH) Act and in 2013 by the HIPAA Final Omnibus Rule.

Privacy and security are addressed separately in HIPAA under two distinct rules, the Privacy Rule and the Security Rule. The Privacy Rule sets the standards for how all protected health information (PHI) should be controlled. Privacy standards define what information must be protected, who is authorized to access, use or disclose information, what processes must be in place to control the access, use, and disclosure of information, and member rights.

The Security Rule defines the standards for covered entities' basic security safeguards to protect electronic protected health information (ePHI). Security is the ability to control access to electronic information, and to protect it from accidental or intentional disclosure to unauthorized persons and from alteration, destruction, or loss. The standards include

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administrative, technical, and physical safeguards designed to protect the confidentiality, integrity, and availability of ePHI.

III. DEFINITION OF PROTECTED HEALTH INFORMATION (PHI)

The HIPAA privacy regulations apply to "protected health information" (PHI). This term is used throughout this HIPAA Privacy and Security Program as well as in the policies and procedures.

Protected Health Information (PHI) has the meaning in 45 Code of Federal Regulations (CFR) § 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media (ePHI), or transmitted or maintained in any other form or medium. This information identifies the individual, or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima Health or its Business Associate(s) 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.

PHI excludes:

1. Education records covered by the Family Educational Rights and Privacy Act;
2. Health records held by post-secondary educational institutions; and
3. Employment records held by a covered entity in its role as employer.

Electronic Protected Health Information (EPHI) is individually identifiable health information that is transmitted by electronic media or maintained in electronic media.

What is not considered PHI?

Health information is not PHI if it is de-identified. De-identified information may be used without restriction and without member authorization. The de-identification standard provides a method for which health information can be designated as de-identified. This method requires the removal of all 18 identifying data elements listed in the regulations. To ensure that PHI is de-identified, two methods can be used to satisfy the Privacy Rule's de-identification standard as specific in 45 CFR §164.514(b)(1) Expert Determination, and 45 CFR §164.514(b)(2) Safe Harbor.

The identifiers of an individual or of relatives, employers, or household members of the individual, which must be removed, are:

1. Names;
2. Geographic subdivisions smaller than a State (addresses);

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3. Elements of dates (except year) for dates directly related to an individual (birthdates);
4. Telephone numbers;
5. Fax numbers;
6. Electronic mail addresses;
7. Social security numbers;
8. Medical records numbers;
9. Health plan beneficiary numbers;
10. Account numbers;
11. Certificate or license numbers;
12. Vehicle identifiers and serial numbers (license plate numbers);
13. Device identifiers and serial numbers;
14. Web Universal Resource Locators (URLs);
15. Internet Protocol (IP) address numbers;
16. Biometric identifiers (finger, eye, and voice prints);
17. Full face photographic images and any comparable images; and
18. Any other unique identifying number, characteristic, or code, except as permitted by paragraph c of 45 CFR §164.514(b)(2).

What member information must we protect?

We must protect all PHI including, but not limited to medical/clinical records, prescriptions, billing records, claim data, referral authorizations, member notifications such as explanation of benefits and other member materials including marketing materials that contain PHI.

We have implemented controls, as well as policies and procedures, for protecting member information pertaining to race, ethnicity, language, gender identity[1], and sexual orientation[2].

IV. THE PRIVACY RULE AND THE SECURITY RULE

Purpose of Privacy Rule

The purpose of the Privacy Rule is to protect and enhance the rights of members by providing them access to their health information and controlling the inappropriate use of that information.

Highlights of Privacy Rule

[1] **Gender identity** is defined as an individual's innermost concept of self and experience of gender (how individuals perceive themselves and what they call themselves). An individual's gender identity may be the same or different from the sex assigned at birth.

[2] **Sexual orientation**, which is separate from gender identity, is defined as an inherent or immutable and enduring emotional, romantic or sexual attraction or nonattraction to individuals of the same and/or other genders.

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The Privacy Rule requires that access to PHI, including ePHI, by CalOptima Health employees is based on the general principles of "need to know" and "minimum necessary," wherein access is limited only to the member information needed to perform a job function.

The Privacy Rule also affords certain rights to members, such as the right to request copies of their health records in paper or electronic format, or to request an amendment of information in their records.

Potential Consequences of Violating the Privacy Rule

The Privacy Rule imposes penalties for non-compliance and for breaches of privacy. These penalties range from $141 per violation to $2,134,831 per violation (with an annual penalty limit of $2,134,831), in addition to costs and attorneys' fees and costs, depending on the type of violation. In addition to civil monetary penalties, other consequences may include civil lawsuits, misdemeanor and felony charges, the reporting of individual violators to licensing boards for violations, and imprisonment.

Purpose of Security Rule

The Security Rule encompasses physical, administrative, and technical security, including computer systems and transmissions of ePHI. The rule's purpose is to:

- Ensure the confidentiality, integrity, and availability of all ePHI that is created, received, maintained, or transmitted by the covered entity.
- Protect against any reasonably anticipated threats or hazards to the security or integrity of ePHI.
- Protect against unauthorized uses or disclosures of ePHI.
- Ensure compliance of the covered entity's workforce.

Definition of Security

"**Security**" is defined as having controls, countermeasures, and procedures in place to ensure the appropriate protection of information assets, and to control access to valued resources. The purpose of security is to minimize the vulnerability of assets and resources.

Requirements and Responsibility for Security

CalOptima Health's Information Cybersecurity Department is responsible for maintaining, monitoring, storing and securing transmission of ePHI data along with oversight of all policies and procedures regarding the security of CalOptima Health information assets.

CalOptima Health employees are responsible for protecting all of CalOptima Health's electronic information resources under their control by employing appropriate and applicable security controls.

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Protection of CalOptima Health electronic information resources encompasses:

- Safeguarding ePHI from accidental or intentional disclosure to unauthorized persons.
- Safeguarding ePHI from accidental or intentional alteration, destruction, or loss.
- Safeguarding systems from viruses and malware.
- Taking precautions that will minimize the potential for theft, destruction, or any type of loss.
- Protecting workstations and mobile devices from unauthorized access and theft (e.g., via encryption, password authenticated access and physical lockdown) to ensure that ePHI is accessed, used, and/or disclosed only by authorized persons.
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Department of Health Care Services
Attention: Office of HIPAA Compliance
P.O. Box 997413, MS 4721
Sacramento, CA 95899-7413
Phone: (916) 552-9444
Fax: (916) 440-7680
Email: hipaateam@dhcs.ca.gov

OR

U.S. Department of Health and Human Services
Office for Civil Rights
Attention: Regional Manager
90 7th Street, Suite 4-100
San Francisco, CA 94103
Phone: (800) 368-1019
Fax: (202) 619-3818
TDD: (800) 537-7697
Email: ocrmail@hhs.gov

In addition, employees who have observed a security incident or HIPAA breach (e.g., unsecured transmission of PHI, etc.) may contact the Compliance Hotline anonymously at: 1-855-507-1805, CalOptima Health's Privacy Officer at Privacy@caloptima.org, or CISO.

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CalOptima Health will not threaten, intimidate, discriminate, or take other retaliatory action against any individual for filing HIPAA complaints, assisting in HIPAA investigations or compliance reviews, or raising concerns with any act or practice that they suspect is in violation of HIPAA and/or state privacy laws when the individual has a good faith belief that the act may be unlawful.

X. ENFORCING STANDARDS THROUGH DISCIPLINARY GUIDELINES

All violators of the HIPAA Privacy and Security Program or of the policies and procedures will be subject to disciplinary action. The precise discipline will depend on the nature and severity of the violation.

Disciplinary Guidelines

Any employee who fails to comply with CalOptima Health's HIPAA Privacy and Security Program or its policies and procedures is subject to focused and/or additional training or discipline. In coordination with CalOptima Health Policy GA.8022: Performance and Behavior Standards, such discipline may include: 1) a verbal warning; 2) written warning; 3) suspension; or 4) termination. The type of discipline rendered will depend on the degree

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of wrongdoing, whether there have been past violations and the individual's cooperation in promptly reporting the incident to the appropriate manager or to the Privacy Officer. Intentional or reckless non-compliance will not be tolerated and will subject the employee to discipline up to and including termination of employment.

CalOptima Health's Office of Compliance may require that an internal department or FDR develop a Corrective Action Plan based on the identified area(s) of non-compliance identified from the HIPAA and/or state privacy laws violation.

Consistent Enforcement of Policies

The range of disciplinary standards for improper conduct will be consistently applied and enforced. All personnel will be treated equally, and disciplinary action will be taken on a fair and equitable basis. CalOptima Health management must comply with and take action to ensure that their direct reports comply with the applicable policies and procedures.

Education on Disciplinary Guidelines

In the training sessions, all employees will be advised of the policy regarding disciplinary actions for non-compliance.

XI. RESPONSE TO DETECTED OFFENSES AND CORRECTIVE ACTION PLANS

Investigation and Corrective Action

If there is a report of non-compliance, or if the Privacy Officer, CISO, a member of the Compliance Committee, or a manager discovers credible evidence of a violation, an investigation will immediately ensue. When CalOptima Health substantiates a reported violation, it is the policy to institute corrective action.

Initiating Systemic Changes to Correct Problems

After a problem has been identified and corrected, the Privacy Officer, CISO, and the Compliance Committee will review the circumstances to determine: 1) whether similar problems have been uncovered elsewhere, and 2) whether modifications of the privacy policies and procedures are necessary to prevent and detect other inappropriate conduct or violations. The Privacy Officer and CISO will work with the Compliance Committee to initiate systemic changes throughout the company to avoid future problems of a similar nature.

Mitigation

If a suspected or actual use or disclosure occurs by CalOptima Health or a business associate that violates the HIPAA regulations and/or state privacy laws, CalOptima Health will take prompt corrective action to mitigate any damaging effects that the potential disclosure could have on the affected members as well as cure any system

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deficiencies to prevent future unauthorized uses or disclosures. CalOptima Health employees and FDRs are required to report any suspected or actual violation that they observe or learn about to his/her supervisor, or the Privacy Officer, CCO, or CISO immediately so that action to mitigate the damage can commence promptly.

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Attachment 6: Summary of Proposed Actions for Office of Compliance Policies and Procedures

Table 1: Revisions to the Office of Compliance Policies and Procedures

The following table lists the proposed revisions to the CalOptima Office of Compliance policies and procedures, by department.

POLICY & DEPARTMENT	REVISION, PROGRAM & CONTACTS	A – NEW B – REVISED C – RETIREMENT D – REVISED [MINOR EDITS] E – ANNUAL REVIEW [NO EDITS]
AA.1270: Certification of Document and Data Submissions *Regulatory Affairs & Compliance*	**B – REVISED:** This policy was updated to outline provisions clarifying what additional types of data, information, and documentation the Department of Health Care Services (DHCS) certification statement applies to align with CalOptima Health's Primary Agreement with DHCS – Amendment 07. Glossary updates were also made to align with current contractual and regulatory guidelines. **Program(s):** Medi-Cal; OneCare	
GA.7508: CalOptima Health Policy and Procedure Review Process *Regulatory Affairs & Compliance, Policies and Procedures*	**B – REVISED:** This policy was revised for language clarity and the removal of Dual Plan Letter (DPL) references as the program has ended and to update the Policy Review Committee (PRC) process for clarification and alignment with the CalOptima Health PRC Charter. **Program(s):** Administrative	
HH.1105: Fraud, Waste, and Abuse Detection *Fraud, Waste, and Abuse – Special Investigations Unit*	**B – REVISED:** This policy was updated to add circumstantial categories in which CalOptima Health may detect fraud, waste, and abuse (FWA) by a first tier, downstream, and related entity (FDR). References were also updated to align with current contractual and regulatory guidelines. **Program(s):** Covered California; Medi-Cal; OneCare; PACE	
HH.1107: Fraud, Waste, and Abuse Investigation and Reporting *Fraud, Waste, and Abuse – Special Investigations Unit*	**B – REVISED:** This policy was updated to add language related to credible allegations of fraud involving CBAS providers, associated reporting processes and Covered California enrollment fraud. **Program(s):** Covered California; Medi-Cal; OneCare; PACE	

POLICY & DEPARTMENT	REVISION, PROGRAM & CONTACTS	A – NEW B – REVISED C – RETIREMENT D – REVISED [MINOR EDITS] E – ANNUAL REVIEW [NO EDITS]
HH.2002: Sanctions *Office of Compliance*	**B – REVISED:** This policy was revised for language updates to clarify processes and types of sanctions CalOptima Health may impose, add bases for the imposition of sanctions, and update procedures for determining sanctions and complaint processes if a first tier, downstream, and related entity (FDR) disagrees with the sanction. Glossary updates were also made to align with current contractual and regulatory guidelines. **Program(s):** Medi-Cal; OneCare; PACE	
HH.2005: Corrective Action Plan *Regulatory Affairs & Compliance*	**B – REVISED:** This policy was revised to include directives establishing CalOptima Health's responsibility to conduct auditing, monitoring, and investigations of CalOptima Health internal departments and its FDRs and initiate required meetings to discuss unacceptable response(s) or failure(s) to respond to immediate corrective action plans (ICAPs) or corrective action plans (CAPs) and provide provisions for responding to failures to maintain adequate resolutions and responsibilities for public posting of annual DHCS Medical Audit reports of CAPs. Reference and glossary updates were also made to align with CalOptima Health policies and current contractual and regulatory guidelines. **Program(s):** Medi-Cal; OneCare; PACE	
HH.2007: Compliance Committee *Office of Compliance*	**B – REVISED:** This policy was revised to clarify Compliance Committee responsibilities and Director of Delegation Oversight reporting functions on behalf of the Delegation Oversight Committee (DOC). References and glossary terms were also updated to align with CalOptima Health policies and current contractual and regulatory guidelines. **Program(s):** Medi-Cal; OneCare; PACE	
HH.2022: Record Retention and Access *Regulatory Affairs & Compliance*	**B – REVISED:** This policy was revised to clarify pertinent records that shall be retained by FDRs for the allotted 10-year minimum requirement, and which regulatory agencies may inspect, evaluate, and audit an FDR at any time. References were also updated to align with current contractual and regulatory guidelines. **Program(s):** Medi-Cal; OneCare; PACE	
HH.3000: Notice of Privacy Practices *Privacy*	**B – REVISED:** This policy was updated to include procedures for accommodating sensitive services and protecting sensitive service information. References were also updated to align with CalOptima Health policies. **Program(s):** Medi-Cal; OneCare; PACE	

POLICY & DEPARTMENT	REVISION, PROGRAM & CONTACTS	A – NEW B – REVISED C – RETIREMENT D – REVISED [MINOR EDITS] E – ANNUAL REVIEW [NO EDITS]
HH.3011: Use and Disclosure of PHI for Treatment, Payment, and Health Care Operations *Privacy*	**B – REVISED:** This policy was updated to clarify procedures for the disclosure of member protected health information (PHI) to family, friends, and caregivers to align with Health Insurance Portability and Accountability (HIPPA) regulations. **Program(s):** Medi-Cal; OneCare; PACE	
HH.3014: Use of Electronic Mail with Protected Health Information (PHI) and Personally Identifiable Information (PII) *Privacy*	**B – REVISED:** This policy was updated to provide clarification on procedures for email encryption to align with CalOptima Health Information Technology (IT) policies. **Program(s):** Medi-Cal; OneCare; PACE	
HH.3016: Guidelines for Handling Protected Health Information Off-site *Privacy*	**B – REVISED:** This policy was updated to clarify general guidelines for handling PHI off-site to align with CalOptima Health Human Resources policies. **Program(s):** Medi-Cal; OneCare; PACE	
HH.3024: Confidentiality of Medical Information Act Compliance *Privacy*	**B – REVISED:** This policy was updated to include provisions supporting the confidentiality of abortion services information in response to a subpoena or request to align with the Confidentiality of Medical Information Act (CMIA). **Program(s):** Covered California; Medi-Cal; OneCare; PACE	
HH.4002: CalOptima Health Internal Oversight *Internal Audit*	**B – REVISED:** This policy was revised to add functional areas in which internal oversight will be provided, update the time frame for sending notice confirming date and scope of audit to management staff, and clarify key performance indicator (KPI)/Dashboard monitoring processes. **Program(s):** Administrative	
HH.4003: Annual Risk Assessment (Internal) *Internal Audit*	**B – REVISED:** This policy was revised to clarify calendar year timeframes for presenting Work Plan and Annual Risk Assessment results and modify language for operational department meetings for discovery and analysis to align with current auditing processes. **Program(s):** Administrative	

POLICY & DEPARTMENT	REVISION, PROGRAM & CONTACTS	A – NEW B – REVISED C – RETIREMENT D – REVISED [MINOR EDITS] E – ANNUAL REVIEW [NO EDITS]
Title revision **HH.4004: Grant Audits/Reviews ~~Auditing~~** *Internal Audit*	**B – REVISED:** This policy's purpose statement and provisions were revised to align with current Grant Auditing practices. Glossary terms were also updated to align with current contractual and regulatory guidelines. **Program(s):** Administrative	
MA.9124: CMS Self-Disclosure *Regulatory Affairs & Compliance*	**B – REVISED:** This policy was revised to establish directives clarifying reporting requirements by CalOptima Health of any significant instances of noncompliance under the DHCS contract for the Medi-Cal program and clarify procedures for submitting a self-disclosure, required information related to the self-disclosing incident, investigations and CAPs, and self-disclosure to regulatory entities. Reference and glossary updates were also made to align with current contractual and regulatory guidelines. **Program(s):** Medi-Cal; OneCare; PACE	

Table 2: Office of Compliance Policies and Procedures: Non-substantive Revisions

The following table contains the list of policies without substantive revisions for the CalOptima Health Office of Compliance, by department.

POLICY & TITLE	SORTED BY DEPARTMENT
HH.3001: Member Access to Designated Record Set	*Privacy*
HH.3002: Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls	*Privacy*
HH.3003: Verification of Identity for Disclosure of Protected Health Information	*Privacy*
HH.3004: Member Request to Amend Records	*Privacy*
HH.3005: Member Request for Accounting of Disclosures	*Privacy*
HH.3006: Tracking and Reporting Disclosures of Protected Health Information	*Privacy*
HH.3007: Member Rights to Request Restrictions on Use and Disclosure of Protected Health Information	*Privacy*
HH.3008: Member Right to Request Confidential Communications	*Privacy*
HH.3010: Protected Health Information Disclosures Permitted and Required by Law	*Privacy*
HH.3015: Member Authorization for the Use and Disclosure of Protected Health Information	*Privacy*
HH.3019: De-identification of Protected Health Information	*Privacy*
HH.3020: Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PII or other Unauthorized Use or Disclosure of PHI/PII	*Privacy*
HH.3022: Business Associate Agreements	*Privacy*
HH.3023: Information Sharing	*Privacy*
AA.1275: Department of Health Care Services (DHCS) File and Use Submission Process	*Regulatory Affairs & Compliance*
GA.7501: Regulatory Communications	*Regulatory Affairs & Compliance*

POLICY & TITLE	SORTED BY DEPARTMENT
GA.7505: Regulatory Liaison Responsibilities	*Regulatory Affairs & Compliance*
HH.2014: Compliance Program	*Regulatory Affairs & Compliance*
HH.2018: Compliance and Ethics Hotline	*Regulatory Affairs & Compliance*
HH.2019: Reporting Suspected or Actual Fraud, Waste, or Abuse (FWA), Violations of Applicable Laws and Regulations, and/or CalOptima Health Policies	*Regulatory Affairs & Compliance*
HH.2020: Conducting Compliance Investigations	*Regulatory Affairs & Compliance*
HH.2023: Compliance Training	*Regulatory Affairs & Compliance*
HH.2028: Code of Conduct	*Regulatory Affairs & Compliance*
HH.3012: Non-Retaliation for Reporting Violations	*Regulatory Affairs & Compliance*

Policy:	AA.1270
Title:	**Certification of Document and Data Submissions**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance
CEO Approval:	*/s/*
Effective Date:	07/01/2017
Revised Date:	10/01/2025
Applicable to:	☐ Administrative ☐ Covered California [Effective 2027] ☒ Medi-Cal ☒ OneCare ☐ PACE

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I. PURPOSE

This policy describes the process for certification of data, information, and documentation submitted to the Department of Health Care Services (DHCS) by CalOptima Health.

II. POLICY

A. In accordance with Title 42, Code of Federal Regulations (CFR), Sections 438.604 and 438.606 and contractual requirements, CalOptima Health shall certify data, information, and documentation submitted to DHCS.

B. CalOptima Health shall submit a completed and signed DHCS-approved certification statement on CalOptima Health letterhead by the final business day of each month to DHCS.

1. The signatory to the signed certification statement shall be the Chief Executive Officer (CEO), Chief Financial Officer (CFO), or an individual who reports directly to the CEO, or CFO, and has delegated authority to sign on his or her behalf. The CEO or CFO shall remain ultimately responsible for the certification and the data, information, and documentation submitted by CalOptima Health to DHCS.

2. The certification statement shall apply to all data, information, and documentation submitted to DHCS, as follows:

   a. Encounter data as set forth in Title 42 CFR Section 438.604(a)(1);

   b. Data used by DHCS to certify actuarial soundness of Capitation Payment rates as set forth in Title 42 CFR Section 438.604(a)(2);

   c. Data submitted for the purpose of determining CalOptima Health's Medical Loss Ratio (MLR) as set forth in Title 42 CFR section 438.604(a)(3);

   d. Financial data regarding provisions against risk of insolvency as set forth in Title 42 CFR Section 438.604(a)(4);

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~~b.~~a. ~~Provider network 274 data;~~

~~c.~~e. Other documentation and data submitted to DHCS describing CalOptima Health's accessibility and availability of services, including network adequacy as set forth in Title 42 CFR section 438.207(b);

~~d.~~a. ~~Data submitted for the purpose of determining CalOptima Health's capitation rates, such as the rate development templates (RDT) and supplemental requests to support the rate setting process;~~

~~e.~~a. ~~Data submitted for the purpose of determining CalOptima Health's Medical Loss Ratio (MLR);~~

~~f.~~a. ~~Documentation submitted to DHCS on a monthly, quarterly, or annual basis related to CalOptima Health's financial status;~~

~~g.~~f. Ownership and control information, including ownership and control information for Subcontractors, Downstream Subcontractors, and Network Providers as required under Title 42, CFR Sections 438.602(c), 438.608(c)(2), and 455.104~~.~~;

~~h.~~g. Annual report of overpayment recoveries as required in 42 CFR, section 438.608(d)(3);

h. Provider network 274 data as required in DHCS Contract, Exhibit A, Attachment III, Subsection 2.1.4;

i. Documentation confirming compliance with CalOptima Health's interoperability requirements and DHCS All Plan Letter (APL) 22-026: Interoperability and Patient Access Final Rule;

j. Data submitted for the purpose of determining CalOptima Health's capitation rates, such as the rate development templates (RDT) and supplemental requests to support the rate setting process;

k. Documentation submitted to DHCS on a monthly, quarterly, or annual basis related to CalOptima Health's financial status;

~~j.~~l. Monthly and quarterly template data;

~~k.~~m. Monthly number of members enrolled in Dual Eligible Special Needs Plans (D-SNP); and

~~l.~~n. Any other data, information or documentation related to the performance of CalOptima Health's obligations under its contract with DHCS upon notification from DHCS that such data, information, or documentation, must be certified.

3. The certification statement shall include the following:

   a. The current month during which all data, information, and documentation submitted to DHCS is certified;

   b. Reference all types of data, information, and documentation as described in Section II.B.2 of this Policy;

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c. A statement that the data, information, and documentation to which the certification applies is accurate, complete, and truthful to CalOptima Health's best information, knowledge, and belief; and

d. Signature of the CEO, CFO, or an individual who reports directly to the CEO, or CFO, and has delegated authority to sign on their behalf.

III. PROCEDURE

A. Submissions to DHCS not via RAC

1. In limited instances, certain CalOptima Health departments submit data, information, and documentation to DHCS not via the Regulatory Affairs & Compliance (RAC) Department, but instead either directly or via another CalOptima Health Department (e.g., Information Technology ~~Services~~). Additionally, in limited instances, certain CalOptima Health departments oversee automated processes that result in the submission of data, information, and documentation directly to DHCS. In either of these scenarios, the following shall occur:

   a. A Designee from each CalOptima Health department responsible for data, information, and documentation submitted to DHCS, not via the RAC Department, shall submit an attestation to the RAC Department no later than three (3) business days prior to the end of the month, in any month(s) during which such information is submitted to DHCS.

      i. The attestation shall be completed on RAC's attestation form template ("[DEPT NAME][MONTH YEAR] Attestation (Submissions not via RAC)") and state that such data, information, and documentation is accurate, complete, and truthful to the submitting individual's best information, knowledge, and belief.

      ii. RAC shall track the timely submission of the attestation and report. Repeated failure to submit the attestation by the due date indicated may result in a request for corrective action, in accordance with CalOptima Health policy HH.2005: Corrective Action Plan.

B. Submissions to DHCS via RAC

1. In most instances, CalOptima Health departments submit data, information, and documentation to the RAC Department that in turn completes the submission(s) to DHCS.

   a. In these instances, a Designee from each CalOptima Health department responsible for data, information, and documentation shall include an attestation to accompany each submission of required data, information, or documentation to the RAC Department.

      i. The attestation shall be completed on RAC's attestation form template ("[DEPT NAME]_[REPORT NAME(S)]_ Attestation (Submissions via RAC)") and state that such data, information, and documentation is accurate, complete, and truthful to the submitting individual's best information, knowledge, and belief.

      ii. RAC shall track the timely submission of the attestation and report. Repeated failure to submit the attestation by the due date indicated may result in a request for corrective action, in accordance with CalOptima Health policy HH.2005: Corrective Action Plan.

      iii. RAC shall conduct a cursory review of the submitted reports, prior to submission to DHCS, to verify that applicable instructions and/or technical specifications have been

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followed. On a quarterly basis, each business area responsible for reporting will receive feedback on data quality and timeliness via a report card. Repeated quality and timeliness issues may result in a request for corrective action, in accordance with CalOptima Health Policy HH.2005: Corrective Action Plan.

C. CalOptima Health's Provider Relations Department shall collect monthly data attestations from each delegated Health Network for data, information, and documentation submitted to CalOptima Health.

D. Based on these internal and Health Network attestations, the RAC Department shall submit the signed certification statement as required by DHCS and pursuant to Section II.B. of this Policy.

IV. ATTACHMENT(S)

A. Document and Data Attestation - Attestation (Submissions via RAC)
B. Document and Data Attestation - Attestation (Submissions not via RAC)
C. Document and Data Attestation - FAQs

V. REFERENCE(S)

A. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Health Policy HH.2005: Corrective Action Plan
C. CalOptima Health State Medicaid Agency Contract (SMAC) with DHCS for Dual Eligible Special Needs Plan (D-SNP)
D. Department of Health Care Services (DHCS) All Plan Letter (APL) 17-005: Certification of Document and Data Submissions
E. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-026: Interoperability and Patient Access Final Rule
F. Title 42, Code of Federal Regulations (C.F.R), §§438.602, 438.604, 438.606, 438.608, and 455.104

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
05/31/2017	Department of Health Care Services (DHCS)	Approved as Submitted
09/23/2019	Department of Health Care Services (DHCS)	Approved as Submitted
09/27/2021	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
12/01/2022	Regular Meeting of the CalOptima Health Board of Directors
11/06/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	07/01/2017	AA.1270	Certification of Document and Data Submissions	Medi-Cal
Revised	11/01/2018	AA.1270	Certification of Document and Data Submissions	Medi-Cal

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Action	Date	Policy	Policy Title	Program(s)
Revised	07/01/2019	AA.1270	Certification of Document and Data Submissions	Medi-Cal
Revised	11/01/2020	AA.1270	Certification of Document and Data Submissions	Medi-Cal
Revised	08/01/2021	AA.1270	Certification of Document and Data Submissions	Medi-Cal
Revised	12/31/2022	AA.1270	Certification of Document and Data Submissions	Medi-Cal OneCare
Revised	09/01/2023	AA.1270	Certification of Document and Data Submissions	Medi-Cal OneCare
Revised	11/07/2024	AA.1270	Certification of Document and Data Submissions	Medi-Cal OneCare
Revised	10/01/2025	AA.1270	Certification of Document and Data Submissions	Medi-Cal OneCare

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IX. GLOSSARY

Term	Definition
Appeal	Medi-Cal: A review by CalOptima Health of an adverse benefit determination, which includes one of the following actions: 1. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a 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: As defined at 42 CFR §422.561 and §423.560, the procedures that deal with the review of adverse initial determinations made by the plan on health care services or benefits under Part C or D the enrollee believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the enrollee) or on any amounts the enrollee must pay for a service or drug as defined in 42 CFR §422.566(b) and §423.566(b). These appeal procedures include a plan reconsideration or redetermination (also referred to as a level 1 appeal), a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (Council), and judicial review. ~~Appeal also includes the review of at-risk determinations made under a drug management program in accordance with § 423.153(f).~~
Department of Health Care Services (DHCS)	Medi-Cal: The single State department responsible for the administration of the Medi-Cal Program, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), and other health related programs as provided by statute and/or regulation. OneCare: The single State Department responsible for administration of the Medi-Cal program, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Downstream Subcontractor	An individual or an entity that has a Downstream Subcontractor Agreement with a Subcontractor or a Downstream Subcontractor. A Network Provider is not a Downstream Subcontractor solely because it enters into a Network Provider Agreement.

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Term	Definition
Grievance	Medi-Cal: Any expression of dissatisfaction about any matter other than an Adverse Benefit Determination (ABD), and may include, but is not limited to the Quality of Care or services provided, aspects of interpersonal relationships with a Provider or CalOptima Health's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by CalOptima Health to make an authorization decision. A complaint is the same as Grievance. An inquiry is a request for more information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other CalOptima Health processes. If CalOptima Health is unable to distinguish between a Grievance and an inquiry, it must be considered a Grievance. OneCare: An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO~~)~~), Subcontractor, or First Tier Entity that contracts with CalOptima Health to provide Covered Services to Members ~~assigned to that Health Network~~.
Medical Loss Ratio (MLR)	The percentage calculated by dividing the Health Network's total medical costs paid on behalf of CalOptima Health Members by the total revenue received from CalOptima Health. Health Network medical costs would include payments to physicians (i.e. capitation, fee-for-service, or salary), medical groups/Independent Practice Associations (IPAs), hospitals, labs, ambulance companies, and other providers of service.
Network Provider	Any Provider or entity that has a Network Provider Agreement with CalOptima Health or CalOptima Health's Subcontractor(s) and receives Medi-Cal funding directly or indirectly to order refer or render Covered Services under the contract between said parties. A Network Provider is not a Subcontractor by virtue of the Network Provider Agreement.
Subcontractor	An individual or entity that has a Subcontractor Agreement with CalOptima Health or CalOptima Health's Subcontractor that relates directly or indirectly to the performance of CalOptima Health's obligations under its contract with DHCS. A Network Provider is not a Subcontractor solely because it enters into a Network Provider Agreement.

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Policy:	AA.1270
Title:	**Certification of Document and Data Submissions**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance
CEO Approval:	*/s/*
Effective Date:	07/01/2017
Revised Date:	10/01/2025
Applicable to:	☐ Administrative ☐ Covered California [Effective 2027] ☒ Medi-Cal ☒ OneCare ☐ PACE

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I. PURPOSE

This policy describes the process for certification of data, information, and documentation submitted to the Department of Health Care Services (DHCS) by CalOptima Health.

II. POLICY

A. In accordance with Title 42, Code of Federal Regulations (CFR), Sections 438.604 and 438.606 and contractual requirements, CalOptima Health shall certify data, information, and documentation submitted to DHCS.

B. CalOptima Health shall submit a completed and signed DHCS-approved certification statement on CalOptima Health letterhead by the final business day of each month to DHCS.

1. The signatory to the signed certification statement shall be the Chief Executive Officer (CEO), Chief Financial Officer (CFO), or an individual who reports directly to the CEO, or CFO, and has delegated authority to sign on his or her behalf. The CEO or CFO shall remain ultimately responsible for the certification and the data, information, and documentation submitted by CalOptima Health to DHCS.

2. The certification statement shall apply to all data, information, and documentation submitted to DHCS, as follows:

   a. Encounter data as set forth in Title 42 CFR Section 438.604(a)(1);

   b. Data used by DHCS to certify actuarial soundness of Capitation Payment rates as set forth in Title 42 CFR Section 438.604(a)(2);

   c. Data submitted for the purpose of determining CalOptima Health's Medical Loss Ratio (MLR) as set forth in Title 42 CFR section 438.604(a)(3);

   d. Financial data regarding provisions against risk of insolvency as set forth in Title 42 CFR Section 438.604(a)(4);

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e. Other documentation and data submitted to DHCS describing CalOptima Health's accessibility and availability of services, including network adequacy as set forth in Title 42 CFR section 438.207(b);

f. Ownership and control information, including ownership and control information for Subcontractors, Downstream Subcontractors, and Network Providers as required under Title 42, CFR Sections 438.602(c), 438.608(c)(2), and 455.104;

g. Annual report of overpayment recoveries as required in 42 CFR, section 438.608(d)(3);

h. Provider network 274 data as required in DHCS Contract, Exhibit A, Attachment III, Subsection 2.1.4;

i. Documentation confirming compliance with CalOptima Health's interoperability requirements and DHCS All Plan Letter (APL) 22-026: Interoperability and Patient Access Final Rule;

j. Data submitted for the purpose of determining CalOptima Health's capitation rates, such as the rate development templates (RDT) and supplemental requests to support the rate setting process;

k. Documentation submitted to DHCS on a monthly, quarterly, or annual basis related to CalOptima Health's financial status;

l. Monthly and quarterly template data;

m. Monthly number of members enrolled in Dual Eligible Special Needs Plans (D-SNP); and

n. Any other data, information or documentation related to the performance of CalOptima Health's obligations under its contract with DHCS upon notification from DHCS that such data, information, or documentation, must be certified.

3. The certification statement shall include the following:

a. The current month during which all data, information, and documentation submitted to DHCS is certified;

b. Reference all types of data, information, and documentation as described in Section II.B.2 of this Policy;

c. A statement that the data, information, and documentation to which the certification applies is accurate, complete, and truthful to CalOptima Health's best information, knowledge, and belief; and

d. Signature of the CEO, CFO, or an individual who reports directly to the CEO, or CFO, and has delegated authority to sign on their behalf.

III. PROCEDURE

A. Submissions to DHCS not via RAC

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1. In limited instances, certain CalOptima Health departments submit data, information, and documentation to DHCS not via the Regulatory Affairs & Compliance (RAC) Department, but instead either directly or via another CalOptima Health Department (e.g., Information Technology). Additionally, in limited instances, certain CalOptima Health departments oversee automated processes that result in the submission of data, information, and documentation directly to DHCS. In either of these scenarios, the following shall occur:

    a. A Designee from each CalOptima Health department responsible for data, information, and documentation submitted to DHCS, not via the RAC Department, shall submit an attestation to the RAC Department no later than three (3) business days prior to the end of the month, in any month(s) during which such information is submitted to DHCS.

        i. The attestation shall be completed on RAC's attestation form template ("[DEPT NAME][MONTH YEAR] Attestation (Submissions not via RAC)") and state that such data, information, and documentation is accurate, complete, and truthful to the submitting individual's best information, knowledge, and belief.

        ii. RAC shall track the timely submission of the attestation and report. Repeated failure to submit the attestation by the due date indicated may result in a request for corrective action, in accordance with CalOptima Health policy HH.2005: Corrective Action Plan.

B. Submissions to DHCS via RAC

1. In most instances, CalOptima Health departments submit data, information, and documentation to the RAC Department that in turn completes the submission(s) to DHCS.

    a. In these instances, a Designee from each CalOptima Health department responsible for data, information, and documentation shall include an attestation to accompany each submission of required data, information, or documentation to the RAC Department.

        i. The attestation shall be completed on RAC's attestation form template ("[DEPT NAME]_[REPORT NAME(S)]_ Attestation (Submissions via RAC)") and state that such data, information, and documentation is accurate, complete, and truthful to the submitting individual's best information, knowledge, and belief.

        ii. RAC shall track the timely submission of the attestation and report. Repeated failure to submit the attestation by the due date indicated may result in a request for corrective action, in accordance with CalOptima Health policy HH.2005: Corrective Action Plan.

        iii. RAC shall conduct a cursory review of the submitted reports, prior to submission to DHCS, to verify that applicable instructions and/or technical specifications have been followed. On a quarterly basis, each business area responsible for reporting will receive feedback on data quality and timeliness via a report card. Repeated quality and timeliness issues may result in a request for corrective action, in accordance with CalOptima Health Policy HH.2005: Corrective Action Plan.

C. CalOptima Health's Provider Relations Department shall collect monthly data attestations from each delegated Health Network for data, information, and documentation submitted to CalOptima Health.

D. Based on these internal and Health Network attestations, the RAC Department shall submit the signed certification statement as required by DHCS and pursuant to Section II.B. of this Policy.

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IV. ATTACHMENT(S)

A. Document and Data Attestation - Attestation (Submissions via RAC)
B. Document and Data Attestation - Attestation (Submissions not via RAC)
C. Document and Data Attestation - FAQs

V. REFERENCE(S)

A. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Health Policy HH.2005: Corrective Action Plan
C. CalOptima Health State Medicaid Agency Contract (SMAC) with DHCS for Dual Eligible Special Needs Plan (D-SNP)
D. Department of Health Care Services (DHCS) All Plan Letter (APL) 17-005: Certification of Document and Data Submissions
E. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-026: Interoperability and Patient Access Final Rule
F. Title 42, Code of Federal Regulations (C.F.R), §§438.602, 438.604, 438.606, 438.608, and 455.104

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
05/31/2017	Department of Health Care Services (DHCS)	Approved as Submitted
09/23/2019	Department of Health Care Services (DHCS)	Approved as Submitted
09/27/2021	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
12/01/2022	Regular Meeting of the CalOptima Health Board of Directors
11/06/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	07/01/2017	AA.1270	Certification of Document and Data Submissions	Medi-Cal
Revised	11/01/2018	AA.1270	Certification of Document and Data Submissions	Medi-Cal
Revised	07/01/2019	AA.1270	Certification of Document and Data Submissions	Medi-Cal
Revised	11/01/2020	AA.1270	Certification of Document and Data Submissions	Medi-Cal
Revised	08/01/2021	AA.1270	Certification of Document and Data Submissions	Medi-Cal
Revised	12/31/2022	AA.1270	Certification of Document and Data Submissions	Medi-Cal OneCare
Revised	09/01/2023	AA.1270	Certification of Document and Data Submissions	Medi-Cal OneCare

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Action	Date	Policy	Policy Title	Program(s)
Revised	11/07/2024	AA.1270	Certification of Document and Data Submissions	Medi-Cal OneCare
Revised	10/01/2025	AA.1270	Certification of Document and Data Submissions	Medi-Cal OneCare

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IX. GLOSSARY

Term	Definition
Appeal	Medi-Cal: A review by CalOptima Health of an adverse benefit determination, which includes one of the following actions: 1. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a 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: As defined at 42 CFR §422.561 and §423.560, the procedures that deal with the review of adverse initial determinations made by the plan on health care services or benefits under Part C or D the enrollee believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the enrollee) or on any amounts the enrollee must pay for a service or drug as defined in 42 CFR §422.566(b) and §423.566(b). These appeal procedures include a plan reconsideration or redetermination (also referred to as a level 1 appeal), a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (Council), and judicial review.
Department of Health Care Services (DHCS)	Medi-Cal: The single State department responsible for the administration of the Medi-Cal Program, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), and other health related programs as provided by statute and/or regulation. OneCare: The single State Department responsible for administration of the Medi-Cal program, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Downstream Subcontractor	An individual or an entity that has a Downstream Subcontractor Agreement with a Subcontractor or a Downstream Subcontractor. A Network Provider is not a Downstream Subcontractor solely because it enters into a Network Provider Agreement.

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Term	Definition
Grievance	Medi-Cal: Any expression of dissatisfaction about any matter other than an Adverse Benefit Determination (ABD), and may include, but is not limited to the Quality of Care or services provided, aspects of interpersonal relationships with a Provider or CalOptima Health's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by CalOptima Health to make an authorization decision. A complaint is the same as Grievance. An inquiry is a request for more information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other CalOptima Health processes. If CalOptima Health is unable to distinguish between a Grievance and an inquiry, it must be considered a Grievance. OneCare: An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO), Subcontractor, or First Tier Entity that contracts with CalOptima Health to provide Covered Services to Members.
Medical Loss Ratio (MLR)	The percentage calculated by dividing the Health Network's total medical costs paid on behalf of CalOptima Health Members by the total revenue received from CalOptima Health. Health Network medical costs would include payments to physicians (i.e. capitation, fee-for-service, or salary), medical groups/Independent Practice Associations (IPAs), hospitals, labs, ambulance companies, and other providers of service.
Network Provider	Any Provider or entity that has a Network Provider Agreement with CalOptima Health or CalOptima Health's Subcontractor(s) and receives Medi-Cal funding directly or indirectly to order refer or render Covered Services under the contract between said parties. A Network Provider is not a Subcontractor by virtue of the Network Provider Agreement.
Subcontractor	An individual or entity that has a Subcontractor Agreement with CalOptima Health or CalOptima Health's Subcontractor that relates directly or indirectly to the performance of CalOptima Health's obligations under its contract with DHCS. A Network Provider is not a Subcontractor solely because it enters into a Network Provider Agreement.

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Document and Data Attestation

Submissions via RAC

Background:

Title 42, Code of Federal Regulations (42 CFR), Sections (§§) 438.604 and 438.606 (revised in ~~May~~ June 201~~6~~7), require certification of data, information, and documentation that are submitted to the Department of Health Care Services (DHCS). Accordingly, DHCS released APL 17-005: Certification of Document and Data Submissions which requires MCPs (the MCP's CEO, CFO, or designee) to submit a monthly certification statement to DHCS attesting that all data, information, and documentation submitted to DHCS for that month are accurate, complete, and truthful to the MCP's best information, knowledge, and belief. CalOptima Health has mirrored this process to require each department that submits data to DHCS (via or not via the Medi-Cal Regulatory Affairs & Compliance (RAC)) to submit an attestation to Medi-Cal RAC Department. Based on these internal attestations, the CEO signs CalOptima Health's monthly certification statement.

Instructions:

Please complete the below information and submit this attestation concurrently with the submission of the data, documentation or information mentioned below. If a section in the table does not apply, please note this. Do not leave any blank fields. A submission will be rejected if the attestation is not provided or is incomplete. Additional information regarding the attestation process is available here in an FAQ document. If you have any questions with regards to this submission or attestation, please contact Mike Wood at mwood@caloptima.org or Monica Domicolo at mdomicolo@caloptima.org.

Data, information, and documentation being attested to:

Report Name *[Title of report, document, or submission]*	**Tab Name (if applicable)** *[Title of tab within the report. If this is not applicable, please note]*	**Reporting Period** *[Data reflected within the submission to DHCS (e.g., Month Year, Quarter Year, Date range]*

By completing and signing the section below, I am attesting that this submission is based on best information, knowledge, and belief, that the data, documentation, and information specified in the table above is accurate, complete, and truthful. I furthermore attest that I have the authority to make such attestation. *(Please refer to the FAQ document linked above for info on who can attest.)*

Additionally, I attest that I have completed the following as appropriate (please check boxes below):

- ☐ Determined if health network (HN) data, or other subcontractor data, is necessary for a complete submission. Unless specified otherwise, I have consolidated data into Plan-level data. I will maintain a record of internal versus HN data should DHCS have any follow up questions.

- ☐ Quality checked data (including HN data) in my submission, which at a minimum may include the data checks below. Data errors have been resolved in the submission and the source data. Note that Health Network

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Relations requires the reporting department to make initial outreach attempts to the health networks to correct any data issues before escalating to them for assistance.

- ✓ Confirmed data is consistent with DHCS' reporting instructions and guidance.
- ✓ Data is complete, accurate, and reasonable (i.e. makes sense).
- ✓ Confirmed use of DHCS' drop-down lists where applicable. DHCS does not allow any changes to drop-down selections as it interferes with their data analysis.
- ✓ No blanks/missing/incomplete data as appropriate.
- ✓ Compared data to prior submission for outliers or significant changes that may require explanation.
- ✓ Provided comments and explained "Other" responses as required in reporting instructions.
- ✓ Incorporated any DHCS' Quality Data for Program Integrity (QDPI) data checks and any prior feedback from DHCS or RAC into the review process.

Name: _____

Title: _____

Department: _____

Signature: _____

NOTE: *If you are using an electronic signature, please be sure the time stamp reflects the current date. If you are using a wet signature, you will need to complete the date below and scan a copy of the attestation.*

Date: _____

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Document and Data Attestation

Submissions not via RAC

Background:
Title 42, Code of Federal Regulations (42 CFR), Sections (§§) 438.604 and 438.606 (revised in June 2017), require certification of data, information, and documentation that are submitted to the Department of Health Care Services (DHCS). Accordingly, DHCS released APL 17-005: Certification of Document and Data Submissions which requires managed care plans (MCPs) (the MCP's CEO, CFO, or designee) to submit a monthly certification statement to DHCS attesting that all data, information, and documentation submitted to DHCS for that month are accurate, complete, and truthful to the MCP's best information, knowledge, and belief. CalOptima Health has mirrored this process to require each department that submits data to DHCS (via or not via Regulatory Affairs & Compliance (RAC) Medi-Cal) to submit an attestation to RAC (Medi-Cal). Based on these internal attestations, the CEO signs CalOptima Health's monthly certification statement.

Instructions: Please complete the below information and submit this attestation to RAC no later than three (3) business days prior to the end of the month, in any month(s) during which such information is submitted to DHCS not via RAC. If a section in the table does not apply, please note this. Do not leave any blank fields. Additional information regarding the attestation process is available here in an FAQ document. If you have any questions with regards to this submission or attestation, please contact Mike Wood or Monica Domicolo.

Data, information, and documentation being attested to:

Report Name *[Title of report, document, or submission]*	**Tab Name (if applicable)** *[Title of tab within the report. If this is not applicable, please note]*	**Reporting Period** *[Data reflected within the submission to DHCS (e.g., Month Year, Quarter Year, Date range]*

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Report Name *[Title of report, document, or submission]*	**Tab Name (if applicable)** *[Title of tab within the report. If this is not applicable, please note]*	**Reporting Period** *[Data reflected within the submission to DHCS (e.g., Month Year, Quarter Year, Date range]*

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By completing and signing the section below, I am attesting that this submission is based on best information, knowledge, and belief, that the data, documentation, and information specified in the table above is accurate, complete, and truthful. I furthermore attest that I have the authority to make such attestation *(refer to the FAQ document linked above for info on who can attest)* **and that the submission was timely to DHCS. Please be sure to notify RAC of any issues of non-compliance (e.g., inaccurate, late, incomplete, etc.) to determine appropriate next steps.**

Name: _____

Title: _____

Department: _____

Signature: _____

NOTE: If you are using an electronic signature, please be sure the time stamp reflects the current date. If you are using a wet signature, you will need to complete the date below and scan a copy of the attestation.

Date: _____

Document and Data Attestation – Frequently Asked Questions (FAQ):

1. **Question:** Who may attest to the data being provided?
   Answer: RAC recommends that the attestation be completed by a person who has the *authority* and/or *knowledge* to make such an attestation. By way of reference, similar attestations are completed by a supervisor or higher.

2. **Question:** Can the attestation include an electronic signature?
   Answer: Yes, as long as the signatory has sole control of the electronic signature. For example, a name typed in cursive font alone is not considered an electronic signature. Please contact IS for technical support if you need assistance to activate the electronic signature function in the form.

   Note: If you choose to use an electronic signature, please be sure the time stamp within the signature reflects the current date.

3. **Question:** My report includes data from CalOptima Health delegates that I do not feel comfortable attesting to. Do I still need to attest to the information?
   Answer: You must attest to the information *your business area* is providing to RAC. If the report submission requires that you consolidate data/information on behalf of the delegates, for the purpose of submission, a separate attestation will be required by the delegate. Health Network Relations is responsible for collecting these on a monthly basis.

4. **Question:** Where can I find a copy of the attestation templates?
   Answer: A copy of the most recent attestation templates can be found on SharePoint for Office of Compliance under "Data Attestations".

   The "Attestation (Submissions via RAC)" template is to be used for submissions to DHCS via RAC. Whereas, the "Attestation (Submissions not via RAC)" template is to be used for any data that you submit to DHCS not via RAC, but rather directly or via another CalOptima Health department (such as IT).

5. **Question:** If I submit multiple reports to RAC, can I submit one attestation for all of the data?
   Answer: It depends on whether you are submitting data via or not via RAC to DHCS, as outlined below.

   Submissions via RAC: Generally, each report will have its own attestation since you will be submitting the attestation concurrently with the data submission. However, if you contribute data to multiple tabs within a report, you only need to submit a single attestation and note the multiple tabs within that report.

   Submissions not via RAC: Yes, you may list all the data submissions for that month in the table within the attestation form. If you need additional space to list submissions, please use multiple forms.

6. **Question:** If an error is identified in my report, post submission to RAC, will I be required to resubmit my attestation?
   Answer: RAC will not require a resubmission, however, continued issues with the quality of the data may result in an investigation to determine the root cause and a corrective action plan may result.

7. **Question:** What happens if I do not submit attestations in a timely manner?
   Answer: Medi-Cal RAC is monitoring attestation submissions and tracking timeliness of these submissions. Continued non-compliance for any requirement may result in a notice of non-compliance and a request for corrective action in accordance with CalOptima Health policy HH.2005: Corrective Action Plan.

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Policy:	GA.7508
Title:	**CalOptima Health Policy and Procedure Review Process**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance, Policies and Procedures
CEO Approval:	*/s/*
Effective Date:	10/05/2023
Revised Date:	09/01/2025
Applicable to:	☒ Administrative ☐ Covered California [Effective 2027] ☐ Medi-Cal ☐ OneCare ☐ PACE

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I. PURPOSE

This Policy outlines CalOptima Health's Policy and Procedure Review Process to develop, review, revise, retire, and ensure Policies and Procedures comply with regulatory and contractual requirements in alignment with CalOptima Health's mission, and vision.

II. POLICY

A. CalOptima Health shall develop Policies and Procedures (Policies) in alignment with regulatory and contractual requirements that encompass the primary directives and general procedures of the agency while providing guidance in conducting business and accomplishing the mission, and vision of CalOptima Health.

1. All Policies shall be reviewed at least annually and in accordance with the guidelines outlined in this Policy to incorporate changes in applicable laws, regulations and requirements and/or organizational operational changes.

2. All Policies will be reviewed by the Chief Executive Officer (CEO) and Policies with substantive edits not driven by regulatory, legal, or contractual requirements, shall be subject to the CalOptima Health Board of Directors (Board) review and approval, in accordance with CalOptima Health Policy GA.3202: Signature Authority.

3. Updates to existing Policies, including the creation of new Policies, are communicated on a monthly basis to the Health Networks, First Tier, Downstream, and Related Entities (FDRs), vendors, any other delegated entities and CalOptima Health employees as outlined in Section III.I. of this policy.

B. CalOptima Health's Regulatory Affairs & Compliance Policies and Procedures (RAC P&P) team manages the Policy review process, to support CalOptima Health's department responsibilities to develop, draft, review, revise, or retire Policies. RAC P&P shall ensure appropriate distribution of Policies reflective of CalOptima Health Health's operations, mission, and vision.

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C. CalOptima Health Policies shall inform CalOptima Health's staff, Board, Health Networks, FDRs, applicable vendors, other delegated entities and Members of the scope and parameters of CalOptima Health's programs and/or operations.

1. CalOptima Health program-specific Policies shall be utilized by a Health Network or FDR, in accordance with the provisions of their respective contract.

2. CalOptima Health administrative Policies shall provide guidelines to CalOptima Health staff for conducting business operations in support of CalOptima Health's mission, and vision. CalOptima Health employees shall be responsible for reviewing and following all Policies, and any updates thereto.

D. All new and/or revised Policies shall be reviewed and approved by the department's leadership, the Policy Review Committee (PRC) presented to the Board (if applicable) and signed by the Chief Executive Officer (CEO), or their Designee, when applicable.

E. CalOptima Health's Human Resources (HR) Department shall provide all employees, members of the Board, and FDRs or other vendors with instructions on how to access CalOptima Health Policies upon hire or engagement.

F. The RAC P&P team shall make available all approved member-facing CalOptima Health Policies on CalOptima Health's public website, www.caloptima.org, and CalOptima Health internal administrative Policies to the CalOptima Health InfoNet.

G. The RAC P&P team shall maintain all historical versions of Policies (retired and revised) in CalOptima Health's archival system.

H. All CalOptima Health departments shall be responsible for the content and accuracy of their Policies and corresponding Policy attachments.

1. Prior to submission to RAC P&P, all Policy Owners shall ensure CalOptima Health created Member-facing documents have been thoroughly reviewed and processed through the Member Materials Approval (MMA) process.

2. Once Policies and Policy attachments are updated, Policy Owners must ensure any updated versions of their documents cascade across all platforms (e.g., CalOptima Health website, Guiding Care, InfoNet, as applicable).

I. RAC P&P, Policy & Procedure Review Process training shall be available for all CalOptima Health employees, upon request.

III. PROCEDURE

A. Policy Owner Review

1. Current Policy Review/Revision

a. CalOptima Health departments shall review all Policies on an annual basis with the exception of the Human Resources department which reviews Policies on a bi-annual basis.

b. Policy Owners may access, review, and revise their Policy(s) at any time in response to operational changes, regulatory guidance, or contract amendments.

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2. New Policy Development

   a. A new Policy may be developed in response to a need for clarity and consistency on an issue, to address audit findings, new laws/regulations/guidance and/or to direct CalOptima Health employees, FDRs, and other contractors on matters including, but not limited to, health and safety, human resources, information services, communications, subpoenas, regulatory requirements, or compliance with CalOptima Health operations.

   b. The universal Policy template found on CalOptima Health's RAC P&P InfoNet page, shall be utilized in the creation of Policies to ensure consistent Policy format.

3. Policy Transfer or Retirement:

   a. A Policy may be transferred to another department or retired for various reasons, including but not limited to, operational changes, changes in the law, or the consolidation/merging of Policies and/or department responsibilities.

   b. The Policy Owner shall solicit input from potentially impacted departments if the Policy will be transferring or retiring the Policy may have unintended consequences or is appropriate based on the circumstances.

      i. If a Policy Owner identifies a need to transfer a Policy, the Policy Owner shall;

         a) Submit a completed Policy Intake Form (PIF), along with the Policy and any applicable attachments.

         a) The Policy Owner shall consult with the receiving department for agreement to the transfer indicating the transfer on the PIF.

      ii. If a Policy Owner identifies a need to retire a Policy, the Policy Owner shall;

         a) Ensure any content that is required as a result of Board's action, contractual requirements, applicable laws, and/or state and federal regulations is addressed or included in another Policy;

         b) Draft a separate desktop procedure (if applicable); and

         c) Complete a Retirement Crosswalk form detailing whether each section of the Policy is either present in another Policy or is no longer applicable to CalOptima Health and why.

4. All Policy reviews shall comply with the RAC P&P Policy Owner Manual, and shall include an assessment for:

   a. Alignment with the most current and applicable statutory or regulatory guidance, Board action or contractual requirements, including, but not limited to:

      i. DHCS Contract(s);

      ii. CMS Contract(s);

      iii. PACE Contract(s);

      iv. All Plan Letters (APL) and Policy Letters (PL);

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v. Health Plan Management System (HPMS) Memorandums;

vi. Other sub-regulatory guidance; and

vii. Relevant federal and state laws, regulations, and guidance.

b. Current overlapping Policies and consider whether incorporation or consolidation into one (1) Policy is appropriate.

c. Accuracy of Policy attachments confirming consistency with any proposed changes to the Policy.

d. Input from additional departments or teams impacted by any revisions to the Policy content.

5. Submission of a Policy to the RAC P&P team via email shall include:

a. Draft Policy;

b. Reviewed attachments, if applicable;

c. A completed PIF; and

d. Any documentation supporting edits or Policy creation.

B. Regulatory Affairs & Compliance Policy Review

1. Upon receipt of a complete submission, with all supporting documentation, the RAC P&P team shall:

a. Review the Policy(s) for the following:

i. Adherence to statutory, contractual, and regulatory requirements;

ii. Consistency with other related Policies, if any;

iii. Clarity of necessary provisions (e.g., new regulatory guidance, audit remediation(s));

iv. Accuracy and completeness of references;

v. Accuracy and completeness of attachments, if any; and

vi. Appropriate language, style, and grammar usage.

b. Where appropriate, secure review from legal counsel for specific legal guidance by submitting a request for legal review on behalf of the Policy Owner and manage the resulting legal review outcome.

C. Legal Counsel Policy Review

1. CalOptima Health's designated legal counsel conducts Policy reviews in response to a request for legal review submitted by the RAC P&P team, on behalf of a Policy Owner, as appropriate or as requested by the Policy Owner.

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2. The RAC P&P team shall be responsible for coordination of legal review requests (i.e., submissions, responses to Policy Owners, and documentation of reviews). However, Policy Owners are still responsible for ensuring all legal counsel recommended edits are addressed and incorporated into their Policy(s), as applicable.

3. All Policies that require approval by the Board must be reviewed and approved by legal counsel in advance of the requested Board meeting materials submission deadline, as established by the Clerk of the Board.

D. Policy Review Committee (PRC)

1. The PRC is a standing committee established through adoption of the Orange County Health Authority ("CalOptima Health") Compliance Plan. The purpose of the PRC is to:

   a. Oversee the review and implementation of policies and procedures designed to mitigate and respond to various compliance and regulatory risks facing CalOptima Health; and

   b. Assist the Chief Compliance Officer, Chief Executive Officer (CEO), and the CalOptima Health Board of Directors in fulfilling their respective oversight responsibility of the regulatory and operational requirements to which CalOptima Health must adhere.

2. The PRC is composed of CalOptima Health's senior management and operational staff or their delegate, as designated by the CEO and Chief Compliance Officer. PRC shall have representation from the following areas:

   a. Compliance

   b. Finance

   c. Medical Management

   d. Operations

3. Each Policy shall be reviewed and approved by, at minimum, a quorum of the PRC, or more than fifty percent (50%) of the PRC members, or their delegate.

4. All CalOptima Health PRC event Policies will be distributed to the PRC via email, allowing members up to five (5) business days to assess and submit an electronic vote.

5. The RAC P&P team shall:

   a. Develop and maintain the schedule, deadlines, and agenda(s) of the PRC;

   b. Facilitate the PRC meetings;

   c. Ensure documentation of PRC members' approval; and

   d. Coordinate final edits with Policy Owners upon approval from the PRC.

6. The Policy Owner, or their delegate, shall:

   a. Submit all Policy materials (e.g., revised Policy, PIF, updated attachments, etc.) no later than four (4) weeks prior to the preferred PRC meeting date (unless otherwise indicated by the RAC P&P team);

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i. If updates to the Policy necessitate Board approval, all Policy materials shall be submitted no later than two (2) months prior to the Board meeting date to ensure appropriate scheduling of a PRC meeting.

b. The Policy Owner listed as the contact listed on the PIF is required to reply for the Policy if questions should arise during the PRC review; and

c. Consider revisions to the Policy(s) as appropriate, upon recommendation from the PRC.

E. CalOptima Health Board of Directors (Board) Policy Review

1. Although the Board and the Compliance Committee have authorized the CEO and the PRC to create, review, revise, and retire CalOptima Health's Policies, all new Policies, substantive edits to Human Resources Policies, and substantive edits to Policies not required to comply with existing law must obtain Board approval after PRC and prior to CEO review.

2. For Policies that do not require approval by the Board, upon request, CalOptima Health shall provide Policy updates to the Board.

F. Regulatory Agency Review

1. If approval by a Regulatory Agency is required, including but not limited to the Centers for Medicare & Medicaid Services (CMS), the Department of Health Care Services (DHCS), or the Department of Managed Health Care (DMHC), CalPERS, or any other outside entity, the RAC P&P team shall coordinate with the appropriate CalOptima Health teams to submit the Policy(s) to the appropriate Regulatory Agency for approval, if applicable, and in accordance with CalOptima Health's contracts with its regulators.

a. Per DHCS guidance and in accordance with CalOptima Health Policy AA.1275: Department of Health Care Services (DHCS) File & Use Submission Process, Policies submitted to DHCS shall be submitted as File and Use if they are unrelated to APLs, implementation readiness, or other DHCS deliverables.

2. For policies submitted to DHCS, if written Regulatory Agency approval is not received within sixty (60) calendar days of submission of the Policy(s), the RAC P&P team shall notify DHCS that the sixty (60) calendar day deadline has passed and that CalOptima Health elects to move forward with the Policy per the CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal. The Policy shall then move forward in the process.

a. If a Regulatory Agency subsequently requests revisions to a Policy approved by PRC, the RAC P&P team, in collaboration with the Policy Owner, shall incorporate any modifications requested by the Regulatory Agency within the required time frame.

3. If state and/or federal mandate(s) requires implementation of a Policy prior to regulatory approval, CalOptima Health shall move forward with implementation of the Policy to ensure regulatory deadlines are met and shall incorporate any modifications to the Policy subsequently received from the Regulatory Agency.

4. Any exceptions to the Regulatory Agency approval process shall require approval by the CEO, or Designee, with concurrence from legal counsel, as appropriate.

G. Chief Executive Officer (CEO) Approval

For 2025 10b BOD Review Only

1. Within seven (7) business days of obtaining all required approvals (e.g., CalOptima Health legal review, PRC, Board, Regulatory Agencies), the RAC P&P team shall submit the Policy(s) to the CEO for final review, approval, and signature completing the review cycle.

H. Posting of Updated Policies and Procedures (Policies)

1. Upon CEO approval of Policies, the RAC P&P team shall publish approved Policies in Compliance 360 (C360) database. Public website approved Member-facing Policies shall be viewable on CalOptima Health's website at www.caloptima.org, and internal only and all other approved Policies shall be viewable to CalOptima Health employees on the CalOptima Health InfoNet within seven (7) business days.

2. The RAC P&P team shall update shared Policy Owner folders on the InfoNet RAC P&P page within seven (7) business days following publication in C360. The folder content will contain the recent CEO approved Policy (PDF format), the Word (locked for tracking) Policy release, and attachments as applicable.

3. The RAC P&P team shall also update the Policy "Table of Contents" accessible on the InfoNet RAC P&P page to ensure all Policy resources are accurate.

I. Monthly Distribution of Policy and Procedure Updates

1. The RAC P&P team shall provide two (2) Monthly Policy Snapshot email notifications of Policies approved in the prior month by the tenth (10th) business day of the current month to:

a. CalOptima Health employees; and

b. Health Networks, FDRs, or any impacted vendors or delegates, disseminated through internal processes by applicable CalOptima Health departments.

IV. ATTACHMENT(S)

A. CalOptima Health Policy Review Committee (PRC) Charter

V. REFERENCE(S)

A. CalOptima Health Compliance Plan
B. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima Health Contract with DHCS for D-SNPs - State Medicaid Agency Contract (SMAC)
E. CalOptima Health PACE Program Agreement
F. CalOptima Health Contract with DHCS for PACE
G. CalOptima Health Policy AA.1275: Department of Health Care Services (DHCS) File & Use Submission Process
H. CalOptima Health Policy GA.3202: CalOptima Health Signature Authority
I. CalOptima Health Policy Review Committee (PRC) Charter
J. Medicare Managed Care Manual, Chapter 21: Compliance Program Guidelines
K. CalOptima Health Policy Intake Form (PIF)
L. Prescription Drug Benefit Manual, Chapter 9: Compliance Program Guidelines
M. Regulatory Affairs & Compliance, Policies and Procedures, Policy Owner Manual

VI. REGULATORY AGENCY APPROVAL(S)

For 20251106 BOD Review Only

None to Date

VII. BOARD ACTION(S)

Date	Meeting
10/05/2023	Regular Meeting of the CalOptima Health Board of Directors
11/07/2024	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	10/05/2023	GA.7508	CalOptima Health Policy and Procedure Review Process	Administrative
Revised	11/07/2024	GA.7508	CalOptima Health Policy and Procedure Review Process	Administrative
Revised	09/01/2025	GA.7508	CalOptima Health Policy and Procedure Review Process	Administrative

For 20251106 BOD Review Only

IX. GLOSSARY

Term	Definition
CalOptima Health Board of Directors (Board)	For purposes of this policy, the Board of Directors of CalOptima Health, which serves as the Governing Body of CalOptima Health, appointed by the Orange County Board of Supervisors in accordance with the Codified Ordinances of the County of Orange.
Centers for Medicare & Medicaid Services (CMS)	The federal agency within the United States Department of Health and Human Services (DHHS) that administers the Federal Medicare program and works in partnership with state governments to administer Medicaid programs.
Department of Health Care Services (DHCS)	The single State department responsible for the administration of the Medi-Cal Program, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), and other health related programs as provided by statute and/or regulation.
Department of Managed Health Care (DMHC)	The State agency responsible for administering the Knox-Keene Health Care Service Plan Act of 1975.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Downstream Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Health Program benefit, below the level of the arrangement between CalOptima Health and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.
First Tier Downstream and Related Entities (FDR)	First Tier, Downstream, or Related Entity, as separately defined herein.
First Tier Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima Health to provide administrative services or health care services to a Member under a CalOptima Health Program.
Health Network (HN)	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, health care service plan, such as a Health Maintenance Organization (HMO), Subcontractor, or First Tier Entity, that contracts with CalOptima Health to provide Covered Services to Members.
Member	A beneficiary who is enrolled in a CalOptima Health Program.
Pharmacy Benefit Manager (PBM)	The entity that performs certain functions and tasks including, but not limited to, Pharmacy credentialing, contracting, and claims processing in accordance with the terms and conditions of the PBM Services Agreement.
Policy	For purposes of this policy, a formal document that communicates broad principles of operation and standards on a particular subject to guide the actions and decision-making of individuals. Desktop Policies and procedures are not included.
Policy Owner	For purposes of this policy, each CalOptima Health department designated staff member with the lead responsibility of the department's Policy and procedure oversight.

For 20251106 BOD Review Only

Term	Definition
Policy Review Committee (PRC)	For purposes of this policy, a committee, chaired by the Chief Compliance Officer's designated CalOptima Health staff member, with the responsibility to oversee the review and implementation of CalOptima Health Policies and procedures and ensure compliance with regulatory guidance and existing operational procedures. The committee is comprised of senior management and key operational staff that have subject matter expertise and knowledge of regulations and standards.
Procedure	For purposes of this policy, an operational set of specific action steps and processes required to support the implementation of the Policy where needed, that may identify roles and assign responsibilities for the activities.
Provider	Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.
Regulatory Agencies	For the purposes of this policy, regulatory agencies include, but are not limited to: Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), and Department of Managed Health Care (DMHC).
Related Entity	Any entity that is related to the Medicare Advantage Organization (MAO) or Part D program by common ownership or control and: 1. Performs some of the MAO or Part D program's management functions under contract or delegation; 2. Furnishes services to Medicare enrollees under an oral or written agreement; or 3. Leases real property or sells materials to the MAO or Part D program at a cost of more than two-thousand five-hundred dollars ($2,**500**) during a contract period.

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Policy:	GA.7508
Title:	**CalOptima Health Policy and Procedure Review Process**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance, Policies and Procedures
CEO Approval:	*/s/*
Effective Date:	10/05/2023
Revised Date:	09/01/2025
Applicable to:	☒ Administrative ☐ Covered California [Effective 2027] ☐ Medi-Cal ☐ OneCare ☐ PACE

For 20251106 BOD Review Only

I. PURPOSE

This Policy outlines CalOptima Health's Policy and Procedure Review Process to develop, review, revise, retire, and ensure Policies and Procedures comply with regulatory and contractual requirements in alignment with CalOptima Health's mission, and vision.

II. POLICY

A. CalOptima Health shall develop Policies and Procedures (Policies) in alignment with regulatory and contractual requirements that encompass the primary directives and general procedures of the agency while providing guidance in conducting business and accomplishing the mission, and vision of CalOptima Health.

1. All Policies shall be reviewed at least annually and in accordance with the guidelines outlined in this Policy to incorporate changes in applicable laws, regulations and requirements and/or organizational operational changes.

2. All Policies will be reviewed by the Chief Executive Officer (CEO) and Policies with substantive edits not driven by regulatory, legal, or contractual requirements, shall be subject to the CalOptima Health Board of Directors (Board) review and approval, in accordance with CalOptima Health Policy GA.3202: Signature Authority.

3. Updates to existing Policies, including the creation of new Policies, are communicated on a monthly basis to the Health Networks, First Tier, Downstream, and Related Entities (FDRs), vendors, any other delegated entities and CalOptima Health employees as outlined in Section III.I. of this policy.

B. CalOptima Health's Regulatory Affairs & Compliance Policies and Procedures (RAC P&P) team manages the Policy review process, to support CalOptima Health's department responsibilities to develop, draft, review, revise, or retire Policies. RAC P&P shall ensure appropriate distribution of Policies reflective of CalOptima Health Health's operations, mission, and vision.

Back to Agenda Back to Item

C. CalOptima Health Policies shall inform CalOptima Health's staff, Board, Health Networks, FDRs, applicable vendors, other delegated entities and Members of the scope and parameters of CalOptima Health's programs and/or operations.

1. CalOptima Health program-specific Policies shall be utilized by a Health Network or FDR, in accordance with the provisions of their respective contract.

2. CalOptima Health administrative Policies shall provide guidelines to CalOptima Health staff for conducting business operations in support of CalOptima Health's mission, and vision. CalOptima Health employees shall be responsible for reviewing and following all Policies, and any updates thereto.

D. All new and/or revised Policies shall be reviewed and approved by the department's leadership, the Policy Review Committee (PRC) presented to the Board (if applicable) and signed by the Chief Executive Officer (CEO), or their Designee, when applicable.

E. CalOptima Health's Human Resources (HR) Department shall provide all employees, members of the Board, and FDRs or other vendors with instructions on how to access CalOptima Health Policies upon hire or engagement.

F. The RAC P&P team shall make available all approved member-facing CalOptima Health Policies on CalOptima Health's public website, www.caloptima.org, and CalOptima Health internal administrative Policies to the CalOptima Health InfoNet.

G. The RAC P&P team shall maintain all historical versions of Policies (retired and revised) in CalOptima Health's archival system.

H. All CalOptima Health departments shall be responsible for the content and accuracy of their Policies and corresponding Policy attachments.

1. Prior to submission to RAC P&P, all Policy Owners shall ensure CalOptima Health created Member-facing documents have been thoroughly reviewed and processed through the Member Materials Approval (MMA) process.

2. Once Policies and Policy attachments are updated, Policy Owners must ensure any updated versions of their documents cascade across all platforms (e.g., CalOptima Health website, Guiding Care, InfoNet, as applicable).

I. RAC P&P, Policy & Procedure Review Process training shall be available for all CalOptima Health employees, upon request.

III. PROCEDURE

A. Policy Owner Review

1. Current Policy Review/Revision

a. CalOptima Health departments shall review all Policies on an annual basis with the exception of the Human Resources department which reviews Policies on a bi-annual basis.

b. Policy Owners may access, review, and revise their Policy(s) at any time in response to operational changes, regulatory guidance, or contract amendments.

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2. New Policy Development

   a. A new Policy may be developed in response to a need for clarity and consistency on an issue, to address audit findings, new laws/regulations/guidance and/or to direct CalOptima Health employees, FDRs, and other contractors on matters including, but not limited to, health and safety, human resources, information services, communications, subpoenas, regulatory requirements, or compliance with CalOptima Health operations.

   b. The universal Policy template found on CalOptima Health's RAC P&P InfoNet page, shall be utilized in the creation of Policies to ensure consistent Policy format.

3. Policy Transfer or Retirement:

   a. A Policy may be transferred to another department or retired for various reasons, including but not limited to, operational changes, changes in the law, or the consolidation/merging of Policies and/or department responsibilities.

   b. The Policy Owner shall solicit input from potentially impacted departments if the Policy will be transferring or retiring the Policy may have unintended consequences or is appropriate based on the circumstances.

      i. If a Policy Owner identifies a need to transfer a Policy, the Policy Owner shall;

         a) Submit a completed Policy Intake Form (PIF), along with the Policy and any applicable attachments.

         a) The Policy Owner shall consult with the receiving department for agreement to the transfer indicating the transfer on the PIF.

      ii. If a Policy Owner identifies a need to retire a Policy, the Policy Owner shall;

         a) Ensure any content that is required as a result of Board's action, contractual requirements, applicable laws, and/or state and federal regulations is addressed or included in another Policy;

         b) Draft a separate desktop procedure (if applicable); and

         c) Complete a Retirement Crosswalk form detailing whether each section of the Policy is either present in another Policy or is no longer applicable to CalOptima Health and why.

4. All Policy reviews shall comply with the RAC P&P Policy Owner Manual, and shall include an assessment for:

   a. Alignment with the most current and applicable statutory or regulatory guidance, Board action or contractual requirements, including, but not limited to:

      i. DHCS Contract(s);

      ii. CMS Contract(s);

      iii. PACE Contract(s);

      iv. All Plan Letters (APL) and Policy Letters (PL);

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v. Health Plan Management System (HPMS) Memorandums;

vi. Other sub-regulatory guidance; and

vii. Relevant federal and state laws, regulations, and guidance.

b. Current overlapping Policies and consider whether incorporation or consolidation into one (1) Policy is appropriate.

c. Accuracy of Policy attachments confirming consistency with any proposed changes to the Policy.

d. Input from additional departments or teams impacted by any revisions to the Policy content.

5. Submission of a Policy to the RAC P&P team via email shall include:

a. Draft Policy;

b. Reviewed attachments, if applicable;

c. A completed PIF; and

d. Any documentation supporting edits or Policy creation.

B. Regulatory Affairs & Compliance Policy Review

1. Upon receipt of a complete submission, with all supporting documentation, the RAC P&P team shall:

a. Review the Policy(s) for the following:

i. Adherence to statutory, contractual, and regulatory requirements;

ii. Consistency with other related Policies, if any;

iii. Clarity of necessary provisions (e.g., new regulatory guidance, audit remediation(s));

iv. Accuracy and completeness of references;

v. Accuracy and completeness of attachments, if any; and

vi. Appropriate language, style, and grammar usage.

b. Where appropriate, secure review from legal counsel for specific legal guidance by submitting a request for legal review on behalf of the Policy Owner and manage the resulting legal review outcome.

C. Legal Counsel Policy Review

1. CalOptima Health's designated legal counsel conducts Policy reviews in response to a request for legal review submitted by the RAC P&P team, on behalf of a Policy Owner, as appropriate or as requested by the Policy Owner.

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2. The RAC P&P team shall be responsible for coordination of legal review requests (i.e., submissions, responses to Policy Owners, and documentation of reviews). However, Policy Owners are still responsible for ensuring all legal counsel recommended edits are addressed and incorporated into their Policy(s), as applicable.

3. All Policies that require approval by the Board must be reviewed and approved by legal counsel in advance of the requested Board meeting materials submission deadline, as established by the Clerk of the Board.

D. Policy Review Committee (PRC)

1. The PRC is a standing committee established through adoption of the Orange County Health Authority ("CalOptima Health") Compliance Plan. The purpose of the PRC is to:

   a. Oversee the review and implementation of policies and procedures designed to mitigate and respond to various compliance and regulatory risks facing CalOptima Health; and

   b. Assist the Chief Compliance Officer, Chief Executive Officer (CEO), and the CalOptima Health Board of Directors in fulfilling their respective oversight responsibility of the regulatory and operational requirements to which CalOptima Health must adhere.

2. The PRC is composed of CalOptima Health's senior management and operational staff or their delegate, as designated by the CEO and Chief Compliance Officer. PRC shall have representation from the following areas:

   a. Compliance

   b. Finance

   c. Medical Management

   d. Operations

3. Each Policy shall be reviewed and approved by, at minimum, a quorum of the PRC, or more than fifty percent (50%) of the PRC members, or their delegate.

4. All CalOptima Health PRC event Policies will be distributed to the PRC via email, allowing members up to five (5) business days to assess and submit an electronic vote.

5. The RAC P&P team shall:

   a. Develop and maintain the schedule, deadlines, and agenda(s) of the PRC;

   b. Facilitate the PRC meetings;

   c. Ensure documentation of PRC members' approval; and

   d. Coordinate final edits with Policy Owners upon approval from the PRC.

6. The Policy Owner, or their delegate, shall:

   a. Submit all Policy materials (e.g., revised Policy, PIF, updated attachments, etc.) no later than four (4) weeks prior to the preferred PRC meeting date (unless otherwise indicated by the RAC P&P team);

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i. If updates to the Policy necessitate Board approval, all Policy materials shall be submitted no later than two (2) months prior to the Board meeting date to ensure appropriate scheduling of a PRC meeting.

b. The Policy Owner listed as the contact listed on the PIF is required to reply for the Policy if questions should arise during the PRC review; and

c. Consider revisions to the Policy(s) as appropriate, upon recommendation from the PRC.

E. CalOptima Health Board of Directors (Board) Policy Review

1. Although the Board and the Compliance Committee have authorized the CEO and the PRC to create, review, revise, and retire CalOptima Health's Policies, all new Policies, substantive edits to Human Resources Policies, and substantive edits to Policies not required to comply with existing law must obtain Board approval after PRC and prior to CEO review.

2. For Policies that do not require approval by the Board, upon request, CalOptima Health shall provide Policy updates to the Board.

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1. If approval by a Regulatory Agency is required, including but not limited to the Centers for Medicare & Medicaid Services (CMS), the Department of Health Care Services (DHCS), or the Department of Managed Health Care (DMHC), CalPERS, or any other outside entity, the RAC P&P team shall coordinate with the appropriate CalOptima Health teams to submit the Policy(s) to the appropriate Regulatory Agency for approval, if applicable, and in accordance with CalOptima Health's contracts with its regulators.

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a. If a Regulatory Agency subsequently requests revisions to a Policy approved by PRC, the RAC P&P team, in collaboration with the Policy Owner, shall incorporate any modifications requested by the Regulatory Agency within the required time frame.

3. If state and/or federal mandate(s) requires implementation of a Policy prior to regulatory approval, CalOptima Health shall move forward with implementation of the Policy to ensure regulatory deadlines are met and shall incorporate any modifications to the Policy subsequently received from the Regulatory Agency.

4. Any exceptions to the Regulatory Agency approval process shall require approval by the CEO, or Designee, with concurrence from legal counsel, as appropriate.

G. Chief Executive Officer (CEO) Approval

For 2025 10b BOD Review Only

1. Within seven (7) business days of obtaining all required approvals (e.g., CalOptima Health legal review, PRC, Board, Regulatory Agencies), the RAC P&P team shall submit the Policy(s) to the CEO for final review, approval, and signature completing the review cycle.

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IV. ATTACHMENT(S)

A. CalOptima Health Policy Review Committee (PRC) Charter

V. REFERENCE(S)

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VI. REGULATORY AGENCY APPROVAL(S)

For 20251106 BOD Review Only

None to Date

VII. BOARD ACTION(S)

Date	Meeting
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For 2025.1106 BOD Review Only

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1

For 20251106 BOD Review Only

CALOPTIMA HEALTH POLICY REVIEW COMMITTEE (PRC) CHARTER

For 2025 1106 BOD Review Only

Purpose

The Policy Review Committee ("PRC") is established through adoption of the Orange County Health Authority ("CalOptima Health") Compliance Plan. The purpose of the PRC is to:

1. Oversee the review and implementation of policies and procedures designed to mitigate and respond to various compliance and regulatory risks facing CalOptima Health; and

2. Assist the Chief Compliance Officer, Chief Executive Officer (CEO), and the CalOptima Health Board of Directors in fulfilling their respective oversight responsibility of the regulatory and operational requirements to which CalOptima Health must adhere.

Composition

The PRC is composed of CalOptima Health leadership, as designated by the CEO and Chief Compliance Officer. Committee membership consists of individuals that have subject matter expertise and operational knowledge of the regulations and standards related to operational areas and may include Chief-level staff, as well as executive and non-executive directors, including those serving in an interim capacity.

The PRC may permit participation by other CalOptima Health staff with relevant expertise and experience, as determined necessary and appropriate to CalOptima Health's operational oversight. Such personnel shall be invited to participate in meetings but, unless otherwise designated by the PRC, shall not be considered PRC member(s) and shall not vote.

The size of the PRC shall be commensurate to the different functional areas within CalOptima Health in order to provide a representational audience and ensure accuracy for policies that impact multiple CalOptima Health departments.

The PRC shall have representation from the following areas:

- Compliance
- Finance
- Medical Management
- Operations

Each PRC voting member shall have a delegate. A delegate must be a member of their staff entrusted to make decisions regarding policies and procedures and vote on their behalf. When feasible, a delegate should be Director-level, or above. Under certain circumstances, PRC members and their delegates may be changed in response to staffing changes; this may, or may not, lead to a Director holding an interim voting member position usually allotted to an Executive Director, or Chief. All changes must be requested by the impacted Chief and approved by the PRC Chair.

CALOPTIMA HEALTH POLICY REVIEW COMMITTEE (PRC) CHARTER

The Chief Compliance Officer shall designate the PRC chairperson. Under the circumstances that it is not feasible for the Chief Compliance Officer to designate the PRC chairperson, the members of the PRC may elect a chairperson by majority vote.

Responsibilities

The PRC is responsible for reviewing all policies and procedures, and corresponding supporting materials, and is authorized to create, revise, or retire policies and procedures.

The CEO and the Compliance Committee jointly delegate the following responsibilities to PRC:

- Recommend policies and strategies that maintain and improve CalOptima Health's mission to serve member health with excellence and dignity, respecting the value and needs of each person;
- Draft, review, approve, and/or update policies and procedures to ensure the successful implementation consistent with regulatory, legal, and contractual requirements; and
- Suggest and implement systems, controls, and other actions, as appropriate, and necessary, to ensure that CalOptima Health and its First Tier, Downstream or Related Entities (FDRs) conduct activities and operations in compliance with applicable laws, regulations, and sound business ethics.

Limitation of Authority

Although the CalOptima Health Board of Directors and Compliance Committee have authorized the CEO and the PRC, to create, review, revise, and retire CalOptima Health's policies and procedures, in accordance with CalOptima Health Policy GA.3202: CalOptima Health Signature Authority, the following policies and procedures must obtain CalOptima Health Board of Directors approval after PRC and prior to CEO review:

- New policies
- Policies with significant edits not driven by regulatory, legal or contractual requirements
- Human Resources policies

Meetings

PRC meetings are held at minimum, on a monthly basis and allow the flexibility of three (3) to five (5) business days for review and vote via email. On occasion, there may be a need for an "Urgent" PRC meeting requiring an expedited review and vote by the PRC. These are determined and implemented at the discretion of the PRC Chair.

PRC members shall be provided with electronic notice of the meeting and duration, a PRC meeting agenda, all applicable policies, and contact information provided for questions or comments to assist PRC member in their reviews.

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CALOPTIMA HEALTH POLICY REVIEW COMMITTEE (PRC) CHARTER

At any PRC meeting, a quorum shall be established when one (1) more than half of the members of the PRC are represented. Each PRC member shall cast one (1) vote for each item presented to the PRC for approval. Action of the PRC shall be based on the affirmative vote of a majority of the PRC quorum and documented in the minutes recorded for each meeting.

The PRC Chair may assign a delegate to be responsible for facilitating meetings in their absence, executing approved policies, and maintaining all documentation for PRC meetings.

Reporting

On a monthly basis, CalOptima Health's employees, FDRs, and suppliers are sent the *CalOptima Health Policies and Procedures - Monthly Policy Snapshot* summarizing all policies and procedures approved during the prior month. This memorandum details the following:

- Policy number and title;
- Policy purpose;
- Policy action;
- Policy line of business; and
- New review/revised date.

On an annual basis, the PRC will receive the Policies and Procedures Fast Facts Report demonstrating progress made for all CalOptima Health policies and procedures.

Custodian: Manager, Regulatory Affairs & Compliance (Policies & Procedures)

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Policy:	HH.1105
Title:	**Fraud, Waste, and Abuse Detection**
Department:	Office of Compliance
Section:	Fraud, Waste, and Abuse – Special Investigations Unit
CEO Approval:	*/s/*
Effective Date:	06/01/1999
Revised Date:	09/01/2025
Applicable to:	☐ Administrative ☒ Covered California [Effective 2027] ☒ Medi-Cal ☒ OneCare ☒ PACE

For 2025.1106 BOD Review Only

I. PURPOSE

This policy establishes a process to detect suspected Fraud, Waste, or Abuse (FWA) in a CalOptima Health program by a Member, Provider or Prescribing Provider, Practitioner, a CalOptima Health Employee, First Tier, Downstream, and Related Entities (FDRs), Billing Intermediary, and CalOptima Health's Health Networks, in accordance with federal and state regulations.

II. POLICY

A. CalOptima Health maintains a zero-tolerance policy toward FWA.

B. CalOptima Health shall follow the process for detecting suspected FWA, outlined in this policy.

C. CalOptima Health and its First Tier, Downstream, and Related Entities (FDRs) shall comply with applicable statutory, regulatory, other requirements, sub-regulatory guidance, and contractual commitments related to the delivery of Covered Services, which include but are not limited to, federal and state False Claims Acts, Anti-Kickback statutes, prohibitions on inducements to beneficiaries, Health Insurance Portability and Accountability Act (HIPAA), and other applicable statutes.

D. CalOptima Health's Pharmacy Management Department shall identify Fraud and Abuse of controlled substances by Members, Prescribing Providers, and Pharmacies dispensing drugs to Members, by conducting drug claim reviews and monitoring utilization safety standards, to detect opioid related misuse, and refer cases to the Office of Compliance in accordance with CalOptima Health Policy GG.1428: Pharmacy Management Medi-Cal Rx Responsibilities.

E. CalOptima Health's Office of Compliance shall investigate, and report suspected Fraud, Waste, or Abuse, in accordance with CalOptima Health Policy HH.1107: Fraud, Waste, and Abuse Investigation and Reporting.

F. CalOptima Health shall provide regular training and information sessions to its Employees and FDRs regarding FWA, and shall inform Members regarding FWA and the provisions of this policy.

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G. CalOptima Health Employees and FDRs are expected and required to promptly report suspected violations of any statute, regulations, or guidelines applicable to any CalOptima Health program. CalOptima Health maintains a strict policy of non-retaliation and non-retribution toward Employees and its FDRs who make such reports in good faith. CalOptima Health shall treat the detection of suspected FWA in a confidential manner to the extent possible.

III. PROCEDURE

A. CalOptima Health may detect FWA by a Member in circumstances that include, but are not limited to, the following:

MEMBER FRAUD OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
M01	Using (selling, loaning, or giving) another individual's identity or documentation of Medi-Cal eligibility to obtain Covered Services	Members with services or prescriptions obtained from multiple areas of service; Members who attempt more than one PCP
M03	Making an unsubstantiated declaration of eligibility	Members with multiple areas of service; Members who attempt more than one PCP; reports of Members who are hiding assets or income
M04	Using a Covered Service for purposes other than the purpose for which it was prescribed, or using a Covered Service inappropriately	Selling a covered wheelchair; selling medications; abusing prescription medications
M05	Failing to report other health coverage.	Payments by OHI
M06	Soliciting or receiving a kickback, bribe, or rebate as an inducement to receive or not receive Covered Services.	Hotline reports; internal reports; reports by Health Networks
M07	Other	Any source
M08	Member Pharmacy Utilization	PBM or prescription reports; data analytics; claims data; Encounter data; FWA software
M09	Doctor Shopping	PBM or prescription reports; data analytics; claims data; Encounter data; FWA software
M10	Altered Prescription	Provider report; DEA report; Pharmacy report; PBM reports; data analytics; claims data; Encounter data; FWA software

B. CalOptima Health may detect FWA by an FDR (i.e., Provider, Vendor) in circumstances that include, but are not limited to, the following:

FDR FRAUD OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
P01	Unsubstantiated declaration of eligibility to participate in the CalOptima Health program	Provider information not able to be verified during credentialing or contracting process; Providers on the excluded Provider list

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FDR FRAUD OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
P02	Submission of claims for Covered Services that are substantially and demonstrably in excess of any individual's usual charges for such Covered Services	PBM reports; data analytics; claims data; Encounter data; FWA software; coding edits
P03	Submission of claims for Covered Services that are not actually provided to the Member for which the claim is submitted	PBM or prescription reports; data analytics; claims data; Encounter data; FWA software; verification surveys; Hotline report; Member interviews
P04	Submission of claims for Covered Services that are in excess of the quantity that is Medically Necessary	PBM or prescription reports; data analytics; claims data; Encounter data; FWA software; Medical Record review
P05	Submission of claims for Covered Services that are that are billed using a code that would result in greater payment than the code that reflects the Covered Services	PBM or prescription reports; data analytics; claims data; Encounter data; FWA software; Medical Record review
P06	Submission of claims for Covered Services that is already included in the capitation rate	PBM or prescription reports; data analytics; claims data; Encounter data; FWA software
P07	Submission of claims for Covered Services that are submitted for payment to both CalOptima Health and another third-party payer without full disclosure	PBM or prescription reports; data analytics; claims data; Encounter data; FWA software; payment by OHI
P08	Charging a Member in excess of allowable co-payments and deductibles for Covered Services	Member report; Hotline report; oversight audits; Member interviews
P09	Billing a Member for Covered Services without obtaining written consent to bill for such service	Member report; Hotline report; oversight audits; Member interviews
P10	Billing Medi-Cal Member for services.	Member report; Hotline report; oversight Audits; Member interviews
P11	Failure to disclose conflict of interest	Hotline; credentialing or contracting process
P12	Receiving, soliciting, or offering a kickback, bribe or rebate to refer or fail to refer a Member	Hotline report; oversight report
P13	Failure to register billing intermediary with the Department of Health Care Services	Oversight audit; report by regulatory body; Hotline report
P14	False certification of Medical Necessity	Medical Record review; claims data; Encounter data; FWA software
P15	Attributing a diagnosis code to a Member that does not reflect the Member's medical condition for the purpose of obtaining higher reimbursement	Medical Record review; claims data; Encounter data; FWA software
P16	False or inaccurate Minimum Standards or credentialing information	Hotline report; credentialing or contracting process

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FDR FRAUD OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
P17	Submitting reports that contain unsubstantiated data, data that is inconsistent with clinical, Encounter or payment records, or has been altered in a manner that is inconsistent with policies, contracts, statutes, or regulations	Medical Record review; claims data; Encounter data; FWA software; Member interviews
P18		
P19	Provider Pharmacy Utilization.	PBM or prescription reports; data analytics; claims data; encounter data; FWA software
P20	Durable Medical Equipment- Covered Services that are not actually provided to a member.	Member report; Hotline report; oversight Audits; verification surveys
P21	Unusual out-of-network Provider billing	Prior authorization data; Claims data; Encounter data; oversight Audits
P22	Unusual/outlier high cost Covered Services or prescriptions	Prior authorization data; Claims data; Encounter data; oversight Audits
P23	Exceeding auto referral thresholds	Prior authorization data; Claims data; Encounter data; oversight Audits
P24	Overutilization of Covered Services or prior authorization volume spikes	Prior authorization data; Claims data; Encounter data; oversight Audits; FWA software
P25	For Hospice, verifying certification of terminal illness with a life expectancy of six months or less	Verification surveys (as outlined in APL 25-008 Hospice Services and Medi-Cal Managed Care)
P26	For Hospice, verifying Member elections of hospice care services	Verification surveys (as outlined in APL 25-008 Hospice Services and Medi-Cal Managed Care)
P27	Other	Any source

C. CalOptima Health may detect FWA by an Employee in circumstances that include, but are not limited to, the following:

EMPLOYEE FRAUD OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
E01	Use of a Member's identity or documentation of Medi-Cal eligibility to obtain services	Hotline report; Data analytics; Referrals to SIU
E02	Use of a Member's identity or documentation of Medi-Cal eligibility to obtain a gain	Hotline report, Referrals to SIU
E03	Employee assistance to Providers with the submission of false claims for Covered Services that are not actually provided to the Member for which the claim is submitted	Hotline report; Referrals to SIU
E04	Employee deceptively accessing company confidential information for purpose of a gain	Hotline report; Data analytics; Referrals to SIU

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D. Training

1. CalOptima Health's Office of Compliance shall provide regular training and education to Employees and FDRs regarding the process for detecting suspected FWA, the specific provisions regarding FWA under the False Claims Act, and the protections afforded to those who report such concerns in good faith and in accordance with CalOptima Health Policy HH.5004: False Claims Act Education.

2. CalOptima Health shall provide regular FWA training and information sessions to:

   a. New Employees, upon hire;

   b. CalOptima Health Employees, on an annual basis; and

   c. Health Networks, on an annual basis.

3. CalOptima Health shall provide Members with information related to FWA through:

   a. The Member Handbook;

   b. Periodic communications; and

   c. The CalOptima Health website.

E. Detection

1. CalOptima Health may receive Complaints of suspected FWA from sources, including but not limited to:

   a. CalOptima Health's Compliance and Ethics Hotline;

   b. Claims data history;

   c. Encounter data;

   d. Medical Records audits;

   e. Member and Provider Complaints, appeals, and grievance reviews;

   f. Utilization Management reports;

   g. Provider utilization profiles;

   h. Pharmacy data;

   i. Monitoring and auditing activities;

   j. Memorandums and resources from CMS;

   k. Referrals from the Department of Health Care Services (DHCS);

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l. Monitoring external health care FWA cases and determining if CalOptima Health's FWA Program can be strengthened with information gleaned from the case activity; and/or

m. Internal and external surveys, reviews, and audits.

2. The Office of Compliance shall provide oversight to the Health Networks' Compliance Programs to ensure that the programs are in place, are comprehensive, and in compliance with CalOptima Health contractual requirements.

3. CalOptima Health shall utilize "claims edits" in accordance with federal and state regulations, the DHCS Contract, and industry best practices, including but not limited to the National Correct Coding Initiative (NCCI).

4. CalOptima Health shall conduct data validation reviews by auditors within the Office of Compliance. These reviews are intended to detect any anomalies between items billed, items rendered, Medical Records, and all affiliated documentation related to the claims and Encounters.

5. CalOptima Health shall utilize data analytics, including software, to identify potential FWA cases. This data compares CalOptima Health claims and Encounters against national data to identify any suspected instances of FWA. These cases are forwarded to the Special Investigations Unit (SIU) for investigation.

6. CalOptima Health shall perform reviews on data samples to test for potential FWA through methods, including, but not limited to:

   a. Reviewing utilization by doctor, specialty, and geographic comparison;

   b. CalOptima Health's Pharmacy Department shall refer cases to the SIU for Members exhibiting drug seeking behavior or suspected of FWA issues related to Pharmacy services.

7. CalOptima Health shall implement a Service Verification Survey process to survey a sampling of Members as needed. The focus of these surveys will vary as decided by the SIU and/or the Office of Compliance designated staff. The focus may be on a specific code, Provider, Member category, geographic area, and DME description, reports by other agencies of potential FWA, and industry findings and best practices. The Service Verification process may be used to ensure that:

   a. Covered Services that were billed were received;

   b. Face-to-face, or telehealth, services were provided for services/equipment/medications requiring recent or regular face-to-face, or telehealth, appointments;

   c. Durable Medical Equipment (DME) that were billed were received; and

   d. Medications that were billed were received.

F. CalOptima Health shall attend and participate in DHCS's quarterly program integrity meetings, as scheduled.

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G. Upon detection of suspected Fraud, Waste, and/or Abuse, the Office of Compliance shall review the suspected activity in accordance with CalOptima Health Policy HH.1107: Fraud, Waste, and Abuse Investigation and Reporting.

H. CalOptima Health shall treat the detection of suspected Fraud, Waste, or Abuse in a confidential manner, and shall not retaliate or make retribution against any CalOptima Health Employee, FDR, or Member for such detection, in accordance with CalOptima Health policy HH.3012: Non-Retaliation for Reporting Violations.

I. CalOptima Health shall not terminate Covered California Member coverage for Fraud without prior review and approval from Covered California.

IV. ATTACHMENT(S)

A. Suspected Fraud or Abuse Referral Form (English)

V. REFERENCE(S)

A. California Government Code, §12650, California False Claims Act
B. CalOptima Health Contract for Health Care Services
C. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
D. CalOptima Health Contract with Department of Health Care Services (DHCS) for Medi-Cal
E. CalOptima Health PACE Program Agreement
F. CalOptima Health Policy GG.1428: Pharmacy Management Medi-Cal Rx Responsibilities
G. CalOptima Health Policy HH.1107: Fraud, Waste and Abuse Investigation and Reporting
H. CalOptima Health Policy HH.3012: Non-Retaliation for Reporting Violations
I. CalOptima Health Policy HH.5004: False Claims Act Education
J. CalOptima Health Anti-Fraud, Waste, and Abuse (FWA) Plan
K. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-026: Federal Drug Utilization Review Requirements Designed to Reduce Opioid Related Fraud, Misuse and Abuse (Supersedes APL 19-012)(Revised 02/20/2024)
L. Department of Health Care Services (DHCS) All Plan Letter (APL) 25-008: Hospice Services and Medi-Cal Managed Care
M. Title 31, United States Code (U.S.C.), §3730(h)
N. Title 42, Code of Federal Regulations (C.F.R.), §§455.2 and 438.608
O. Welfare and Institutions Code, §§14026 and 14107.2
P. Welfare and Institutions Code, §14043.1(a)

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/06/2018	Regular Meeting of the CalOptima Board of Directors
12/05/2019	Regular Meeting of the CalOptima Board of Directors

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Date	Meeting
12/03/2020	Regular Meeting of the CalOptima Board of Directors
12/20/2021	Special Meeting of the CalOptima Board of Directors
11/07/2024	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	06/01/1999	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal
Revised	08/01/2000	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal
Revised	09/01/2004	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal
Revised	01/01/2007	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal
Revised	02/01/2013	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal OneCare
Revised	04/01/2014	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal
Revised	09/01/2015	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal
Revised	06/01/2016	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal
Revised	12/01/2016	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal OneCare OneCare Connect PACE
Revised	12/07/2017	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal OneCare OneCare Connect PACE
Revised	05/01/2018	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal OneCare OneCare Connect PACE
Revised	12/03/2020	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal OneCare OneCare Connect PACE
Revised	12/20/2021	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal OneCare PACE

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Action	Date	Policy	Policy Title	Program(s)
Revised	09/01/2023	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal OneCare PACE
Revised	11/07/2024	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal OneCare PACE
Revised	05/01/2025	HH.1105	Fraud, Waste, and Abuse Detection	Covered California Medi-Cal OneCare PACE
Revised	09/01/2025	HH.1105	Fraud, Waste, and Abuse Detection	Covered California Medi-Cal OneCare PACE

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IX. GLOSSARY

Term	Definition
Abuse	Covered California: Excessive, or improper use of something, or the use of something in a manner contrary to the natural or legal rules for its use; the intentional destruction, diversion, manipulation, misapplication, maltreatment, or misuse of resources; or extravagant or excessive use to abuse one's position or authority. Often, the terms fraud and abuse are used simultaneously with the primary distinction is the intent. Inappropriate practices that begin as abuse can quickly evolve into fraud. Abuse can occur in financial or non-financial settings. Examples of abuse include excessive charges, improper billing practices, payment for services that do not meet recognized standards of care and payment for medically unnecessary services. Medi-Cal: Practices that are inconsistent with sound fiscal and business practices or medical standards, and result in an unnecessary cost to the Medi-Cal program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to the Medi-Cal program. OneCare: A Provider practice that is inconsistent with sound fiscal, business, or medical practice, and results in an unnecessary cost to CalOptima Health and the OneCare program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to CalOptima Health and the OneCare program.
Centers for Medicare & Medicaid Services (CMS)	The federal agency within the United States Department of Health and Human Services (DHHS) that administers the Federal Medicare program and works in partnership with state governments to administer Medicaid programs.
Complaint	Medi-Cal: A complaint is the same as a Grievance. If CalOptima Health is unable to distinguish between a Grievance and an Inquiry, it must be considered a Grievance. OneCare: Any expression of dissatisfaction to CalOptima Health, a Provider, or the Quality Improvement Organization (QIO) by a Member made orally or in writing. A Complaint may also involve CalOptima Health's refusal to provide services to which a Member believes he or she is entitled. A Complaint may be a Grievance or an Appeal, or a single Complaint could include both.
Covered Service	Covered California: Health care services that are covered benefits under CalOptima Health's contract with Covered California, as further described in the Evidence of Coverage and supporting documents. Medi-Cal: Those health care services, set forth in W&I sections 14000 et seq. and 14131 et seq., 22 CCR section 51301 et seq., 17 CCR section 6800 et seq., the Medi-Cal Provider Manual, the California Medicaid State Plan, the California Section 1115 Medicaid Demonstration Project, the contract with DHCS for Medi-Cal, and DHCS APLs that are made the responsibility of CalOptima Health pursuant to the California Section 1915(b) Medicaid

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Term	Definition
	Waiver authorizing the Medi-Cal managed care program or other federally approved managed care authorities maintained by DHCS. Covered Services do not include: 1. Home and Community-Based Services (HCBS) program as specified in the DHCS contract for Medi-Cal Exhibit A, Attachment III, Subsections 4.3.15 (Services for Persons with Developmental Disabilities), 4.3.20 (Home and Community-Based Services Programs) regarding waiver programs, 4.3.21 (In-Home Supportive Services), and Department of Developmental Services (DDS) Administered Medicaid Home and Community-Based Services Waiver. HCBS programs do not include services that are available as an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) service, as described in 22 CCR sections 51184, 51340 and 51340.1. EPSDT services are covered under the DHCS contract for Medi-Cal, as specified in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services), Subsection F4 regarding services for Members less than twenty-one (21) years of age. CalOptima Health is financially responsible for the payment of all EPSDT services; 2. California Children's Services (CCS) as specified in Exhibit A, Attachment III, Subsection 4.3.14 (California Children's Services), except for Contractors providing Whole Child Model (WCM) services; 3. Specialty Mental Health Services as specified in Exhibit A, Attachment III, Subsection 4.3.12 (Mental Health Services); 4. Alcohol and SUD treatment services, and outpatient heroin and other opioid detoxification, except for medications for addiction treatment as specified in Exhibit A, Attachment III, Subsection 4.3.13 (Alcohol and Substance Use Disorder Treatment Services); 5. Fabrication of optical lenses except as specified in Exhibit A, Attachment III, Subsection 5.3.7 (Services for All Members); 6. Direct Observed Therapy for Treatment of Tuberculosis (TB) as specified in Exhibit A, Attachment III, Subsection 4.3.18 (Direct Observed Therapy for Treatment of Tuberculosis); 7. Dental services as specified in W&I sections 14131.10, 14132(h), 14132.22, 14132.23, and 14132.88, and EPSDT dental services as described in 22 CCR section 51340.1(b). However, CalOptima Health is responsible for all Covered Services as specified in Exhibit A, Attachment III, Subsection 4.3.17 (Dental) regarding dental services; 8. Prayer or spiritual healing as specified in 22 CCR section 51312; 9. Educationally Necessary Behavioral Health Services that are covered by a Local Education Agency (LEA) and provided pursuant to a Member's Individualized Education Plan (IEP) as set forth in Education Code section 56340 et seq., Individualized Family Service Plan (IFSP) as set forth in California Government Code (GC) section 95020, or Individualized Health and Support Plan (IHSP). However, CalOptima Health is responsible for all Medically Necessary Behavioral Health Services as specified in Exhibit A, Attachment III Subsection 4.3.16 (School-Based Services);

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Term	Definition
	10. Laboratory services provided under the State serum alpha-feto-protein-testing program administered by the Genetic Disease Branch of California Department of Public Health (CDPH); 11. Pediatric Day Health Care, except for Contractors providing Whole Child Model (WCM) services; 12. State Supported Services; 13. Targeted Case Management (TCM) services as set forth in 42 USC section 1396n(g), W&I sections 14132.48 and 14021.3, 22 CCR sections 51185 and 51351, and as described in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services). However, if Members less than twenty-one (21) years of age are not eligible for or accepted by a Regional Center (RC) or a local government health program for TCM services, CalOptima Health must ensure access to comparable services under the EPSDT benefit in accordance with DHCS APL 23-005; 14. Childhood lead poisoning case management provided by county health departments; 15. Non-medical services provided by Regional Centers (RC) to individuals with Developmental Disabilities, including but not limited to respite, out-of-home placement, and supportive living; 16. End of life services as stated in Health and Safety Code (H&S) section 443 et seq., and DHCS APL 16-006; and 17. Prescribed and covered outpatient drugs, medical supplies, and enteral nutritional products when appropriately billed by a pharmacy on a pharmacy claim, in accordance with DHCS APL 22-012. OneCare: Those medical services, equipment, or supplies that CalOptima Health is obligated to provide to Members under the Center of Medicare & Medicaid Services (CMS) Contract. 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 Health, or other services as authorized by the CalOptima Health Board of Directors.
Department of Health Care Services (DHCS)	The single State department responsible for the administration of the Medi-Cal Program, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), and other health related programs as provided by statute and/or regulation.
Department of Managed Health Care (DMHC)	California state agency that regulates and oversees health maintenance organizations (HMOs) and other managed care plans.
Downstream Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Health Program benefit, below the level of arrangement between CalOptima Health and a First Tier Entity. These written arrangements continue down to the level of the ultimate Provider of both health and administrative services.

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Term	Definition
Durable Medical Equipment (DME)	Medi-Cal: Medically Necessary medical equipment as defined by 22 CCR section 51160 that a Provider prescribes for a Member that the Member uses in the home, in the community, or in a facility that is used as a home. OneCare & PACE: Durable medical equipment means equipment prescribed by a licensed practitioner to meet medical equipment needs of the Member that: 1. Can withstand repeated use. 2. Is used to serve a medical purpose. 3. Is not useful to an individual in the absence of an illness, injury, functional impairment, or congenital anomaly. 4. Is appropriate for use in or out of the patient's home.
Employee	For purposes of this policy, any and all Employees of CalOptima Health, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary Employees and volunteers.
Encounter	Medi-Cal: Any unit of Covered Services provided to a Member by a Health Network regardless of Health Network reimbursement methodology. Such Covered Services include any service provided to a Member regardless of the service location or Provider, including out-of-network services and sub-capitated and delegated Covered Services. OneCare: Any unit of Covered Service provided to a Member by a Health Network regardless of Health Network reimbursement methodology. These services include any Covered Services provided to a Member, regardless of the service location or Provider, including out-of-network Covered Services and sub-capitated and delegated Covered Services. Encounter data submitted to CalOptima Health should not include denied, adjusted, or duplicate claims.
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 groups, Physician Hospital Consortia, and Health Maintenance Organizations.
First Tier Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima Health to provide administrative services or health care services to a Member under a CalOptima Health Program.
Fraud	Covered California: Consists of an intentional misrepresentation, deceit, or concealment of a material fact known to the defendant with the intention on the part of the defendant of thereby depriving a person of property or legal rights or otherwise causing injury. (CA Civil Code §3294 (c)(3), CA Penal Code §§470-483.5). Prevention and early detection of fraudulent activities is crucial to ensuring affordable healthcare for all individuals. Examples of fraud include false applications to obtain payment, false information to obtain insurance, billing for services that were not rendered. Fraud includes, but is not limited to, knowingly making or causing to be made any false or fraudulent claim for payment of a health care benefit, in accordance with Health and Safety Code section 1348. Medi-Cal & OneCare: An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law, in accordance with

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Term	Definition
	Title 42 Code of Federal Regulations section 455.2, Welfare and Institutions Code section 14043.1(i).
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information as amended.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO), Subcontractor, or First Tier Entity, that contracts with CalOptima Health to provide Covered Services to Members.
Medical Record	Medi-Cal & Covered California: The record of a Member's medical information including but not limited to, medical history, care or treatments received, test results, diagnoses, and prescribed medications. OneCare: A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal. PACE: Written documentary evidence of treatments rendered to plan Members.
Medically Necessary or Medical Necessity	Covered California: Health care and related services and supplies provided to a Member for the purpose of evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms and that are: (i) in accordance with generally accepted standards of medical practice; (ii) appropriate for the symptoms, diagnosis, or treatment of the Member's condition, disease, illness or injury; (iii) not primarily for the convenience of the Member or health care Provider; and (iv) not more costly than an alternative service, or suite of services, and at least as likely to produce equivalent results. For treatment of a mental health or substance use disorder, Medical Necessity shall include: A service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of an illness, injury, condition, or its symptoms, in a manner that is all of the following: (i) in accordance with the generally accepted standards of mental health and substance use disorder care; (ii) clinically appropriate in terms of type, frequency, extent, site, and duration; (iii) not primarily for the economic benefit of the disability insurer and insureds or for the convenience of the patient, treating physician, or other health care Provider, as required by HSC §1374.72 (a)(3)(A). 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-

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Term	Definition
	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 Health shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child. OneCare: Reasonable and necessary medical services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. PACE: 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.
Member	An individual enrolled in a CalOptima Health Program.
Other Health Coverage (OHC)	Medi-Cal: Health coverage from another entity that is responsible for payment of the reasonable value of all or part of the health care services provided to a Member. OHC may result from a health insurance policy or other contractual agreement or legal obligation to pay for health care services provided to a Member, excluding tort liability. OHC may originate under State (other than the Medi-Cal program), federal, or local medical care program, or under other contractual or legal entitlements. OneCare: Evidence of health coverage other than OneCare including, but not necessarily limited to: 1. The CalOptima Health Medi-Cal program; 2. Group health plans; 3. Federal Employee Health Benefits Program (FEHB); 4. Military coverage, including TRICARE; 5. Worker's Compensation; 6. Personal Injury Liability compensation; 7. Black Lung federal coverage; 8. Indian Health Service; 9. Federally qualified health centers (FQHC); 10. Rural health centers (RHC); and/or 11. Other health benefit plans or programs that provide coverage or financial assistance for the purchase or provision of Covered Part D Drugs on behalf of Part D eligible individuals as the Centers for Medicare & Medicaid Services (CMS) may specify.

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Term	Definition
Personal Representative	Has the meaning given such term in section 164.502(g) of title 45, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of un-emancipated minors.
Pharmacy	An area, place, or premise licensed by the State Board of Pharmacy in which the profession of pharmacy is practiced and where Prescriptions are compounded and dispensed.
Pharmacy Benefit Manager (PBM)	Medi-Cal: The entity that performs certain functions and tasks including, but not limited to, Pharmacy credentialing, contracting, and claims processing in accordance with the terms and conditions of the PBM Services Agreement. OneCare: An entity that provides Pharmacy benefit management services, including contracting with a network of pharmacies; establishing payment levels for network pharmacies; negotiating rebate arrangements; developing and managing formularies, preferred drug lists, and Prior Authorization programs; maintaining patient compliance programs; performing drug utilization review; and operating disease management programs.
Practitioner	A licensed independent Practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.
Prescribing Provider	The physician, osteopath, podiatrist, dentist, optometrist, or authorized mid-level medical Practitioner who prescribes a medication for a Member.
Prior Authorization	Covered California: A formal process requiring a Provider to obtain advanced approval for the amount, duration, and scope of non-emergent Covered Services. Medi-Cal: A formal process requiring a health care Provider to obtain advance approval of Medically Necessary Covered Services, including the amount, duration and scope of services, except in the case of an emergency. OneCare: A process through which a physician or other health care provider is required to obtain advance approval, from CalOptima Health and/or a delegated entity, that payment will be made for a service or item furnished to a Member. PACE: A formal process requiring a health care provider to obtain advance approval to provide specific services or procedures, or the process by which an IDT approves a member to receive a specific service or procedure.

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Term	Definition
Provider	Covered California: A licensed health care facility or as stipulated by local or international jurisdictions, a program, agency or health professional that delivers Covered Services. Medi-Cal: Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so. OneCare: Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier, etc.) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of Covered Services under Medicare Part B.
Related Entity	Any entity that is related to the Medicare Advantage organization by common ownership or control and: 1. Performs some of the Medicare Advantage organization's management functions under contract or delegation; 2. Furnishes services to Medicare enrollees under an oral or written agreement; or 3. Leases real property or sells materials to the Medicare Advantage organization at a cost of more than two thousand five hundred dollars ($2,**500)** during a contract period.
Waste	Covered California: Intentional or unintentional, extravagant careless or needless expenditures, consumption, mismanagement, use, or squandering of resources, to the detriment or potential detriment of entities, but without an intent to deceive or misrepresent. Waste includes incurring unnecessary costs because of inefficient or ineffective practices, systems, decisions, or controls. Medi-Cal: The overutilization or inappropriate utilization of services and misuse of resources. OneCare: The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Health Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

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Policy:	HH.1105
Title:	**Fraud, Waste, and Abuse Detection**
Department:	Office of Compliance
Section:	Fraud, Waste, and Abuse – Special Investigations Unit
CEO Approval:	*/s/*
Effective Date:	06/01/1999
Revised Date:	09/01/2025
Applicable to:	☐ Administrative ☒ Covered California [Effective 2027] ☒ Medi-Cal ☒ OneCare ☒ PACE

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I. PURPOSE

This policy establishes a process to detect suspected Fraud, Waste, or Abuse (FWA) in a CalOptima Health program by a Member, Provider or Prescribing Provider, Practitioner, a CalOptima Health Employee, First Tier, Downstream, and Related Entities (FDRs), Billing Intermediary, and CalOptima Health's Health Networks, in accordance with federal and state regulations.

II. POLICY

A. CalOptima Health maintains a zero-tolerance policy toward FWA.

B. CalOptima Health shall follow the process for detecting suspected FWA, outlined in this policy.

C. CalOptima Health and its First Tier, Downstream, and Related Entities (FDRs) shall comply with applicable statutory, regulatory, other requirements, sub-regulatory guidance, and contractual commitments related to the delivery of Covered Services, which include but are not limited to, federal and state False Claims Acts, Anti-Kickback statutes, prohibitions on inducements to beneficiaries, Health Insurance Portability and Accountability Act (HIPAA), and other applicable statutes.

D. CalOptima Health's Pharmacy Management Department shall identify Fraud and Abuse of controlled substances by Members, Prescribing Providers, and Pharmacies dispensing drugs to Members, by conducting drug claim reviews and monitoring utilization safety standards, to detect opioid related misuse, and refer cases to the Office of Compliance in accordance with CalOptima Health Policy GG.1428: Pharmacy Management Medi-Cal Rx Responsibilities.

E. CalOptima Health's Office of Compliance shall investigate, and report suspected Fraud, Waste, or Abuse, in accordance with CalOptima Health Policy HH.1107: Fraud, Waste, and Abuse Investigation and Reporting.

F. CalOptima Health shall provide regular training and information sessions to its Employees and FDRs regarding FWA, and shall inform Members regarding FWA and the provisions of this policy.

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G. CalOptima Health Employees and FDRs are expected and required to promptly report suspected violations of any statute, regulations, or guidelines applicable to any CalOptima Health program. CalOptima Health maintains a strict policy of non-retaliation and non-retribution toward Employees and its FDRs who make such reports in good faith. CalOptima Health shall treat the detection of suspected FWA in a confidential manner to the extent possible.

III. PROCEDURE

A. CalOptima Health may detect FWA by a Member in circumstances that include, but are not limited to, the following:

MEMBER FRAUD OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
M01	Using (selling, loaning, or giving) another individual's identity or documentation of Medi-Cal eligibility to obtain Covered Services	Members with services or prescriptions obtained from multiple areas of service; Members who attempt more than one PCP
M03	Making an unsubstantiated declaration of eligibility	Members with multiple areas of service; Members who attempt more than one PCP; reports of Members who are hiding assets or income
M04	Using a Covered Service for purposes other than the purpose for which it was prescribed, or using a Covered Service inappropriately	Selling a covered wheelchair; selling medications; abusing prescription medications
M05	Failing to report other health coverage.	Payments by OHI
M06	Soliciting or receiving a kickback, bribe, or rebate as an inducement to receive or not receive Covered Services.	Hotline reports; internal reports; reports by Health Networks
M07	Other	Any source
M08	Member Pharmacy Utilization	PBM or prescription reports; data analytics; claims data; Encounter data; FWA software
M09	Doctor Shopping	PBM or prescription reports; data analytics; claims data; Encounter data; FWA software
M10	Altered Prescription	Provider report; DEA report; Pharmacy report; PBM reports; data analytics; claims data; Encounter data; FWA software

B. CalOptima Health may detect FWA by an FDR (i.e., Provider, Vendor) in circumstances that include, but are not limited to, the following:

FDR FRAUD OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
P01	Unsubstantiated declaration of eligibility to participate in the CalOptima Health program	Provider information not able to be verified during credentialing or contracting process; Providers on the excluded Provider list

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FDR FRAUD OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
P02	Submission of claims for Covered Services that are substantially and demonstrably in excess of any individual's usual charges for such Covered Services	PBM reports; data analytics; claims data; Encounter data; FWA software; coding edits
P03	Submission of claims for Covered Services that are not actually provided to the Member for which the claim is submitted	PBM or prescription reports; data analytics; claims data; Encounter data; FWA software; verification surveys; Hotline report; Member interviews
P04	Submission of claims for Covered Services that are in excess of the quantity that is Medically Necessary	PBM or prescription reports; data analytics; claims data; Encounter data; FWA software; Medical Record review
P05	Submission of claims for Covered Services that are that are billed using a code that would result in greater payment than the code that reflects the Covered Services	PBM or prescription reports; data analytics; claims data; Encounter data; FWA software; Medical Record review
P06	Submission of claims for Covered Services that is already included in the capitation rate	PBM or prescription reports; data analytics; claims data; Encounter data; FWA software
P07	Submission of claims for Covered Services that are submitted for payment to both CalOptima Health and another third-party payer without full disclosure	PBM or prescription reports; data analytics; claims data; Encounter data; FWA software; payment by OHI
P08	Charging a Member in excess of allowable co-payments and deductibles for Covered Services	Member report; Hotline report; oversight audits; Member interviews
P09	Billing a Member for Covered Services without obtaining written consent to bill for such service	Member report; Hotline report; oversight audits; Member interviews
P10	Billing Medi-Cal Member for services.	Member report; Hotline report; oversight Audits; Member interviews
P11	Failure to disclose conflict of interest	Hotline; credentialing or contracting process
P12	Receiving, soliciting, or offering a kickback, bribe or rebate to refer or fail to refer a Member	Hotline report; oversight report
P13	Failure to register billing intermediary with the Department of Health Care Services	Oversight audit; report by regulatory body; Hotline report
P14	False certification of Medical Necessity	Medical Record review; claims data; Encounter data; FWA software
P15	Attributing a diagnosis code to a Member that does not reflect the Member's medical condition for the purpose of obtaining higher reimbursement	Medical Record review; claims data; Encounter data; FWA software
P16	False or inaccurate Minimum Standards or credentialing information	Hotline report; credentialing or contracting process

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FDR FRAUD OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
P17	Submitting reports that contain unsubstantiated data, data that is inconsistent with clinical, Encounter or payment records, or has been altered in a manner that is inconsistent with policies, contracts, statutes, or regulations	Medical Record review; claims data; Encounter data; FWA software; Member interviews
P18		
P19	Provider Pharmacy Utilization.	PBM or prescription reports; data analytics; claims data; encounter data; FWA software
P20	Durable Medical Equipment- Covered Services that are not actually provided to a member.	Member report; Hotline report; oversight Audits; verification surveys
P21	Unusual out-of-network Provider billing	Prior authorization data; Claims data; Encounter data; oversight Audits
P22	Unusual/outlier high cost Covered Services or prescriptions	Prior authorization data; Claims data; Encounter data; oversight Audits
P23	Exceeding auto referral thresholds	Prior authorization data; Claims data; Encounter data; oversight Audits
P24	Overutilization of Covered Services or prior authorization volume spikes	Prior authorization data; Claims data; Encounter data; oversight Audits; FWA software
P25	For Hospice, verifying certification of terminal illness with a life expectancy of six months or less	Verification surveys (as outlined in APL 25-008 Hospice Services and Medi-Cal Managed Care)
P26	For Hospice, verifying Member elections of hospice care services	Verification surveys (as outlined in APL 25-008 Hospice Services and Medi-Cal Managed Care)
P27	Other	Any source

C. CalOptima Health may detect FWA by an Employee in circumstances that include, but are not limited to, the following:

EMPLOYEE FRAUD OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
E01	Use of a Member's identity or documentation of Medi-Cal eligibility to obtain services	Hotline report; Data analytics; Referrals to SIU
E02	Use of a Member's identity or documentation of Medi-Cal eligibility to obtain a gain	Hotline report, Referrals to SIU
E03	Employee assistance to Providers with the submission of false claims for Covered Services that are not actually provided to the Member for which the claim is submitted	Hotline report; Referrals to SIU
E04	Employee deceptively accessing company confidential information for purpose of a gain	Hotline report; Data analytics; Referrals to SIU

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D. Training

1. CalOptima Health's Office of Compliance shall provide regular training and education to Employees and FDRs regarding the process for detecting suspected FWA, the specific provisions regarding FWA under the False Claims Act, and the protections afforded to those who report such concerns in good faith and in accordance with CalOptima Health Policy HH.5004: False Claims Act Education.

2. CalOptima Health shall provide regular FWA training and information sessions to:

   a. New Employees, upon hire;

   b. CalOptima Health Employees, on an annual basis; and

   c. Health Networks, on an annual basis.

3. CalOptima Health shall provide Members with information related to FWA through:

   a. The Member Handbook;

   b. Periodic communications; and

   c. The CalOptima Health website.

E. Detection

1. CalOptima Health may receive Complaints of suspected FWA from sources, including but not limited to:

   a. CalOptima Health's Compliance and Ethics Hotline;

   b. Claims data history;

   c. Encounter data;

   d. Medical Records audits;

   e. Member and Provider Complaints, appeals, and grievance reviews;

   f. Utilization Management reports;

   g. Provider utilization profiles;

   h. Pharmacy data;

   i. Monitoring and auditing activities;

   j. Memorandums and resources from CMS;

   k. Referrals from the Department of Health Care Services (DHCS);

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l. Monitoring external health care FWA cases and determining if CalOptima Health's FWA Program can be strengthened with information gleaned from the case activity; and/or

m. Internal and external surveys, reviews, and audits.

2. The Office of Compliance shall provide oversight to the Health Networks' Compliance Programs to ensure that the programs are in place, are comprehensive, and in compliance with CalOptima Health contractual requirements.

3. CalOptima Health shall utilize "claims edits" in accordance with federal and state regulations, the DHCS Contract, and industry best practices, including but not limited to the National Correct Coding Initiative (NCCI).

4. CalOptima Health shall conduct data validation reviews by auditors within the Office of Compliance. These reviews are intended to detect any anomalies between items billed, items rendered, Medical Records, and all affiliated documentation related to the claims and Encounters.

5. CalOptima Health shall utilize data analytics, including software, to identify potential FWA cases. This data compares CalOptima Health claims and Encounters against national data to identify any suspected instances of FWA. These cases are forwarded to the Special Investigations Unit (SIU) for investigation.

6. CalOptima Health shall perform reviews on data samples to test for potential FWA through methods, including, but not limited to:

   a. Reviewing utilization by doctor, specialty, and geographic comparison;

   b. CalOptima Health's Pharmacy Department shall refer cases to the SIU for Members exhibiting drug seeking behavior or suspected of FWA issues related to Pharmacy services.

7. CalOptima Health shall implement a Service Verification Survey process to survey a sampling of Members as needed. The focus of these surveys will vary as decided by the SIU and/or the Office of Compliance designated staff. The focus may be on a specific code, Provider, Member category, geographic area, and DME description, reports by other agencies of potential FWA, and industry findings and best practices. The Service Verification process may be used to ensure that:

   a. Covered Services that were billed were received;

   b. Face-to-face, or telehealth, services were provided for services/equipment/medications requiring recent or regular face-to-face, or telehealth, appointments;

   c. Durable Medical Equipment (DME) that were billed were received; and

   d. Medications that were billed were received.

F. CalOptima Health shall attend and participate in DHCS's quarterly program integrity meetings, as scheduled.

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G. Upon detection of suspected Fraud, Waste, and/or Abuse, the Office of Compliance shall review the suspected activity in accordance with CalOptima Health Policy HH.1107: Fraud, Waste, and Abuse Investigation and Reporting.

H. CalOptima Health shall treat the detection of suspected Fraud, Waste, or Abuse in a confidential manner, and shall not retaliate or make retribution against any CalOptima Health Employee, FDR, or Member for such detection, in accordance with CalOptima Health policy HH.3012: Non-Retaliation for Reporting Violations.

I. CalOptima Health shall not terminate Covered California Member coverage for Fraud without prior review and approval from Covered California.

IV. ATTACHMENT(S)

A. Suspected Fraud or Abuse Referral Form (English)

V. REFERENCE(S)

A. California Government Code, §12650, California False Claims Act
B. CalOptima Health Contract for Health Care Services
C. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
D. CalOptima Health Contract with Department of Health Care Services (DHCS) for Medi-Cal
E. CalOptima Health PACE Program Agreement
F. CalOptima Health Policy GG.1428: Pharmacy Management Medi-Cal Rx Responsibilities
G. CalOptima Health Policy HH.1107: Fraud, Waste and Abuse Investigation and Reporting
H. CalOptima Health Policy HH.3012: Non-Retaliation for Reporting Violations
I. CalOptima Health Policy HH.5004: False Claims Act Education
J. CalOptima Health Anti-Fraud, Waste, and Abuse (FWA) Plan
K. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-026: Federal Drug Utilization Review Requirements Designed to Reduce Opioid Related Fraud, Misuse and Abuse (Supersedes APL 19-012)(Revised 02/20/2024)
L. Department of Health Care Services (DHCS) All Plan Letter (APL) 25-008: Hospice Services and Medi-Cal Managed Care
M. Title 31, United States Code (U.S.C.), §3730(h)
N. Title 42, Code of Federal Regulations (C.F.R.), §§455.2 and 438.608
O. Welfare and Institutions Code, §§14026 and 14107.2
P. Welfare and Institutions Code, §14043.1(a)

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/06/2018	Regular Meeting of the CalOptima Board of Directors
12/05/2019	Regular Meeting of the CalOptima Board of Directors

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Date	Meeting
12/03/2020	Regular Meeting of the CalOptima Board of Directors
12/20/2021	Special Meeting of the CalOptima Board of Directors
11/07/2024	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	06/01/1999	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal
Revised	08/01/2000	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal
Revised	09/01/2004	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal
Revised	01/01/2007	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal
Revised	02/01/2013	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal OneCare
Revised	04/01/2014	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal
Revised	09/01/2015	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal
Revised	06/01/2016	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal
Revised	12/01/2016	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal OneCare OneCare Connect PACE
Revised	12/07/2017	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal OneCare OneCare Connect PACE
Revised	05/01/2018	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal OneCare OneCare Connect PACE
Revised	12/03/2020	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal OneCare OneCare Connect PACE
Revised	12/20/2021	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal OneCare PACE

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Action	Date	Policy	Policy Title	Program(s)
Revised	09/01/2023	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal OneCare PACE
Revised	11/07/2024	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal OneCare PACE
Revised	05/01/2025	HH.1105	Fraud, Waste, and Abuse Detection	Covered California Medi-Cal OneCare PACE
Revised	09/01/2025	HH.1105	Fraud, Waste, and Abuse Detection	Covered California Medi-Cal OneCare PACE

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IX. GLOSSARY

Term	Definition
Abuse	Covered California: Excessive, or improper use of something, or the use of something in a manner contrary to the natural or legal rules for its use; the intentional destruction, diversion, manipulation, misapplication, maltreatment, or misuse of resources; or extravagant or excessive use to abuse one's position or authority. Often, the terms fraud and abuse are used simultaneously with the primary distinction is the intent. Inappropriate practices that begin as abuse can quickly evolve into fraud. Abuse can occur in financial or non-financial settings. Examples of abuse include excessive charges, improper billing practices, payment for services that do not meet recognized standards of care and payment for medically unnecessary services. Medi-Cal: Practices that are inconsistent with sound fiscal and business practices or medical standards, and result in an unnecessary cost to the Medi-Cal program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to the Medi-Cal program. OneCare: A Provider practice that is inconsistent with sound fiscal, business, or medical practice, and results in an unnecessary cost to CalOptima Health and the OneCare program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to CalOptima Health and the OneCare program.
Centers for Medicare & Medicaid Services (CMS)	The federal agency within the United States Department of Health and Human Services (DHHS) that administers the Federal Medicare program and works in partnership with state governments to administer Medicaid programs.
Complaint	Medi-Cal: A complaint is the same as a Grievance. If CalOptima Health is unable to distinguish between a Grievance and an Inquiry, it must be considered a Grievance. OneCare: Any expression of dissatisfaction to CalOptima Health, a Provider, or the Quality Improvement Organization (QIO) by a Member made orally or in writing. A Complaint may also involve CalOptima Health's refusal to provide services to which a Member believes he or she is entitled. A Complaint may be a Grievance or an Appeal, or a single Complaint could include both.
Covered Service	Covered California: Health care services that are covered benefits under CalOptima Health's contract with Covered California, as further described in the Evidence of Coverage and supporting documents. Medi-Cal: Those health care services, set forth in W&I sections 14000 et seq. and 14131 et seq., 22 CCR section 51301 et seq., 17 CCR section 6800 et seq., the Medi-Cal Provider Manual, the California Medicaid State Plan, the California Section 1115 Medicaid Demonstration Project, the contract with DHCS for Medi-Cal, and DHCS APLs that are made the responsibility of CalOptima Health pursuant to the California Section 1915(b) Medicaid

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Term	Definition
	Waiver authorizing the Medi-Cal managed care program or other federally approved managed care authorities maintained by DHCS. Covered Services do not include: 1. Home and Community-Based Services (HCBS) program as specified in the DHCS contract for Medi-Cal Exhibit A, Attachment III, Subsections 4.3.15 (Services for Persons with Developmental Disabilities), 4.3.20 (Home and Community-Based Services Programs) regarding waiver programs, 4.3.21 (In-Home Supportive Services), and Department of Developmental Services (DDS) Administered Medicaid Home and Community-Based Services Waiver. HCBS programs do not include services that are available as an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) service, as described in 22 CCR sections 51184, 51340 and 51340.1. EPSDT services are covered under the DHCS contract for Medi-Cal, as specified in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services), Subsection F4 regarding services for Members less than twenty-one (21) years of age. CalOptima Health is financially responsible for the payment of all EPSDT services; 2. California Children's Services (CCS) as specified in Exhibit A, Attachment III, Subsection 4.3.14 (California Children's Services), except for Contractors providing Whole Child Model (WCM) services; 3. Specialty Mental Health Services as specified in Exhibit A, Attachment III, Subsection 4.3.12 (Mental Health Services); 4. Alcohol and SUD treatment services, and outpatient heroin and other opioid detoxification, except for medications for addiction treatment as specified in Exhibit A, Attachment III, Subsection 4.3.13 (Alcohol and Substance Use Disorder Treatment Services); 5. Fabrication of optical lenses except as specified in Exhibit A, Attachment III, Subsection 5.3.7 (Services for All Members); 6. Direct Observed Therapy for Treatment of Tuberculosis (TB) as specified in Exhibit A, Attachment III, Subsection 4.3.18 (Direct Observed Therapy for Treatment of Tuberculosis); 7. Dental services as specified in W&I sections 14131.10, 14132(h), 14132.22, 14132.23, and 14132.88, and EPSDT dental services as described in 22 CCR section 51340.1(b). However, CalOptima Health is responsible for all Covered Services as specified in Exhibit A, Attachment III, Subsection 4.3.17 (Dental) regarding dental services; 8. Prayer or spiritual healing as specified in 22 CCR section 51312; 9. Educationally Necessary Behavioral Health Services that are covered by a Local Education Agency (LEA) and provided pursuant to a Member's Individualized Education Plan (IEP) as set forth in Education Code section 56340 et seq., Individualized Family Service Plan (IFSP) as set forth in California Government Code (GC) section 95020, or Individualized Health and Support Plan (IHSP). However, CalOptima Health is responsible for all Medically Necessary Behavioral Health Services as specified in Exhibit A, Attachment III Subsection 4.3.16 (School-Based Services);

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Term	Definition
	10. Laboratory services provided under the State serum alpha-feto-protein-testing program administered by the Genetic Disease Branch of California Department of Public Health (CDPH); 11. Pediatric Day Health Care, except for Contractors providing Whole Child Model (WCM) services; 12. State Supported Services; 13. Targeted Case Management (TCM) services as set forth in 42 USC section 1396n(g), W&I sections 14132.48 and 14021.3, 22 CCR sections 51185 and 51351, and as described in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services). However, if Members less than twenty-one (21) years of age are not eligible for or accepted by a Regional Center (RC) or a local government health program for TCM services, CalOptima Health must ensure access to comparable services under the EPSDT benefit in accordance with DHCS APL 23-005; 14. Childhood lead poisoning case management provided by county health departments; 15. Non-medical services provided by Regional Centers (RC) to individuals with Developmental Disabilities, including but not limited to respite, out-of-home placement, and supportive living; 16. End of life services as stated in Health and Safety Code (H&S) section 443 et seq., and DHCS APL 16-006; and 17. Prescribed and covered outpatient drugs, medical supplies, and enteral nutritional products when appropriately billed by a pharmacy on a pharmacy claim, in accordance with DHCS APL 22-012. OneCare: Those medical services, equipment, or supplies that CalOptima Health is obligated to provide to Members under the Center of Medicare & Medicaid Services (CMS) Contract. 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 Health, or other services as authorized by the CalOptima Health Board of Directors.
Department of Health Care Services (DHCS)	The single State department responsible for the administration of the Medi-Cal Program, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), and other health related programs as provided by statute and/or regulation.
Department of Managed Health Care (DMHC)	California state agency that regulates and oversees health maintenance organizations (HMOs) and other managed care plans.
Downstream Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Health Program benefit, below the level of arrangement between CalOptima Health and a First Tier Entity. These written arrangements continue down to the level of the ultimate Provider of both health and administrative services.

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Term	Definition
Durable Medical Equipment (DME)	Medi-Cal: Medically Necessary medical equipment as defined by 22 CCR section 51160 that a Provider prescribes for a Member that the Member uses in the home, in the community, or in a facility that is used as a home. OneCare & PACE: Durable medical equipment means equipment prescribed by a licensed practitioner to meet medical equipment needs of the Member that: 1. Can withstand repeated use. 2. Is used to serve a medical purpose. 3. Is not useful to an individual in the absence of an illness, injury, functional impairment, or congenital anomaly. 4. Is appropriate for use in or out of the patient's home.
Employee	For purposes of this policy, any and all Employees of CalOptima Health, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary Employees and volunteers.
Encounter	Medi-Cal: Any unit of Covered Services provided to a Member by a Health Network regardless of Health Network reimbursement methodology. Such Covered Services include any service provided to a Member regardless of the service location or Provider, including out-of-network services and sub-capitated and delegated Covered Services. OneCare: Any unit of Covered Service provided to a Member by a Health Network regardless of Health Network reimbursement methodology. These services include any Covered Services provided to a Member, regardless of the service location or Provider, including out-of-network Covered Services and sub-capitated and delegated Covered Services. Encounter data submitted to CalOptima Health should not include denied, adjusted, or duplicate claims.
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 groups, Physician Hospital Consortia, and Health Maintenance Organizations.
First Tier Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima Health to provide administrative services or health care services to a Member under a CalOptima Health Program.
Fraud	Covered California: Consists of an intentional misrepresentation, deceit, or concealment of a material fact known to the defendant with the intention on the part of the defendant of thereby depriving a person of property or legal rights or otherwise causing injury. (CA Civil Code §3294 (c)(3), CA Penal Code §§470-483.5). Prevention and early detection of fraudulent activities is crucial to ensuring affordable healthcare for all individuals. Examples of fraud include false applications to obtain payment, false information to obtain insurance, billing for services that were not rendered. Fraud includes, but is not limited to, knowingly making or causing to be made any false or fraudulent claim for payment of a health care benefit, in accordance with Health and Safety Code section 1348. Medi-Cal & OneCare: An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law, in accordance with

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Term	Definition
	Title 42 Code of Federal Regulations section 455.2, Welfare and Institutions Code section 14043.1(i).
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information as amended.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO), Subcontractor, or First Tier Entity, that contracts with CalOptima Health to provide Covered Services to Members.
Medical Record	Medi-Cal & Covered California: The record of a Member's medical information including but not limited to, medical history, care or treatments received, test results, diagnoses, and prescribed medications. OneCare: A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal. PACE: Written documentary evidence of treatments rendered to plan Members.
Medically Necessary or Medical Necessity	Covered California: Health care and related services and supplies provided to a Member for the purpose of evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms and that are: (i) in accordance with generally accepted standards of medical practice; (ii) appropriate for the symptoms, diagnosis, or treatment of the Member's condition, disease, illness or injury; (iii) not primarily for the convenience of the Member or health care Provider; and (iv) not more costly than an alternative service, or suite of services, and at least as likely to produce equivalent results. For treatment of a mental health or substance use disorder, Medical Necessity shall include: A service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of an illness, injury, condition, or its symptoms, in a manner that is all of the following: (i) in accordance with the generally accepted standards of mental health and substance use disorder care; (ii) clinically appropriate in terms of type, frequency, extent, site, and duration; (iii) not primarily for the economic benefit of the disability insurer and insureds or for the convenience of the patient, treating physician, or other health care Provider, as required by HSC §1374.72 (a)(3)(A). 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-

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Term	Definition
	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 Health shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child. OneCare: Reasonable and necessary medical services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. PACE: 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.
Member	An individual enrolled in a CalOptima Health Program.
Other Health Coverage (OHC)	Medi-Cal: Health coverage from another entity that is responsible for payment of the reasonable value of all or part of the health care services provided to a Member. OHC may result from a health insurance policy or other contractual agreement or legal obligation to pay for health care services provided to a Member, excluding tort liability. OHC may originate under State (other than the Medi-Cal program), federal, or local medical care program, or under other contractual or legal entitlements. OneCare: Evidence of health coverage other than OneCare including, but not necessarily limited to: 1. The CalOptima Health Medi-Cal program; 2. Group health plans; 3. Federal Employee Health Benefits Program (FEHB); 4. Military coverage, including TRICARE; 5. Worker's Compensation; 6. Personal Injury Liability compensation; 7. Black Lung federal coverage; 8. Indian Health Service; 9. Federally qualified health centers (FQHC); 10. Rural health centers (RHC); and/or 11. Other health benefit plans or programs that provide coverage or financial assistance for the purchase or provision of Covered Part D Drugs on behalf of Part D eligible individuals as the Centers for Medicare & Medicaid Services (CMS) may specify.

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Term	Definition
Personal Representative	Has the meaning given such term in section 164.502(g) of title 45, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of un-emancipated minors.
Pharmacy	An area, place, or premise licensed by the State Board of Pharmacy in which the profession of pharmacy is practiced and where Prescriptions are compounded and dispensed.
Pharmacy Benefit Manager (PBM)	Medi-Cal: The entity that performs certain functions and tasks including, but not limited to, Pharmacy credentialing, contracting, and claims processing in accordance with the terms and conditions of the PBM Services Agreement. OneCare: An entity that provides Pharmacy benefit management services, including contracting with a network of pharmacies; establishing payment levels for network pharmacies; negotiating rebate arrangements; developing and managing formularies, preferred drug lists, and Prior Authorization programs; maintaining patient compliance programs; performing drug utilization review; and operating disease management programs.
Practitioner	A licensed independent Practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.
Prescribing Provider	The physician, osteopath, podiatrist, dentist, optometrist, or authorized mid-level medical Practitioner who prescribes a medication for a Member.
Prior Authorization	Covered California: A formal process requiring a Provider to obtain advanced approval for the amount, duration, and scope of non-emergent Covered Services. Medi-Cal: A formal process requiring a health care Provider to obtain advance approval of Medically Necessary Covered Services, including the amount, duration and scope of services, except in the case of an emergency. OneCare: A process through which a physician or other health care provider is required to obtain advance approval, from CalOptima Health and/or a delegated entity, that payment will be made for a service or item furnished to a Member. PACE: A formal process requiring a health care provider to obtain advance approval to provide specific services or procedures, or the process by which an IDT approves a member to receive a specific service or procedure.

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Term	Definition
Provider	Covered California: A licensed health care facility or as stipulated by local or international jurisdictions, a program, agency or health professional that delivers Covered Services. Medi-Cal: Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so. OneCare: Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier, etc.) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of Covered Services under Medicare Part B.
Related Entity	Any entity that is related to the Medicare Advantage organization by common ownership or control and: 1. Performs some of the Medicare Advantage organization's management functions under contract or delegation; 2. Furnishes services to Medicare enrollees under an oral or written agreement; or 3. Leases real property or sells materials to the Medicare Advantage organization at a cost of more than two thousand five hundred dollars ($2,**500)** during a contract period.
Waste	Covered California: Intentional or unintentional, extravagant careless or needless expenditures, consumption, mismanagement, use, or squandering of resources, to the detriment or potential detriment of entities, but without an intent to deceive or misrepresent. Waste includes incurring unnecessary costs because of inefficient or ineffective practices, systems, decisions, or controls. Medi-Cal: The overutilization or inappropriate utilization of services and misuse of resources. OneCare: The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Health Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

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CONFIDENTIAL

CalOptima Health

INSTRUCTIONS FOR COMPLETING A SUSPECTED FRAUD OR ABUSE REFERRAL FORM

To submit a request to investigate suspected fraud or abuse, please complete a CalOptima Health Suspected Fraud or Abuse Referral Form. Examples of "Member" or "Provider" fraud or abuse are listed on the form. These are examples only. The list does not represent every situation in which fraud or abuse can take place.

Complete all applicable sections of the form. It is very important to complete the entire form so we can effectively investigate the issue.

If desired, requestor may remain anonymous; however, if the requestor does not provide his/her name and phone number, the CalOptima Health Office of Compliance will be unable to contact him/her if there are any questions about the information submitted, which may prevent completion of the investigation.

Submit the completed form with supporting documents to CalOptima Health's Office of Compliance via one of the following methods:

1. Email: Fraud@CalOptima.org
2. U.S. Mail: CalOptima Health
   Office of Compliance — SIU
   505 City Parkway West
   Orange CA 92868
3. Fax: **1-714-481-6457**

MARK ALL CORRESPONDENCE AS "CONFIDENTIAL."

You may also report suspected fraud or abuse to CalOptima Health's Ethics and Compliance hotline, 24 hours a day, 7 days a week, toll-free at 1-855-507-1805. TDD/TTY users can call toll-free at 1-800-735-2929. We have staff that speak your language.

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CalOptima Health

SUSPECTED FRAUD OR ABUSE REFERRAL FORM

REFERRAL INFORMATION		
Date: _____		Notice involves suspected fraud or abuse by a:
Referred by: Name: _____	Title: _____	☐ Member
Dept.: _____	Phone#: _____	☐ Provider

MEMBER	PROVIDER
CalOptima Health Program: ☐ Medi-Cal ☐ OneCare ☐ PACE	Provider Name:
Member Name:	Type of provider:
Member ID:	Provider ID:
Address:	Address:
City: ZIP:	City: ZIP:
Date of service if applicable:	Date of service if applicable:
Member ID, if applicable:	If multiple members are involved, please attach a list.

Examples of suspected fraud or abuse:

- ☐ Using another individual's identity or documentation of Medi-Cal eligibility to obtain covered services and prescriptions (unless that person is an authorized representative who is presenting such information to obtain covered services on behalf of a member)
- ☐ Selling, loaning or giving a member's identity or documentation of eligibility to obtain covered services (other than to a family member to obtain covered services on behalf of a member)
- ☐ Falsely claiming eligibility
- ☐ Using a covered service for purposes other than the purposes for which it was prescribed, including use by an individual other than the member for whom the covered service was prescribed or provided
- ☐ Failing to report other health coverage
- ☐ Soliciting or receiving a kickback, bribe or rebate as an inducement to receive or not receive covered services
- ☐ Other (please specify) _____

Allegation of suspected fraud or abuse:

- ☐ Falsely claiming eligibility to participate in the CalOptima Health program.
- ☐ Submission of claims for covered services that are:
  - ☐ Substantially and demonstrably more than any individual's usual charges for such covered services
  - ☐ Not actually provided to the member for which the claim is submitted
  - ☐ More than the quantity that is medically necessary
  - ☐ Billed using a code that would result in greater payment than the code that reflects the covered service
  - ☐ Already included in capitation rate
  - ☐ Submitted for payment to both CalOptima Health and another third-party payer without full disclosure
- ☐ Charging a member in excess of allowable co-payments and deductibles for covered services
- ☐ Billing a member for covered services without obtaining written consent to bill for such services

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CalOptima Health

SUSPECTED FRAUD OR ABUSE REFERRAL FORM

	☐ Failure to disclose conflict of interest ☐ Receiving, soliciting or offering a kickback, bribe or rebate to refer or fail to refer a member ☐ Failure to register billing intermediary with the Department of Health Care Services (DHCS) ☐ False certification of medical necessity ☐ Attributing a diagnosis code to a member that does not reflect the member's medical condition to obtain higher reimbursement ☐ False or inaccurate Minimum Standards or credentialing information ☐ Submitting reports that contain unsubstantiated data, data that is inconsistent with records or has been altered in a manner that is inconsistent with policies, contracts, statutes or regulations. ☐ Other (please specify) _____

DOCUMENTATION (PLEASE ATTACH):

☐ Claims data ☐ Medical records ☐ Complaint, appeal or grievance ☐ UM reports
☐ Audit ☐ Other (please specify) _____

Please provide a brief explanation of how the documentation provided supports concerns of fraudulent activity: _____

Please provide the root cause of this suspected fraudulent activity: _____

OTHER RELEVANT INFORMATION (PLEASE ATTACH):

Are there any prior suspected fraud or abuse issues by this member, provider, pharmacy, other: _____

1. ☐ No
   ☐ Yes. Please describe:

2. If yes, what was the outcome?

Please submit this form with all pertinent documentation to the OFFICE OF COMPLIANCE SPECIAL INVESTIGATIONS UNIT (SIU). The Office of Compliance SIU shall report as appropriate to local and state entities. If you do not receive an acknowledgement of receipt of this form within five (5) working days, please send an email to Fraud@CalOptima.org.

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Policy:	HH.1107
Title:	**Fraud, Waste, and Abuse Investigation and Reporting**
Department:	Office of Compliance
Section:	Fraud, Waste, and Abuse – Special Investigations Unit
CEO Approval:	*/s/*
Effective Date:	09/01/2004
Revised Date:	11/01/2025
Applicable to:	☐ Administrative ☒ Covered California [Effective 2027] ☒ Medi-Cal ☒ OneCare ☒ PACE

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I. PURPOSE

This policy establishes a process to investigate, and report suspected Fraud, Waste, or Abuse (FWA) committed by a Member, Provider, CalOptima Health Employee, CalOptima Health board member, First Tier, Downstream, and Related Entity (FDR), other contractor, and/or CalOptima Health's Health Network involving a CalOptima Health program, in accordance with federal and state regulations and contractual requirements, and the CalOptima Health Anti-Fraud, Waste, and Abuse (FWA) Plan.

II. POLICY

A. CalOptima Health maintains a zero-tolerance policy toward FWA by a Member, Provider, CalOptima Health Employee, CalOptima Health board member, FDR, other contractor and/or a Health Network.

B. CalOptima Health shall comply with applicable statutory, regulatory, other requirements, sub-regulatory guidance, and contractual commitments related to the delivery of Covered Services, which include, but are not limited to, federal and state False Claims Acts and Anti-Kickback laws, the federal Exclusion Statute, the federal Administrative Remedies Act, the federal Social Security Act laws prohibiting inducements to Members, the federal Health Insurance Portability and Accountability Act (HIPAA), and other applicable statutes.

C. CalOptima Health Employees and FDRs are expected and required to promptly report suspected violations of any statute, regulations, or guidelines applicable to any CalOptima Health program. CalOptima Health maintains a strict policy of non-retaliation and non-retribution toward Employees and FDRs who make such reports in good faith.

D. CalOptima Health shall establish a process for timely and reasonable investigation and reporting of suspected FWA, in accordance with this Policy.

E. CalOptima Health's Office of Compliance shall coordinate all activities associated with the investigation and reporting of suspected FWA.

F. CalOptima Health's Office of Compliance shall maintain a system for the review of suspect claims to detect and prevent FWA, in accordance with federal and state regulations, and to identify FWA resulting overpayments for recoupment, in accordance with CalOptima Health Policies HH.5000: Provider Overpayment Investigation and Determination, and HH.1105: Fraud, Waste and Abuse Detection, and CalOptima Health's Anti-Fraud, Waste, and Abuse (FWA) Plan.

G. CalOptima Health's Office of Compliance shall collaborate with the CalOptima Health Pharmacy Management Department, and other appropriate departments, to reduce controlled substances and opioid-related Fraud, Abuse, and misuse, as outlined in CalOptima Health Policies GG.1428: Pharmacy Management Medi-Cal Rx Responsibilities, and MA.6104: Opioid Medication Utilization Management.

1. The CalOptima Health SIU shall investigate suspected FWA of prescription drugs, and/or controlled substances, in accordance with this Policy.

H. CalOptima Health shall coordinate and cooperate with the Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), Covered California, Centers for Medicare & Medicaid (CMS), and law enforcement agencies related to any FWA investigations, or audits.

I. CalOptima Health shall conduct preliminary research of any allegation of suspected FWA and shall report suspected FWA to the appropriate agency, in accordance with its contracts with DHCS or Covered California, and/or CMS, and this Policy. All allegations received shall be documented in a FWA tracking log within one (1) business day.

J. Upon determination of validity of the allegation, CalOptima Health shall refer suspected FWA to DHCS, DMHC, Covered California, and/or CMS for further investigation, as appropriate.

K. CalOptima Health's Office of Compliance shall maintain a database and a uniform filing system to maintain suspected FWA referrals, including reports, investigations, and correspondence, in accordance with CalOptima Health's Compliance Program. CalOptima Health's Office of Compliance shall ensure appropriate confidentiality of case files, or other documentation relating to any investigation of a suspected FWA case.

L. Following a determination that a credible allegation of fraud exists involving a Community-Based Adult Services (CBAS) Provider, DHCS will notify CalOptima Health of the finding promptly. In addition to the actions required in APL 15-026: Actions Required Following Notice of a Credible Allegation of Fraud, CalOptima Health shall report to DHCS, in a timeframe and manner specified by DHCS but no less frequently than quarterly, all payments made to the CBAS Provider involved in a credible allegation of fraud for CBAS benefits provided after the date of notification.

~~L.~~M. CalOptima Health's Office of Compliance shall function as the liaison between CalOptima Health and DHCS, DMHC, Covered California, CMS, appropriate state Medical Boards, the State Board of Pharmacy, other licensing entities, law enforcement, prosecuting agencies, as appropriate, and other relevant entities.

~~M.~~N. CalOptima Health's Office of Compliance shall report the status and results of suspected FWA investigations to CalOptima Health's Compliance Committee, as appropriate.

~~N.~~O. CalOptima Health's Office of Compliance shall investigate, and report suspected FWA, in accordance with this Policy.

~~O.~~P. All reports of suspected FWA are kept confidential to the extent permitted by applicable law and circumstances.

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III. PROCEDURE

A. Reporting FWA to CalOptima Health:

1. CalOptima Health shall provide a method for CalOptima Health Employees, FDRs, and Members to anonymously report suspected FWA to the Office of Compliance. CalOptima Health Employees and its FDRs may call the Compliance and Ethics Hotline at 1-855-507-1805 to anonymously report concerns regarding Fraud, Waste, and Abuse.

2. A CalOptima Health Employee who detects suspected FWA may also complete a Suspected Fraud or Abuse Referral Form and transmit it to the Office of Compliance.

3. An FDR with a contractual obligation to report suspected FWA shall notify CalOptima Health of suspected FWA, in accordance with the terms and conditions of its contract and this Policy.

4. Any state, federal, and/or other Managed Care Plans referrals to CalOptima Health of potential Medi-Cal- or Medicare-related FWA are investigated and reported to DHCS's Program Integrity Unit (PIU) and shall remain confidential, as needed.

B. Suspected FWA may proactively be detected as outlined in CalOptima Health Policy HH.1105: Fraud, Waste, and Abuse Detection.

~~B.~~C. Investigation of FWA:

1. When a report is received concerning suspected FWA, the Office of Compliance shall verify the suspected activity using data from reports, including, but not limited to, the following:

   a. CalOptima Health's Compliance and Ethics Hotline, or other reporting mechanisms;

   b. Claims data history;

   c. Encounter data;

   d. Member and Provider complaints, appeals, and grievance reviews;

   e. Medical Record audits;

   f. Pharmacy data;

   g. Utilization Management reports;

   h. Provider utilization profiles;

   i. Member interviews and/or service verification surveys;

   j. Employee interviews;

   k. Provider and/or provider staff interviews;

   l. Monitoring and auditing activities;

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m. Monitoring external health care FWA cases and determining if CalOptima Health's FWA program can be strengthened with information gleaned from the case activity; and/or

n. Internal and external surveys, reviews, and audits.

2. All reports of suspected FWA shall be preliminarily researched to build on the information provided in the allegation in the attempt to have sufficient data for conducting an investigation. CalOptima Health has a target goal of ten (10) business days to determine if sufficient information can be garnered for an allegation in order to conduct an investigation.

   a. Information needed to begin an investigation is considered on a case-by-case basis and may include:

      i. Subject name;

      ii. Verifiable data;

      iii. Relativity/applicability to CalOptima Health; and/or

      iv. Sufficient detail to determine the allegation or the potential offender.

         a) An example would be if an allegation is anonymously reported and the complainant simply states his provider committed fraud, but did not give a name of a provider, there is insufficient information to conduct an investigation.

         b) If there is insufficient information to proceed with conducting an investigation, the Office of Compliance may refer it to another department, agency, or other appropriate entity, and shall document the case for tracking.

            1) An example would be a member grievance (complaint) that staff at a provider's office are rude. The case would not be considered an allegation of FWA and would be forwarded to the Grievances and Appeals Resolution Services (GARS) department.

3. CalOptima Health shall ~~refer potential Fraud activities identified through Fraud detection and response measures to Covered California. CalOptima Health shall follow the established Carrier Referral Process posted on CalOptima Health's extranet website provided by Covered California.~~ notify and involve impacted Health Networks, as needed, during an investigation.

4. Potential fraud investigations shall follow the established internal desktop procedures and FWA checklist and job aids. Any deterrence from the established protocols is discussed with the FWA department management and documented in internal case reports.

5. For allegations of CalOptima Health Employee's misconduct investigations that involve potential FWA, a referral to SIU should be made by the CalOptima Health staff involved in the initial Employee misconduct investigation. Each referral is considered on a case-by-case basis. The referral to SIU for Employee misconduct investigations will authorize the SIU to have primary responsibility of the Employee misconduct investigation as it relates to potential FWA.

6. When the FWA Investigator is able to determine the probable root cause of the suspected FWA, the information will be documented in the internal case management tracking log and may be reported during the quarterly Compliance Committee meetings.

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7. If an investigation finds no component of FWA, and the actions investigated are more appropriately classified as non-compliance, the remediation shall be handled in accordance with CalOptima Health Policies HH.2005: Corrective Actions Plans, HH.2002: Sanctions, or GA.8022: Performance and Behavior Standards.

8. CalOptima Health shall issue corrective actions to Employees, FDRs, and other contractors related to validated instances of FWA. Corrective actions will be monitored by the Compliance Committee, or the Human Resources Department, as appropriate. Corrective actions may include financial sanctions, regulatory reporting, performance improvement plans, or termination. If the validated instance of FWA is determined to be criminal in nature, actions may also include a referral to law enforcement.

9. The Office of Compliance will initiate review and discussion at the first Compliance Committee Meeting following the date when significant instances of FWA are identified.

10. If CalOptima Health's SIU investigation yields findings involving an FDR, the SIU shall notify the impacted CalOptima Health department(s), CalOptima Health, Health Network(s), and/or business partners, as needed.

11. For investigations involving suspected FWA of prescription drugs, including controlled substances, the CalOptima Health SIU will collaborate with the CalOptima Health Pharmacy Management Department during the investigation. If the investigation yields findings related to FWA, the SIU will work with Pharmacy Management and Quality Improvement to implement actions in accordance with CalOptima Health Policies MA.5013: Pharmacy Audits and Reviews, GG.1428: Pharmacy Management Medi-Cal Rx Responsibilities, GG.1615: Corrective Action Plan for Practitioners, and MA.6104: Opioid Medication Utilization Management.

12. The SIU shall enter all documentation related to any suspected FWA case into the internal case management tracking log within one (1) business day and document the final disposition once the case has been determined to be closed.

~~C.~~D. Notices of a Credible Allegation of Fraud

1. For investigations involving situations when DHCS, CMS, or another regulatory agency notifies CalOptima Health that a Credible Allegation of Fraud has been found against an FDR, other contractor, or Provider, CalOptima Health must take one (1) or more of the following options and submit any supporting documentation as requested or appropriate to DHCS and/or CMS:

   a. Terminate the FDR or Provider from its network;

   b. Temporarily suspend the FDR or Provider from its network pending resolution of the Fraud allegation;

   c. Temporarily suspend payment to the FDR or Provider pending resolution of the Fraud allegation; and/or

   d. Conduct additional monitoring including audits of the FDR's or Provider's claims history and future claims submissions for appropriate billing.

   ~~d.~~e. In the event DHCS sends CalOptima Health a credible allegation of Fraud related to a CBAS or Hospice Provider, CalOptima Health will conduct data analysis, request provider

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documents from the Provider Data Management Systems or Contracting Department, and report data to DHCS as necessary.

2. For investigations involving situations when there is a Credible Allegation of Fraud against a pharmacy, CalOptima Health shall work with the PBM and/or appropriate regulatory agency to take one or more of the options above.

~~D.~~E. Reports of changes to a Member's circumstances which may impact a Member's Medi-Cal or Covered California eligibility are promptly reported to DHCS, Covered California and/or the local Social Service Agency, as needed.

~~E.~~F. CalOptima Health Reporting to Regulators:

1. For investigations involving the Medi-Cal program, CalOptima Health shall report to DHCS PIU all cases of suspected Fraud and/or Abuse where there is reason to believe that an incident of Fraud and/or Abuse has occurred by CalOptima Health Employees, FDRs, other contractors, or Members. CalOptima Health shall conduct, complete and report to DHCS, the results of a preliminary investigation of suspected Fraud and/or Abuse. The referral shall be submitted within ten (10) business days on a Medi-Cal Complaint Report (MC609) and sent to DHCS PIU via secure email to PIU.Cases@dhcs.ca.gov. Any completed investigations and quarterly FWA reports will be made to the DHCS PIU.

2. For investigations involving the PACE program, CalOptima Health shall report to DHCS PIU all cases of suspected Fraud and/or Abuse where there is reason to believe that an incident of Fraud and/or Abuse has occurred by CalOptima Health Employees, FDRs, other contractors, or Members. CalOptima Health shall conduct, complete and report to DHCS, the results of a preliminary investigation of suspected Fraud and/or Abuse. The referral shall be submitted within ten (10) business days on a Medi-Cal Complaint Report (MC609) and is sent to DHCS PACE PIU via secure email to DHCSPace.PIU@dhcs.ca.gov. Any completed investigations and quarterly FWA reports will be made to the DHCS PACE PIU.

3. For investigations involving the OneCare program, CalOptima Health shall report to DHCS PIU in accordance with Section III.F1. above, as well as to CMS all cases of suspected Fraud and/or Abuse where there is reason to believe that an incident of Fraud and/or Abuse has occurred by CalOptima Health Employees, FDRs, other contractors, or Members. CalOptima Health shall conduct a preliminary investigation and report to CMS within thirty (30) calendar days of the date potential Fraudulent or abusive activity is identified via the Health Plan Management System (HPMS) FWA reporting module.

   a. For investigations involving the OneCare programs, the referral shall be submitted via the Health Plan Management System (HPMS) FWA reporting module. For investigations involving OneCare where the allegation is exclusively a compromised identification, the referral to CMS shall be submitted on an I MEDIC ID Compromised ID Report Form via secure email, secure facsimile, Federal Express with a tracking number, or certified mail. CalOptima Health shall submit applicable police reports, investigation documentation (background, interviews, etc.), Member information, Provider enrollment data, confirmation of services, list items or services furnished by Provider, pharmaceutical data, and any other pertinent information.

4. For investigations involving Covered California programs, CalOptima Health shall communicate within ten (10) days to Covered California any material concerns identified by CalOptima Health or material concerns, including any enforcement actions resulting in monetary penalties equal to or exceeding $100,000, identified by state and federal regulators

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related to regulatory compliance that may impact performance under the agreement between CalOptima Health and Covered California following CalOptima Health's knowledge of such occurrence. If an occurrence may reasonably be deemed to adversely affect the quality of care or safety of Covered California Members, CalOptima will provide notification to Covered California immediately. All notifications will be made according to the Contract Reporting Requirements table posted on CalOptima Health's extranet website provided by Covered California.

a. If CalOptima Health receives any preliminary or final reports, findings, or orders related to material concerns identified by state and federal regulators that may impact performance under the contract with Covered California, CalOptima Health shall provide Covered California with copies of them within forty-eight (48) hours of receiving them from state and federal regulators.

b. CalOptima Health shall provide Covered California with a description of its Fraud, Waste, and Abuse detection and prevention programs and report total monies recovered by CalOptima Health in the most recent twelve (12)-month period for CalOptima Health's total book of business as well as, total monies recovered for Covered California business only.

   i. This description shall be updated during each year that the contract with Covered California is in effect and shall include an overview of Fraud and Abuse detection and prevention program activities conducted by CalOptima Health, participating providers, other subcontractors, and their authorized agents, including a summary of key findings, relevant data analytics and fraud risk assessments to circumvent fraud, waste, and abuse, and the development, implementation, and enforcement of any corrective action plans for changing, upgrading, or improving these programs.

IV. ATTACHMENT(S)

A. Suspected Fraud or Abuse Referral Form (English)
B. Form MC609 - Confidential Medi-Cal Complaint Report form
C. CalOptima Health Referral to MEDIC ID Compromised

V. REFERENCE(S)

A. California Government Code, §12650, California False Claims Act
B. CalOptima Health Anti-Fraud, Waste, and Abuse (FWA) Plan
C. CalOptima Health Compliance Plan
D. CalOptima Health Contract for Health Care Services
E. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
F. CalOptima Health Contract with Covered California
G. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
H. CalOptima Health PACE Program Agreement
I. CalOptima Health Policy GA.8022: Performance and Behavior Standards
J. CalOptima Health Policy GG.1428: Pharmacy Management Medi-Cal Rx Responsibilities
K. CalOptima Health Policy GG.1615: Corrective Action Plan for Practitioners
L. CalOptima Health Policy HH.1105: Fraud, Waste, and Abuse Detection
M. CalOptima Health Policy HH.2002: Sanctions
N. CalOptima Health Policy HH.2005: Corrective Action Plan
O. CalOptima Health Policy HH.5000: Provider Overpayment Investigation and Determination
P. CalOptima Health Policy MA.5013: Pharmacy Audits and Reviews

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Q. CalOptima Health Policy MA.6104: Opioid Medication Utilization Management
R. CalOptima Health Anti-Fraud, Waste, and Abuse (FWA) Plan
S. Contract Year 2022 Centers for Medicare & Medicaid Services (CMS) Part C and D Final Rule
T. Department of Health Care Services (DHCS) All Plan Letter (APL) 15-026: Actions Required Following Notice of a Credible Allegation of Fraud
U. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-026: Federal Drug Utilization Review Requirements Designed to Reduce Opioid Related Fraud, Misuse and Abuse (Supersedes APL 19-012) Department of Health Care Services (DHCS) Medi-Cal Managed Care Division (MMCD) All Plan Letter (APL) 03-011: Fraud Referral Procedure to Audits and Investigations (A&I)
V. Health and Safety Code §1348
W. Medicare Managed Care Manual, Chapters 9 and 21
X. Title 31, United States Code, §3730(h), Civil actions for false claims
Y. Title 42, Code of Federal Regulations, §455.2
Z. Welfare and Institutions Code, §14043.1(a)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
08/01/2016	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/06/2018	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
06/01/2023	Regular Meeting of the CalOptima Health Board of Directors
11/07/2024	Regular Meeting of the CalOptima Health Board of Directors
11/01/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	09/01/2004	HH.1107	Fraud and Abuse Investigation and Reporting	Medi-Cal
Revised	01/01/2008	HH.1107	Fraud, Waste and Abuse Investigation and Reporting	Medi-Cal
Revised	12/01/2010	HH.1107	Fraud, Waste and Abuse Investigation and Reporting	Medi-Cal
Revised	02/01/2013	HH.1107	Fraud, Waste and Abuse Investigation and Reporting	Medi-Cal
Revised	07/01/2014	HH.1107	Fraud, Waste and Abuse Investigation and Reporting	Medi-Cal
Revised	09/01/2015	HH.1107	Fraud, Waste and Abuse Investigation and Reporting	Medi-Cal

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Action	Date	Policy	Policy Title	Program(s)
Revised	06/01/2016	HH.1107	Fraud, Waste, and Abuse Investigation and Reporting	Medi-Cal
Revised	12/01/2016	HH.1107	Fraud, Waste, and Abuse Investigation and Reporting	Medi-Cal OneCare OneCare Connect PACE
Revised	12/07/2017	HH.1107	Fraud, Waste, and Abuse Investigation and Reporting	Medi-Cal OneCare OneCare Connect PACE
Revised	05/01/2018	HH.1107	Fraud, Waste, and Abuse Investigation and Reporting	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.1107	Fraud, Waste, and Abuse Investigation and Reporting	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.1107	Fraud, Waste, and Abuse Investigation and Reporting	Medi-Cal OneCare OneCare Connect PACE
Revised	12/03/2020	HH.1107	Fraud, Waste, and Abuse Investigation and Reporting	Medi-Cal OneCare OneCare Connect PACE
Revised	12/20/2021	HH.1107	Fraud, Waste, and Abuse Investigation and Reporting	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	HH.1107	Fraud, Waste, and Abuse Investigation and Reporting	Medi-Cal OneCare PACE
Revised	06/01/2023	HH.1107	Fraud, Waste, and Abuse Investigation and Reporting	Medi-Cal OneCare PACE
Revised	09/01/2023	HH.1107	Fraud, Waste, and Abuse Investigation and Reporting	Medi-Cal OneCare PACE
Revised	11/07/2024	HH.1107	Fraud, Waste, and Abuse Investigation and Reporting	Medi-Cal OneCare PACE
Revised	05/01/2025	HH.1107	Fraud, Waste, and Abuse Investigation and Reporting	Covered California Medi-Cal OneCare PACE
Revised	09/01/2025	HH.1007	Fraud, Waste, and Abuse Investigation and Reporting	Covered California Medi-Cal OneCare PACE

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IX. GLOSSARY

Term	Definition
Abuse	Covered California: Excessive, or improper use of something, or the use of something in a manner contrary to the natural or legal rules for its use; the intentional destruction, diversion, manipulation, misapplication, maltreatment, or misuse of resources; or extravagant or excessive use to abuse one's position or authority. Often, the terms fraud and abuse are used simultaneously with the primary distinction is the intent. Inappropriate practices that begin as abuse can quickly evolve into fraud. Abuse can occur in financial or non-financial settings. Examples of abuse include excessive charges, improper billing practices, payment for services that do not meet recognized standards of care and payment for medically unnecessary services. Medi-Cal: Practices that are inconsistent with sound fiscal and business practices or medical standards, and result in an unnecessary cost to the Medi-Cal program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to the Medi-Cal program. OneCare: A Provider practice that is inconsistent with sound fiscal, business, or medical practice, and results in an unnecessary cost to CalOptima Health and the OneCare program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to CalOptima Health and the OneCare program.
Centers for Medicare & Medicaid Services (CMS)	The federal agency within the United States Department of Health and Human Services (DHHS) that administers the federal Medicare program and works in partnership with state governments to administer Medicaid programs.
Compliance Committee	The committee designated by the Chief Executive Officer (CEO) to implement and oversee the Compliance Program and to participate in carrying out provisions of this Compliance Plan. The composition of the Compliance Committee shall consist of Executive staff that may include, but is not limited to, the: Chief Executive Officer; Chief Medical Officer; Chief Operating Officer; Chief Financial Officer; Chief Compliance Officer; and Chief Human Resources Officer.
Compliance Program	Medi-Cal: The program including, without limitation, the Compliance Plan, Code of Conduct, and CalOptima Health policies, developed and adopted by CalOptima Health to promote, monitor, and ensure that CalOptima Health's operations and practices and the practices of its Board Members, employees, FDRs, other contractors, and providers comply with applicable law and ethical standards. OneCare: A comprehensive program that incorporates the fundamental elements identified by the state and federal governments and CalOptima Health as necessary to prevent and detect violations of ethical standards, contractual obligations, and applicable laws and the involvement of CalOptima Health's governing body and executive staff. Elements of the Compliance Program include standards, oversight, training, reporting, monitoring, enforcement, and remediation. The Compliance Program applies to CalOptima Health's Board of Directors, employees, and other contractors including delegated entities, providers, and suppliers.

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Term	Definition
Covered Service	Covered California: Health care services that are covered benefits under CalOptima Health's contract with Covered California, as further described in the Evidence of Coverage and supporting documents. Medi-Cal: Those health care services, set forth in W&I sections 14000 et seq. and 14131 et seq., 22 CCR section 51301 et seq., 17 CCR section 6800 et seq., the Medi-Cal Provider Manual, the California Medicaid State Plan, the California Section 1115 Medicaid Demonstration Project, the contract with DHCS for Medi-Cal, and DHCS APLs that are made the responsibility of CalOptima Health pursuant to the California Section 1915(b) Medicaid Waiver authorizing the Medi-Cal managed care program or other federally approved managed care authorities maintained by DHCS. Covered Services do not include: 1. Home and Community-Based Services (HCBS) program as specified in the DHCS contract for Medi-Cal Exhibit A, Attachment III, Subsections 4.3.15 (Services for Persons with Developmental Disabilities), 4.3.20 (Home and Community-Based Services Programs) regarding waiver programs, 4.3.21 (In-Home Supportive Services), and Department of Developmental Services (DDS) Administered Medicaid Home and Community-Based Services Waiver. HCBS programs do not include services that are available as an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) service, as described in 22 CCR sections 51184, 51340 and 51340.1. EPSDT services are covered under the DHCS contract for Medi-Cal, as specified in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services), Subsection F4 regarding services for Members less than twenty-one (21) years of age. CalOptima Health is financially responsible for the payment of all EPSDT services; 2. California Children's Services (CCS) as specified in Exhibit A, Attachment III, Subsection 4.3.14 (California Children's Services), except for contractors providing Whole Child Model (WCM) services; 3. Specialty Mental Health Services as specified in Exhibit A, Attachment III, Subsection 4.3.12 (Mental Health Services); 4. Alcohol and SUD treatment services, and outpatient heroin and other opioid detoxification, except for medications for addiction treatment as specified in Exhibit A, Attachment III, Subsection 4.3.13 (Alcohol and Substance Use Disorder Treatment Services); 5. Fabrication of optical lenses except as specified in Exhibit A, Attachment III, Subsection 5.3.7 (Services for All Members); 6. Direct Observed Therapy for Treatment of Tuberculosis (TB) as specified in Exhibit A, Attachment III, Subsection 4.3.18 (Direct Observed Therapy for Treatment of Tuberculosis); 7. Dental services as specified in W&I sections 14131.10, 14132(h), 14132.22, 14132.23, and 14132.88, and EPSDT dental services as described in 22 CCR section 51340.1(b). However, CalOptima Health is responsible for all Covered Services as specified in Exhibit A, Attachment III, Subsection 4.3.17 (Dental) regarding dental services; 8. Prayer or spiritual healing as specified in 22 CCR section 51312; 9. Educationally Necessary Behavioral Health Services that are covered by a Local Education Agency (LEA) and provided pursuant to a Member's

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Term	Definition
	Individualized Education Plan (IEP) as set forth in Education Code section 56340 et seq., Individualized Family Service Plan (IFSP) as set forth in California Government Code (GC) section 95020, or Individualized Health and Support Plan (IHSP). However, CalOptima Health is responsible for all Medically Necessary Behavioral Health Services as specified in Exhibit A, Attachment III Subsection 4.3.16 (School-Based Services); 10. Laboratory services provided under the State serum alpha-feto-protein-testing program administered by the Genetic Disease Branch of California Department of Public Health (CDPH); 11. Pediatric Day Health Care, except for contractors providing Whole Child Model (WCM) services; 12. State Supported Services; 13. Targeted Case Management (TCM) services as set forth in 42 USC section 1396n(g), W&I sections 14132.48 and 14021.3, 22 CCR sections 51185 and 51351, and as described in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services). However, if Members less than twenty-one (21) years of age are not eligible for or accepted by a Regional Center (RC) or a local government health program for TCM services, CalOptima Health must ensure access to comparable services under the EPSDT benefit in accordance with DHCS APL 23-005; 14. Childhood lead poisoning case management provided by county health departments; 15. Non-medical services provided by Regional Centers (RC) to individuals with Developmental Disabilities, including but not limited to respite, out-of-home placement, and supportive living; 16. End of life services as stated in Health and Safety Code (H&S) section 443 et seq., and DHCS APL 16-006; and 17. Prescribed and covered outpatient drugs, medical supplies, and enteral nutritional products when appropriately billed by a pharmacy on a pharmacy claim, in accordance with DHCS APL 22-012. OneCare: Those medical services, equipment, or supplies that CalOptima Health is obligated to provide to Members under the Center of Medicare & Medicaid Services (CMS) Contract. 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 Health, or other services as authorized by the CalOptima Health Board of Directors.
Credible Allegation of Fraud	A Credible Allegation of Fraud may be an allegation, which has been verified by the State, from any source, including but not limited to the following: (1) Fraud hotline complaints. (2) Claims data mining. (3) Patterns identified through Provider audits, civil false claims cases, and law enforcement investigations. Allegations are considered to be credible when they have indicia of reliability, and the State Medicaid agency has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis.
Department of Health Care Services (DHCS)	The state agency that oversees California's Medicaid program, known as Medi-Cal.

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Term	Definition
Department of Managed Health Care (DMHC)	California state agency that regulates and oversees health maintenance organizations (HMOs) and other managed care plans.
Downstream Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Health Program benefit, below the level of arrangement between CalOptima Health and a First Tier Entity. These written arrangements continue down to the level of the ultimate Provider of both health and administrative services.
Employee	Covered California: A "qualified employee," as defined in 45 CFR § 155.20. For purposes of this policy, any and all Employees of CalOptima Health, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary Employees and volunteers.
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 Consortiums, and Health Maintenance Organizations.
First Tier Entity	Medi-Cal: Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima Health to provide administrative services or health care services to a Member under a CalOptima Health Program. OneCare: Any party that enters into a written arrangement, acceptable to CMS, with an MAO or Part D plan sponsor or applicant to provide administrative services or health care services to a Medicare eligible individual under the MA program or Part D program.
Fraud	Covered California: Consists of an intentional misrepresentation, deceit, or concealment of a material fact known to the defendant with the intention on the part of the defendant of thereby depriving a person of property or legal rights or otherwise causing injury. (CA Civil Code section 3294 (c)(3), CA Penal Code section 470-483.5). Prevention and early detection of fraudulent activities is crucial to ensuring affordable healthcare for all individuals. Examples of fraud include false applications to obtain payment, false information to obtain insurance, billing for services that were not rendered. Fraud includes, but is not limited to, knowingly making or causing to be made any false or fraudulent claim for payment of a health care benefit, in accordance with Health and Safety Code section 1348. Medi-Cal: An intentional deception or misrepresentation made by a person with the knowledge that deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law, in accordance with Title 42 Code of Federal Regulations section 455.2, Welfare and Institutions Code section 14043.1(i).
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information, and as subsequently amended.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) subcontractor, or First Tier Entity, that contracts with CalOptima Health to provide Covered Services to Members.

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Term	Definition
Medically Necessary or Medical Necessity	Covered California: Health care and related services and supplies provided to a Member for the purpose of evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms and that are: (i) in accordance with generally accepted standards of medical practice; (ii) appropriate for the symptoms, diagnosis, or treatment of the Member's condition, disease, illness or injury; (iii) not primarily for the convenience of the Member or health care Provider; and (iv) not more costly than an alternative service, or suite of services, and at least as likely to produce equivalent results. For treatment of a mental health or substance use disorder, Medical Necessity shall include: A service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of an illness, injury, condition, or its symptoms, in a manner that is all of the following: (i) in accordance with the generally accepted standards of mental health and substance use disorder care; (ii) clinically appropriate in terms of type, frequency, extent, site, and duration; (iii) not primarily for the economic benefit of the disability insurer and insureds or for the convenience of the patient, treating physician, or other health care Provider, as required by HSC §1374.72 (a)(3)(A). 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 Health shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child. OneCare: Reasonable and necessary medical services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. PACE: 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.
Medical Record	Medi-Cal & Covered California: The record of a Member's medical information including but not limited to, medical history, care or treatments received, test results, diagnoses, and prescribed medications.

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Term	Definition
	OneCare: A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal. PACE: Written documentary evidence of treatments rendered to plan Members.
Member	An individual enrolled in a CalOptima Health Program.
Pharmacy Benefit Manager (PBM)	An entity that provides pharmacy benefit management services, including contracting with a network of pharmacies; establishing payment levels for network pharmacies; negotiating rebate arrangements; developing and managing formularies, preferred drug lists, and prior authorization programs; maintaining patient Compliance Programs; performing drug utilization review; and operating disease management programs.
Provider	Covered California: A licensed health care facility or as stipulated by local or international jurisdictions, a program, agency or health professional that delivers Covered Services. 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.
Related Entity	Any entity that is related to the Medicare Advantage organization by common ownership or control and: 1. Performs some of the Medicare Advantage organization's management functions under contract or delegation; 2. Furnishes services to Medicare enrollees under an oral or written agreement; or 3. Leases real property or sells materials to the Medicare Advantage organization at a cost of more than two-thousand five-hundred dollars ($2,500) during a contract period.

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Term	Definition
Waste	Covered California: Intentional or unintentional, extravagant careless or needless expenditures, consumption, mismanagement, use, or squandering of resources, to the detriment or potential detriment of entities, but without an intent to deceive or misrepresent. Waste includes incurring unnecessary costs because of inefficient or ineffective practices, systems, decisions, or controls. Medi-Cal: The overutilization or inappropriate utilization of services and misuse of resources. OneCare: The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Health Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

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Policy:	HH.1107
Title:	**Fraud, Waste, and Abuse Investigation and Reporting**
Department:	Office of Compliance
Section:	Fraud, Waste, and Abuse – Special Investigations Unit
CEO Approval:	*/s/*
Effective Date:	09/01/2004
Revised Date:	11/01/2025
Applicable to:	☐ Administrative ☒ Covered California [Effective 2027] ☒ Medi-Cal ☒ OneCare ☒ PACE

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I. PURPOSE

This policy establishes a process to investigate, and report suspected Fraud, Waste, or Abuse (FWA) committed by a Member, Provider, CalOptima Health Employee, CalOptima Health board member, First Tier, Downstream, and Related Entity (FDR), other contractor, and/or CalOptima Health's Health Network involving a CalOptima Health program, in accordance with federal and state regulations and contractual requirements, and the CalOptima Health Anti-Fraud, Waste, and Abuse (FWA) Plan.

II. POLICY

A. CalOptima Health maintains a zero-tolerance policy toward FWA by a Member, Provider, CalOptima Health Employee, CalOptima Health board member, FDR, other contractor and/or a Health Network.

B. CalOptima Health shall comply with applicable statutory, regulatory, other requirements, sub-regulatory guidance, and contractual commitments related to the delivery of Covered Services, which include, but are not limited to, federal and state False Claims Acts and Anti-Kickback laws, the federal Exclusion Statute, the federal Administrative Remedies Act, the federal Social Security Act laws prohibiting inducements to Members, the federal Health Insurance Portability and Accountability Act (HIPAA), and other applicable statutes.

C. CalOptima Health Employees and FDRs are expected and required to promptly report suspected violations of any statute, regulations, or guidelines applicable to any CalOptima Health program. CalOptima Health maintains a strict policy of non-retaliation and non-retribution toward Employees and FDRs who make such reports in good faith.

D. CalOptima Health shall establish a process for timely and reasonable investigation and reporting of suspected FWA, in accordance with this Policy.

E. CalOptima Health's Office of Compliance shall coordinate all activities associated with the investigation and reporting of suspected FWA.

F. CalOptima Health's Office of Compliance shall maintain a system for the review of suspect claims to detect and prevent FWA, in accordance with federal and state regulations, and to identify FWA resulting overpayments for recoupment, in accordance with CalOptima Health Policies HH.5000: Provider Overpayment Investigation and Determination, and HH.1105: Fraud, Waste and Abuse Detection, and CalOptima Health's Anti-Fraud, Waste, and Abuse (FWA) Plan.

G. CalOptima Health's Office of Compliance shall collaborate with the CalOptima Health Pharmacy Management Department, and other appropriate departments, to reduce controlled substances and opioid-related Fraud, Abuse, and misuse, as outlined in CalOptima Health Policies GG.1428: Pharmacy Management Medi-Cal Rx Responsibilities, and MA.6104: Opioid Medication Utilization Management.

1. The CalOptima Health SIU shall investigate suspected FWA of prescription drugs, and/or controlled substances, in accordance with this Policy.

H. CalOptima Health shall coordinate and cooperate with the Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), Covered California, Centers for Medicare & Medicaid (CMS), and law enforcement agencies related to any FWA investigations, or audits.

I. CalOptima Health shall conduct preliminary research of any allegation of suspected FWA and shall report suspected FWA to the appropriate agency, in accordance with its contracts with DHCS or Covered California, and/or CMS, and this Policy. All allegations received shall be documented in a FWA tracking log within one (1) business day.

J. Upon determination of validity of the allegation, CalOptima Health shall refer suspected FWA to DHCS, DMHC, Covered California, and/or CMS for further investigation, as appropriate.

K. CalOptima Health's Office of Compliance shall maintain a database and a uniform filing system to maintain suspected FWA referrals, including reports, investigations, and correspondence, in accordance with CalOptima Health's Compliance Program. CalOptima Health's Office of Compliance shall ensure appropriate confidentiality of case files, or other documentation relating to any investigation of a suspected FWA case.

L. Following a determination that a credible allegation of fraud exists involving a Community-Based Adult Services (CBAS) Provider, DHCS will notify CalOptima Health of the finding promptly. In addition to the actions required in APL 15-026: Actions Required Following Notice of a Credible Allegation of Fraud, CalOptima Health shall report to DHCS, in a timeframe and manner specified by DHCS but no less frequently than quarterly, all payments made to the CBAS Provider involved in a credible allegation of fraud for CBAS benefits provided after the date of notification.

M. CalOptima Health's Office of Compliance shall function as the liaison between CalOptima Health and DHCS, DMHC, Covered California, CMS, appropriate state Medical Boards, the State Board of Pharmacy, other licensing entities, law enforcement, prosecuting agencies, as appropriate, and other relevant entities.

N. CalOptima Health's Office of Compliance shall report the status and results of suspected FWA investigations to CalOptima Health's Compliance Committee, as appropriate.

O. CalOptima Health's Office of Compliance shall investigate, and report suspected FWA, in accordance with this Policy.

P. All reports of suspected FWA are kept confidential to the extent permitted by applicable law and circumstances.

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III. PROCEDURE

A. Reporting FWA to CalOptima Health:

1. CalOptima Health shall provide a method for CalOptima Health Employees, FDRs, and Members to anonymously report suspected FWA to the Office of Compliance. CalOptima Health Employees and its FDRs may call the Compliance and Ethics Hotline at 1-855-507-1805 to anonymously report concerns regarding Fraud, Waste, and Abuse.

2. A CalOptima Health Employee who detects suspected FWA may also complete a Suspected Fraud or Abuse Referral Form and transmit it to the Office of Compliance.

3. An FDR with a contractual obligation to report suspected FWA shall notify CalOptima Health of suspected FWA, in accordance with the terms and conditions of its contract and this Policy.

4. Any state, federal, and/or other Managed Care Plans referrals to CalOptima Health of potential Medi-Cal- or Medicare-related FWA are investigated and reported to DHCS's Program Integrity Unit (PIU) and shall remain confidential, as needed.

B. Suspected FWA may proactively be detected as outlined in CalOptima Health Policy HH.1105: Fraud, Waste, and Abuse Detection.

C. Investigation of FWA:

1. When a report is received concerning suspected FWA, the Office of Compliance shall verify the suspected activity using data from reports, including, but not limited to, the following:

   a. CalOptima Health's Compliance and Ethics Hotline, or other reporting mechanisms;

   b. Claims data history;

   c. Encounter data;

   d. Member and Provider complaints, appeals, and grievance reviews;

   e. Medical Record audits;

   f. Pharmacy data;

   g. Utilization Management reports;

   h. Provider utilization profiles;

   i. Member interviews and/or service verification surveys;

   j. Employee interviews;

   k. Provider and/or provider staff interviews;

   l. Monitoring and auditing activities;

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m. Monitoring external health care FWA cases and determining if CalOptima Health's FWA program can be strengthened with information gleaned from the case activity; and/or

n. Internal and external surveys, reviews, and audits.

2. All reports of suspected FWA shall be preliminarily researched to build on the information provided in the allegation in the attempt to have sufficient data for conducting an investigation. CalOptima Health has a target goal of ten (10) business days to determine if sufficient information can be garnered for an allegation in order to conduct an investigation.

   a. Information needed to begin an investigation is considered on a case-by-case basis and may include:

      i. Subject name;

      ii. Verifiable data;

      iii. Relativity/applicability to CalOptima Health; and/or

      iv. Sufficient detail to determine the allegation or the potential offender.

         a) An example would be if an allegation is anonymously reported and the complainant simply states his provider committed fraud, but did not give a name of a provider, there is insufficient information to conduct an investigation.

         b) If there is insufficient information to proceed with conducting an investigation, the Office of Compliance may refer it to another department, agency, or other appropriate entity, and shall document the case for tracking.

            1) An example would be a member grievance (complaint) that staff at a provider's office are rude. The case would not be considered an allegation of FWA and would be forwarded to the Grievances and Appeals Resolution Services (GARS) department.

3. CalOptima Health shall notify and involve impacted Health Networks, as needed, during an investigation.

4. Potential fraud investigations shall follow the established internal desktop procedures and FWA checklist and job aids. Any deterrence from the established protocols is discussed with the FWA department management and documented in internal case reports.

5. For allegations of CalOptima Health Employee's misconduct investigations that involve potential FWA, a referral to SIU should be made by the CalOptima Health staff involved in the initial Employee misconduct investigation. Each referral is considered on a case-by-case basis. The referral to SIU for Employee misconduct investigations will authorize the SIU to have primary responsibility of the Employee misconduct investigation as it relates to potential FWA.

6. When the FWA Investigator is able to determine the probable root cause of the suspected FWA, the information will be documented in the internal case management tracking log and may be reported during the quarterly Compliance Committee meetings.

7. If an investigation finds no component of FWA, and the actions investigated are more appropriately classified as non-compliance, the remediation shall be handled in accordance with

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CalOptima Health Policies HH.2005: Corrective Actions Plans, HH.2002: Sanctions, or GA.8022: Performance and Behavior Standards.

8. CalOptima Health shall issue corrective actions to Employees, FDRs, and other contractors related to validated instances of FWA. Corrective actions will be monitored by the Compliance Committee, or the Human Resources Department, as appropriate. Corrective actions may include financial sanctions, regulatory reporting, performance improvement plans, or termination. If the validated instance of FWA is determined to be criminal in nature, actions may also include a referral to law enforcement.

9. The Office of Compliance will initiate review and discussion at the first Compliance Committee Meeting following the date when significant instances of FWA are identified.

10. If CalOptima Health's SIU investigation yields findings involving an FDR, the SIU shall notify the impacted CalOptima Health department(s), CalOptima Health, Health Network(s), and/or business partners, as needed.

11. For investigations involving suspected FWA of prescription drugs, including controlled substances, the CalOptima Health SIU will collaborate with the CalOptima Health Pharmacy Management Department during the investigation. If the investigation yields findings related to FWA, the SIU will work with Pharmacy Management and Quality Improvement to implement actions in accordance with CalOptima Health Policies MA.5013: Pharmacy Audits and Reviews, GG.1428: Pharmacy Management Medi-Cal Rx Responsibilities, GG.1615: Corrective Action Plan for Practitioners, and MA.6104: Opioid Medication Utilization Management.

12. The SIU shall enter all documentation related to any suspected FWA case into the internal case management tracking log within one (1) business day and document the final disposition once the case has been determined to be closed.

D. Notices of a Credible Allegation of Fraud

1. For investigations involving situations when DHCS, CMS, or another regulatory agency notifies CalOptima Health that a Credible Allegation of Fraud has been found against an FDR, other contractor, or Provider, CalOptima Health must take one (1) or more of the following options and submit any supporting documentation as requested or appropriate to DHCS and/or CMS:

   a. Terminate the FDR or Provider from its network;

   b. Temporarily suspend the FDR or Provider from its network pending resolution of the Fraud allegation;

   c. Temporarily suspend payment to the FDR or Provider pending resolution of the Fraud allegation; and/or

   d. Conduct additional monitoring including audits of the FDR's or Provider's claims history and future claims submissions for appropriate billing.

   e. In the event DHCS sends CalOptima Health a credible allegation of Fraud related to a CBAS or Hospice Provider, CalOptima Health will conduct data analysis, request provider documents from the Provider Data Management Systems or Contracting Department, and report data to DHCS as necessary.

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2. For investigations involving situations when there is a Credible Allegation of Fraud against a pharmacy, CalOptima Health shall work with the PBM and/or appropriate regulatory agency to take one or more of the options above.

E. Reports of changes to a Member's circumstances which may impact a Member's Medi-Cal or Covered California eligibility are promptly reported to DHCS, Covered California and/or the local Social Service Agency, as needed.

F. CalOptima Health Reporting to Regulators:

1. For investigations involving the Medi-Cal program, CalOptima Health shall report to DHCS PIU all cases of suspected Fraud and/or Abuse where there is reason to believe that an incident of Fraud and/or Abuse has occurred by CalOptima Health Employees, FDRs, other contractors, or Members. CalOptima Health shall conduct, complete and report to DHCS, the results of a preliminary investigation of suspected Fraud and/or Abuse. The referral shall be submitted within ten (10) business days on a Medi-Cal Complaint Report (MC609) and sent to DHCS PIU via secure email to PIU.Cases@dhcs.ca.gov. Any completed investigations and quarterly FWA reports will be made to the DHCS PIU.

2. For investigations involving the PACE program, CalOptima Health shall report to DHCS PIU all cases of suspected Fraud and/or Abuse where there is reason to believe that an incident of Fraud and/or Abuse has occurred by CalOptima Health Employees, FDRs, other contractors, or Members. CalOptima Health shall conduct, complete and report to DHCS, the results of a preliminary investigation of suspected Fraud and/or Abuse. The referral shall be submitted within ten (10) business days on a Medi-Cal Complaint Report (MC609) and is sent to DHCS PACE PIU via secure email to DHCSPace.PIU@dhcs.ca.gov. Any completed investigations and quarterly FWA reports will be made to the DHCS PACE PIU.
3. For investigations involving the OneCare program, CalOptima Health shall report to DHCS PIU in accordance with Section III.F1. above, as well as to CMS all cases of suspected Fraud and/or Abuse where there is reason to believe that an incident of Fraud and/or Abuse has occurred by CalOptima Health Employees, FDRs, other contractors, or Members. CalOptima Health shall conduct a preliminary investigation and report to CMS within thirty (30) calendar days of the date potential Fraudulent or abusive activity is identified via the Health Plan Management System (HPMS) FWA reporting module.

   a. For investigations involving the OneCare programs, the referral shall be submitted via the Health Plan Management System (HPMS) FWA reporting module. For investigations involving OneCare where the allegation is exclusively a compromised identification, the referral to CMS shall be submitted on an I MEDIC ID Compromised ID Report Form via secure email, secure facsimile, Federal Express with a tracking number, or certified mail. CalOptima Health shall submit applicable police reports, investigation documentation (background, interviews, etc.), Member information, Provider enrollment data, confirmation of services, list items or services furnished by Provider, pharmaceutical data, and any other pertinent information.

4. For investigations involving Covered California programs, CalOptima Health shall communicate within ten (10) days to Covered California any material concerns identified by CalOptima Health or material concerns, including any enforcement actions resulting in monetary penalties equal to or exceeding $100,000, identified by state and federal regulators related to regulatory compliance that may impact performance under the agreement between CalOptima Health and Covered California following CalOptima Health's knowledge of such occurrence. If an occurrence may reasonably be deemed to adversely affect the quality of care or safety of Covered California Members, CalOptima will provide notification to Covered

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California immediately. All notifications will be made according to the Contract Reporting Requirements table posted on CalOptima Health's extranet website provided by Covered California.

a. If CalOptima Health receives any preliminary or final reports, findings, or orders related to material concerns identified by state and federal regulators that may impact performance under the contract with Covered California, CalOptima Health shall provide Covered California with copies of them within forty-eight (48) hours of receiving them from state and federal regulators.

b. CalOptima Health shall provide Covered California with a description of its Fraud, Waste, and Abuse detection and prevention programs and report total monies recovered by CalOptima Health in the most recent twelve (12)-month period for CalOptima Health's total book of business as well as, total monies recovered for Covered California business only.

   i. This description shall be updated during each year that the contract with Covered California is in effect and shall include an overview of Fraud and Abuse detection and prevention program activities conducted by CalOptima Health, participating providers, other subcontractors, and their authorized agents, including a summary of key findings, relevant data analytics and fraud risk assessments to circumvent fraud, waste, and abuse, and the development, implementation, and enforcement of any corrective action plans for changing, upgrading, or improving these programs.

IV. ATTACHMENT(S)

A. Suspected Fraud or Abuse Referral Form (English)
B. Form MC609 - Confidential Medi-Cal Complaint Report form
C. CalOptima Health Referral to MEDIC ID Compromised

V. REFERENCE(S)

A. California Government Code, §12650, California False Claims Act
B. CalOptima Health Anti-Fraud, Waste, and Abuse (FWA) Plan
C. CalOptima Health Compliance Plan
D. CalOptima Health Contract for Health Care Services
E. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
F. CalOptima Health Contract with Covered California
G. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
H. CalOptima Health PACE Program Agreement
I. CalOptima Health Policy GA.8022: Performance and Behavior Standards
J. CalOptima Health Policy GG.1428: Pharmacy Management Medi-Cal Rx Responsibilities
K. CalOptima Health Policy GG.1615: Corrective Action Plan for Practitioners
L. CalOptima Health Policy HH.1105: Fraud, Waste, and Abuse Detection
M. CalOptima Health Policy HH.2002: Sanctions
N. CalOptima Health Policy HH.2005: Corrective Action Plan
O. CalOptima Health Policy HH.5000: Provider Overpayment Investigation and Determination
P. CalOptima Health Policy MA.5013: Pharmacy Audits and Reviews
Q. CalOptima Health Policy MA.6104: Opioid Medication Utilization Management
R. CalOptima Health Anti-Fraud, Waste, and Abuse (FWA) Plan
S. Contract Year 2022 Centers for Medicare & Medicaid Services (CMS) Part C and D Final Rule

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T. Department of Health Care Services (DHCS) All Plan Letter (APL) 15-026: Actions Required Following Notice of a Credible Allegation of Fraud
U. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-026: Federal Drug Utilization Review Requirements Designed to Reduce Opioid Related Fraud, Misuse and Abuse (Supersedes APL 19-012) Department of Health Care Services (DHCS) Medi-Cal Managed Care Division (MMCD) All Plan Letter (APL) 03-011: Fraud Referral Procedure to Audits and Investigations (A&I)
V. Health and Safety Code §1348
W. Medicare Managed Care Manual, Chapters 9 and 21
X. Title 31, United States Code, §3730(h), Civil actions for false claims
Y. Title 42, Code of Federal Regulations, §455.2
Z. Welfare and Institutions Code, §14043.1(a)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
08/01/2016	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/06/2018	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
06/01/2023	Regular Meeting of the CalOptima Health Board of Directors
11/07/2024	Regular Meeting of the CalOptima Health Board of Directors
11/01/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	09/01/2004	HH.1107	Fraud and Abuse Investigation and Reporting	Medi-Cal
Revised	01/01/2008	HH.1107	Fraud, Waste and Abuse Investigation and Reporting	Medi-Cal
Revised	12/01/2010	HH.1107	Fraud, Waste and Abuse Investigation and Reporting	Medi-Cal
Revised	02/01/2013	HH.1107	Fraud, Waste and Abuse Investigation and Reporting	Medi-Cal
Revised	07/01/2014	HH.1107	Fraud, Waste and Abuse Investigation and Reporting	Medi-Cal
Revised	09/01/2015	HH.1107	Fraud, Waste and Abuse Investigation and Reporting	Medi-Cal
Revised	06/01/2016	HH.1107	Fraud, Waste, and Abuse Investigation and Reporting	Medi-Cal

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Action	Date	Policy	Policy Title	Program(s)
Revised	12/01/2016	HH.1107	Fraud, Waste, and Abuse Investigation and Reporting	Medi-Cal OneCare OneCare Connect PACE
Revised	12/07/2017	HH.1107	Fraud, Waste, and Abuse Investigation and Reporting	Medi-Cal OneCare OneCare Connect PACE
Revised	05/01/2018	HH.1107	Fraud, Waste, and Abuse Investigation and Reporting	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.1107	Fraud, Waste, and Abuse Investigation and Reporting	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.1107	Fraud, Waste, and Abuse Investigation and Reporting	Medi-Cal OneCare OneCare Connect PACE
Revised	12/03/2020	HH.1107	Fraud, Waste, and Abuse Investigation and Reporting	Medi-Cal OneCare OneCare Connect PACE
Revised	12/20/2021	HH.1107	Fraud, Waste, and Abuse Investigation and Reporting	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	HH.1107	Fraud, Waste, and Abuse Investigation and Reporting	Medi-Cal OneCare PACE
Revised	06/01/2023	HH.1107	Fraud, Waste, and Abuse Investigation and Reporting	Medi-Cal OneCare PACE
Revised	09/01/2023	HH.1107	Fraud, Waste, and Abuse Investigation and Reporting	Medi-Cal OneCare PACE
Revised	11/07/2024	HH.1107	Fraud, Waste, and Abuse Investigation and Reporting	Medi-Cal OneCare PACE
Revised	05/01/2025	HH.1107	Fraud, Waste, and Abuse Investigation and Reporting	Covered California Medi-Cal OneCare PACE
Revised	09/01/2025	HH.1007	Fraud, Waste, and Abuse Investigation and Reporting	Covered California Medi-Cal OneCare PACE

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IX. GLOSSARY

Term	Definition
Abuse	Covered California: Excessive, or improper use of something, or the use of something in a manner contrary to the natural or legal rules for its use; the intentional destruction, diversion, manipulation, misapplication, maltreatment, or misuse of resources; or extravagant or excessive use to abuse one's position or authority. Often, the terms fraud and abuse are used simultaneously with the primary distinction is the intent. Inappropriate practices that begin as abuse can quickly evolve into fraud. Abuse can occur in financial or non-financial settings. Examples of abuse include excessive charges, improper billing practices, payment for services that do not meet recognized standards of care and payment for medically unnecessary services. Medi-Cal: Practices that are inconsistent with sound fiscal and business practices or medical standards, and result in an unnecessary cost to the Medi-Cal program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to the Medi-Cal program. OneCare: A Provider practice that is inconsistent with sound fiscal, business, or medical practice, and results in an unnecessary cost to CalOptima Health and the OneCare program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to CalOptima Health and the OneCare program.
Centers for Medicare & Medicaid Services (CMS)	The federal agency within the United States Department of Health and Human Services (DHHS) that administers the federal Medicare program and works in partnership with state governments to administer Medicaid programs.
Compliance Committee	The committee designated by the Chief Executive Officer (CEO) to implement and oversee the Compliance Program and to participate in carrying out provisions of this Compliance Plan. The composition of the Compliance Committee shall consist of Executive staff that may include, but is not limited to, the: Chief Executive Officer; Chief Medical Officer; Chief Operating Officer; Chief Financial Officer; Chief Compliance Officer; and Chief Human Resources Officer.
Compliance Program	Medi-Cal: The program including, without limitation, the Compliance Plan, Code of Conduct, and CalOptima Health policies, developed and adopted by CalOptima Health to promote, monitor, and ensure that CalOptima Health's operations and practices and the practices of its Board Members, employees, FDRs, other contractors, and providers comply with applicable law and ethical standards. OneCare: A comprehensive program that incorporates the fundamental elements identified by the state and federal governments and CalOptima Health as necessary to prevent and detect violations of ethical standards, contractual obligations, and applicable laws and the involvement of CalOptima Health's governing body and executive staff. Elements of the Compliance Program include standards, oversight, training, reporting, monitoring, enforcement, and remediation. The Compliance Program applies to CalOptima Health's Board of Directors, employees, and other contractors including delegated entities, providers, and suppliers.

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Term	Definition
Covered Service	Covered California: Health care services that are covered benefits under CalOptima Health's contract with Covered California, as further described in the Evidence of Coverage and supporting documents. Medi-Cal: Those health care services, set forth in W&I sections 14000 et seq. and 14131 et seq., 22 CCR section 51301 et seq., 17 CCR section 6800 et seq., the Medi-Cal Provider Manual, the California Medicaid State Plan, the California Section 1115 Medicaid Demonstration Project, the contract with DHCS for Medi-Cal, and DHCS APLs that are made the responsibility of CalOptima Health pursuant to the California Section 1915(b) Medicaid Waiver authorizing the Medi-Cal managed care program or other federally approved managed care authorities maintained by DHCS. Covered Services do not include: 1. Home and Community-Based Services (HCBS) program as specified in the DHCS contract for Medi-Cal Exhibit A, Attachment III, Subsections 4.3.15 (Services for Persons with Developmental Disabilities), 4.3.20 (Home and Community-Based Services Programs) regarding waiver programs, 4.3.21 (In-Home Supportive Services), and Department of Developmental Services (DDS) Administered Medicaid Home and Community-Based Services Waiver. HCBS programs do not include services that are available as an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) service, as described in 22 CCR sections 51184, 51340 and 51340.1. EPSDT services are covered under the DHCS contract for Medi-Cal, as specified in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services), Subsection F4 regarding services for Members less than twenty-one (21) years of age. CalOptima Health is financially responsible for the payment of all EPSDT services; 2. California Children's Services (CCS) as specified in Exhibit A, Attachment III, Subsection 4.3.14 (California Children's Services), except for contractors providing Whole Child Model (WCM) services; 3. Specialty Mental Health Services as specified in Exhibit A, Attachment III, Subsection 4.3.12 (Mental Health Services); 4. Alcohol and SUD treatment services, and outpatient heroin and other opioid detoxification, except for medications for addiction treatment as specified in Exhibit A, Attachment III, Subsection 4.3.13 (Alcohol and Substance Use Disorder Treatment Services); 5. Fabrication of optical lenses except as specified in Exhibit A, Attachment III, Subsection 5.3.7 (Services for All Members); 6. Direct Observed Therapy for Treatment of Tuberculosis (TB) as specified in Exhibit A, Attachment III, Subsection 4.3.18 (Direct Observed Therapy for Treatment of Tuberculosis); 7. Dental services as specified in W&I sections 14131.10, 14132(h), 14132.22, 14132.23, and 14132.88, and EPSDT dental services as described in 22 CCR section 51340.1(b). However, CalOptima Health is responsible for all Covered Services as specified in Exhibit A, Attachment III, Subsection 4.3.17 (Dental) regarding dental services; 8. Prayer or spiritual healing as specified in 22 CCR section 51312; 9. Educationally Necessary Behavioral Health Services that are covered by a Local Education Agency (LEA) and provided pursuant to a Member's

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Term	Definition
	Individualized Education Plan (IEP) as set forth in Education Code section 56340 et seq., Individualized Family Service Plan (IFSP) as set forth in California Government Code (GC) section 95020, or Individualized Health and Support Plan (IHSP). However, CalOptima Health is responsible for all Medically Necessary Behavioral Health Services as specified in Exhibit A, Attachment III Subsection 4.3.16 (School-Based Services); 10. Laboratory services provided under the State serum alpha-feto-protein-testing program administered by the Genetic Disease Branch of California Department of Public Health (CDPH); 11. Pediatric Day Health Care, except for contractors providing Whole Child Model (WCM) services; 12. State Supported Services; 13. Targeted Case Management (TCM) services as set forth in 42 USC section 1396n(g), W&I sections 14132.48 and 14021.3, 22 CCR sections 51185 and 51351, and as described in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services). However, if Members less than twenty-one (21) years of age are not eligible for or accepted by a Regional Center (RC) or a local government health program for TCM services, CalOptima Health must ensure access to comparable services under the EPSDT benefit in accordance with DHCS APL 23-005; 14. Childhood lead poisoning case management provided by county health departments; 15. Non-medical services provided by Regional Centers (RC) to individuals with Developmental Disabilities, including but not limited to respite, out-of-home placement, and supportive living; 16. End of life services as stated in Health and Safety Code (H&S) section 443 et seq., and DHCS APL 16-006; and 17. Prescribed and covered outpatient drugs, medical supplies, and enteral nutritional products when appropriately billed by a pharmacy on a pharmacy claim, in accordance with DHCS APL 22-012. OneCare: Those medical services, equipment, or supplies that CalOptima Health is obligated to provide to Members under the Center of Medicare & Medicaid Services (CMS) Contract. 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 Health, or other services as authorized by the CalOptima Health Board of Directors.
Credible Allegation of Fraud	A Credible Allegation of Fraud may be an allegation, which has been verified by the State, from any source, including but not limited to the following: (1) Fraud hotline complaints. (2) Claims data mining. (3) Patterns identified through Provider audits, civil false claims cases, and law enforcement investigations. Allegations are considered to be credible when they have indicia of reliability, and the State Medicaid agency has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis.
Department of Health Care Services (DHCS)	The state agency that oversees California's Medicaid program, known as Medi-Cal.

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Term	Definition
Department of Managed Health Care (DMHC)	California state agency that regulates and oversees health maintenance organizations (HMOs) and other managed care plans.
Downstream Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Health Program benefit, below the level of arrangement between CalOptima Health and a First Tier Entity. These written arrangements continue down to the level of the ultimate Provider of both health and administrative services.
Employee	Covered California: A "qualified employee," as defined in 45 CFR § 155.20. For purposes of this policy, any and all Employees of CalOptima Health, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary Employees and volunteers.
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 Consortiums, and Health Maintenance Organizations.
First Tier Entity	Medi-Cal: Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima Health to provide administrative services or health care services to a Member under a CalOptima Health Program. OneCare: Any party that enters into a written arrangement, acceptable to CMS, with an MAO or Part D plan sponsor or applicant to provide administrative services or health care services to a Medicare eligible individual under the MA program or Part D program.
Fraud	Covered California: Consists of an intentional misrepresentation, deceit, or concealment of a material fact known to the defendant with the intention on the part of the defendant of thereby depriving a person of property or legal rights or otherwise causing injury. (CA Civil Code section 3294 (c)(3), CA Penal Code section 470-483.5). Prevention and early detection of fraudulent activities is crucial to ensuring affordable healthcare for all individuals. Examples of fraud include false applications to obtain payment, false information to obtain insurance, billing for services that were not rendered. Fraud includes, but is not limited to, knowingly making or causing to be made any false or fraudulent claim for payment of a health care benefit, in accordance with Health and Safety Code section 1348. Medi-Cal: An intentional deception or misrepresentation made by a person with the knowledge that deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law, in accordance with Title 42 Code of Federal Regulations section 455.2, Welfare and Institutions Code section 14043.1(i).
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information, and as subsequently amended.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) subcontractor, or First Tier Entity, that contracts with CalOptima Health to provide Covered Services to Members.

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Term	Definition
Medically Necessary or Medical Necessity	Covered California: Health care and related services and supplies provided to a Member for the purpose of evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms and that are: (i) in accordance with generally accepted standards of medical practice; (ii) appropriate for the symptoms, diagnosis, or treatment of the Member's condition, disease, illness or injury; (iii) not primarily for the convenience of the Member or health care Provider; and (iv) not more costly than an alternative service, or suite of services, and at least as likely to produce equivalent results. For treatment of a mental health or substance use disorder, Medical Necessity shall include: A service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of an illness, injury, condition, or its symptoms, in a manner that is all of the following: (i) in accordance with the generally accepted standards of mental health and substance use disorder care; (ii) clinically appropriate in terms of type, frequency, extent, site, and duration; (iii) not primarily for the economic benefit of the disability insurer and insureds or for the convenience of the patient, treating physician, or other health care Provider, as required by HSC §1374.72 (a)(3)(A). 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 Health shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child. OneCare: Reasonable and necessary medical services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. PACE: 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.
Medical Record	Medi-Cal & Covered California: The record of a Member's medical information including but not limited to, medical history, care or treatments received, test results, diagnoses, and prescribed medications.

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Term	Definition
	OneCare: A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal. PACE: Written documentary evidence of treatments rendered to plan Members.
Member	An individual enrolled in a CalOptima Health Program.
Pharmacy Benefit Manager (PBM)	An entity that provides pharmacy benefit management services, including contracting with a network of pharmacies; establishing payment levels for network pharmacies; negotiating rebate arrangements; developing and managing formularies, preferred drug lists, and prior authorization programs; maintaining patient Compliance Programs; performing drug utilization review; and operating disease management programs.
Provider	Covered California: A licensed health care facility or as stipulated by local or international jurisdictions, a program, agency or health professional that delivers Covered Services. 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.
Related Entity	Any entity that is related to the Medicare Advantage organization by common ownership or control and: 1. Performs some of the Medicare Advantage organization's management functions under contract or delegation; 2. Furnishes services to Medicare enrollees under an oral or written agreement; or 3. Leases real property or sells materials to the Medicare Advantage organization at a cost of more than two-thousand five-hundred dollars ($2,500) during a contract period.

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Term	Definition
Waste	Covered California: Intentional or unintentional, extravagant careless or needless expenditures, consumption, mismanagement, use, or squandering of resources, to the detriment or potential detriment of entities, but without an intent to deceive or misrepresent. Waste includes incurring unnecessary costs because of inefficient or ineffective practices, systems, decisions, or controls. Medi-Cal: The overutilization or inappropriate utilization of services and misuse of resources. OneCare: The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Health Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

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CalOptima Health

INSTRUCTIONS FOR COMPLETING A SUSPECTED FRAUD OR ABUSE REFERRAL FORM

To submit a request to investigate suspected fraud or abuse, please complete a CalOptima Health Suspected Fraud or Abuse Referral Form. Examples of "Member" or "Provider" fraud or abuse are listed on the form. These are examples only. The list does not represent every situation in which fraud or abuse can take place.

Complete all applicable sections of the form. It is very important to complete the entire form so we can effectively investigate the issue.

If desired, requestor may remain anonymous; however, if the requestor does not provide his/her name and phone number, the CalOptima Health Office of Compliance will be unable to contact him/her if there are any questions about the information submitted, which may prevent completion of the investigation.

Submit the completed form with supporting documents to CalOptima Health's Office of Compliance via one of the following methods:

1. Email: Fraud@CalOptima.org
2. U.S. Mail: CalOptima Health
   Office of Compliance — SIU
   505 City Parkway West
   Orange CA 92868
3. Fax: **1-714-481-6457**

MARK ALL CORRESPONDENCE AS "CONFIDENTIAL."

You may also report suspected fraud or abuse to CalOptima Health's Ethics and Compliance hotline, 24 hours a day, 7 days a week, toll-free at 1-855-507-1805. TDD/TTY users can call toll-free at 1-800-735-2929. We have staff that speak your language.

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CalOptima Health

SUSPECTED FRAUD OR ABUSE REFERRAL FORM

REFERRAL INFORMATION		
Date: _____		Notice involves suspected fraud or abuse by a:
Referred by: Name: _____	Title: _____	☐ Member
Dept.: _____	Phone#: _____	☐ Provider

MEMBER	PROVIDER
CalOptima Health Program: ☐ Medi-Cal ☐ OneCare ☐ PACE	Provider Name:
Member Name:	Type of provider:
Member ID:	Provider ID #:
Address:	Address:
City: ZIP:	City: ZIP:
Date of service if applicable:	Date of service if applicable:
Member ID, if applicable:	If multiple members are involved, please attach a list.

Examples of suspected fraud or abuse:

- ☐ Using another individual's identity or documentation of Medi-Cal eligibility to obtain covered services and prescriptions (unless that person is an authorized representative who is presenting such information to obtain covered services on behalf of a member)
- ☐ Selling, loaning or giving a member's identity or documentation of eligibility to obtain covered services (other than to a family member to obtain covered services on behalf of a member)
- ☐ Falsely claiming eligibility
- ☐ Using a covered service for purposes other than the purposes for which it was prescribed, including use by an individual other than the member for whom the covered service was prescribed or provided
- ☐ Failing to report other health coverage
- ☐ Soliciting or receiving a kickback, bribe or rebate as an inducement to receive or not receive covered services
- ☐ Other (please specify) _____

Allegation of suspected fraud or abuse:

- ☐ Falsely claiming eligibility to participate in the CalOptima Health program.
- ☐ Submission of claims for covered services that are:
  - ☐ Substantially and demonstrably more than any individual's usual charges for such covered services
  - ☐ Not actually provided to the member for which the claim is submitted
  - ☐ More than the quantity that is medically necessary
  - ☐ Billed using a code that would result in greater payment than the code that reflects the covered service
  - ☐ Already included in capitation rate
  - ☐ Submitted for payment to both CalOptima Health and another third-party payer without full disclosure

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SUSPECTED FRAUD OR ABUSE REFERRAL FORM

	☐ Charging a member in excess of allowable co-payments and deductibles for covered services ☐ Billing a member for covered services without obtaining written consent to bill for such services ☐ Failure to disclose conflict of interest ☐ Receiving, soliciting or offering a kickback, bribe or rebate to refer or fail to refer a member ☐ Failure to register billing intermediary with the Department of Health Care Services (DHCS) ☐ False certification of medical necessity ☐ Attributing a diagnosis code to a member that does not reflect the member's medical condition to obtain higher reimbursement ☐ False or inaccurate Minimum Standards or credentialing information ☐ Submitting reports that contain unsubstantiated data, data that is inconsistent with records or has been altered in a manner that is inconsistent with policies, contracts, statutes or regulations. ☐ Other (please specify) _____

DOCUMENTATION (PLEASE ATTACH):

☐ Claims data ☐ Medical records ☐ Complaint, appeal or grievance ☐ UM reports
☐ Audit ☐ Other (please specify) _____

Please provide a brief explanation of how the documentation provided supports concerns of fraudulent activity: _____

Please provide the root cause of this suspected fraudulent activity: _____

OTHER RELEVANT INFORMATION (PLEASE ATTACH):

Are there any prior suspected fraud or abuse issues by this member, provider, pharmacy, other: _____

1. ☐ No
   ☐ Yes. Please describe:

2. If yes, what was the outcome?

Please submit this form with all pertinent documentation to the OFFICE OF COMPLIANCE SPECIAL INVESTIGATIONS UNIT (SIU). The Office of Compliance SIU shall report as appropriate to local and state entities.

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SUSPECTED FRAUD OR ABUSE REFERRAL FORM

If you do not receive an acknowledgement of receipt of this form within five (5) working days, please send an email to Fraud@CalOptima.org.

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CONFIDENTIAL
MEDI-CAL COMPLAINT REPORT

GENERAL INTAKE INFORMATION - AGENCY RECEIVING COMPLAINT

◯ DHCS ◯ County ◯ Other (specify) _____

Name of Staff Taking Complaint:	Title:
Agency Name (if other than DHCS):	Address if other than DHCS:
Telephone Number:	Email:
How complaint was received:	Date suspected fraud/overpayment identified:

Type of Complaint: ◯ Provider ◯ Recipient ◯ Drug ◯ IHSS
◯ Other: _____

COMPLAINANT INFORMATION

Name of Person Reporting Complaint:	Email:	
Phone:	Address:	City & Zip:

SUBJECT INFORMATION

Subject Name:	Address:	
City & Zip:	Subject Phone Number:	Email:
Recipient Name:	Social Security Number:	Date of Birth:
Address: (Number, Street)	City & Zip:	Phone:
Provider Name & DBA:	NPI, Provider Number, or SSN	Date of Birth (IHSS):
Address: (Number, Street)	City, State:	Phone:

Managed Care Plan Only – Identified overpayment (when applicable):

Relationship to recipient: (IHSS)

Other information:

NATURE OF COMPLAINT:

(Attach additional sheets if necessary)

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NATURE OF COMPLAINT (continued):

(Attach additional sheets if necessary)

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COMPLAINT PROCESSED FOR INVESTIGATION: (For DHCS ID Use Only)		
Possible Statute, Regulation, Policy, or Code Violation:		
Code Description:		Open Date:
Date Assigned by PAU:	PAU Internal Tracking Number:	
☐ Supporting Documents	Case Number:	
☐ Credible Allegation of Fraud	Supervisor Assigned:	Date:
☐ Est. Medi-Cal Program Loss:	Investigator Assigned:	Date:
☐ Referral to DOJ Date:	☐ Referral to Other Agency:	Date:

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Qlarant

I-MEDIC Compromised ID Report Form

Instructions: The purpose of this form is to report compromised Health Insurance Claim Numbers (HICNs), and/or Medicare Beneficiary Identifiers (MBIs); prescribing provider identifiers, or dispensing provider identifiers in the Medicare Parts C & D programs. Qlarant may contact you upon receipt of this report, so please be sure to furnish sufficient contact information. Please supply one compromised subject per form. To ensure compliance with all applicable laws, please do not send Protected Health Information (PHI) via email.

Please fax this form to 410-819-8698, Attn: Qlarant, Investigations MEDIC, Complaints Manager, or email it as an encrypted attachment to I-MEDICComplaints@qlarant.com.

Submitter Contact Information

Name: _____ Phone: _____ Fax: _____

Organization: _____ Email: _____

Address: _____ City: _____ State: _____ Zip:_____

Compromised ID Information:

Type of entity: ◯ Beneficiary ◯ Prescriber/Provider ◯ Pharmacy

Description of Identifier which has been compromised (e.g. HICN, MBI, DEA NPI, NCPDP):

Identifier(s) which has been compromised:

Name of entity or individual:

Address of entity or individual: City: State:

Type of issue: ◯ Part C Issue ◯ Part D Issue ◯ Part C and D Issue

Report Details:

Please provide any information regarding how the number was compromised, subjects involved, etc. This may include a description of how the theft occurred, dates that the fraud occurred, description of individuals and/or businesses involved in the alleged activity, names and contact information for victims, and copies of documentation regarding the fraudulent activity including letters, advertising, attestations, affidavits, verification forms, etc. (enter details on page 2).

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Policy:	HH.2002
Title:	**Sanctions**
Department:	Office of Compliance
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	10/01/1998
Revised Date:	10/01/2025
Applicable to:	☐ Administrative ☐ Covered California [Effective 2027] ☒ Medi-Cal ☒ OneCare ☒ PACE

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I. PURPOSE

This policy describes the process by which CalOptima Health shall impose Sanctions on a First Tier, Downstream, or Related Entity (FDR), including a Health Network, to enforce effective correction of non-compliance with statutory, regulatory, contractual, or CalOptima Health policy requirements, Fraud, Waste, and Abuse, or the FDR's failure to satisfactorily implement corrective actions.

II. POLICY

A. CalOptima Health's Compliance Committee, Delegation Oversight Committee (DOC) or other CalOptima Health Committee may propose Sanctions against an FDR if it fails to comply with statutory, regulatory, contractual, CalOptima Health policy, and other requirements related to CalOptima Health programs. The applicable committee shall determine whether to impose any Sanction and submit the recommendation to the Compliance Committee. The Compliance Committee shall vote to approve all Sanctions.

B. CalOptima Health may impose Sanctions against a Health Network or FDR immediately following the entity's failure to comply with statutory, regulatory, contractual, CalOptima Health policy, or other requirements related to CalOptima Health programs, with or without a Corrective Action Plan (CAP) requirement.

C. If required by CalOptima Health, a Health Network or FDR must submit a CAP response to CalOptima Health, in accordance with CalOptima Health Policy HH.2005: Corrective Action Plan. CalOptima Health may also impose Sanctions if an Health Network or FDR fails to submit, remediate, or implement a CAP response, or take corrective action under any approved CAP in the time, or manner, required by CalOptima Health.

D. The extent of the Sanction shall be commensurate with the severity of the deficiency identified as it relates to the risk posed to the CalOptima Health Member(s), as well as other financial or accreditation exposure to CalOptima Health and designed to correct the underlying issue and prevent future recurrence.

E. Sanctions include, but are not limited to, financial penalties, suspension of membership enrollment, suspension of incentive or quality payments, de-delegation, and/or termination of contract.

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CalOptima Health retains the right to take termination action in addition to, and notwithstanding, the imposition of other Sanctions under this Policy.

F. In the event a Health Network or FDR fails to remediate its non-compliance in the time or manner required by CalOptima Health, CalOptima Health may impose additional and/or more severe Sanctions.

III. PROCEDURE

A. Basis for Sanctions

1. CalOptima Health may impose Sanctions or take any other action against a Health Network or FDR based on the identification of deficient performance or non-compliance of an FDR. Non-compliance may be established through and may include, but is not limited to:

   a. Findings from performance reviews and/or delegation oversight activities, in accordance with CalOptima Health Policy GG.1619: Delegation Oversight;

   b. Findings from regulatory reviews; including but not limited to the Department of Health Care Services (DHCS), the Department of Managed Health Care (DMHC), and the Centers for Medicare & Medicaid Services (CMS) audits;

   c. Findings from FDR annual contract performance reviews;

   d. Findings from Provider and Member complaints and surveys;

   e. Engaging in Fraud, Waste, or Abuse as specified in CalOptima Health Policy HH.1105: Fraud, Waste, and Abuse Detection;

   f. Failing to report data, or other information, in the time or manner required by CalOptima Health including, but not limited to, Encounter data;

   g. Engaging in any prohibited Marketing Activities, as outlined in CalOptima Health Policy MA.2001: Marketing Materials Standards;

   h. Failing to have the required amounts and types of financial reserves, or to meet financial solvency requirements;

   i. Failing to comply with the CalOptima Health Compliance Program and investigations including, but not limited to, CalOptima Health's Code of Conduct and policies;

   j. Breaching any covenant, condition, or term of the contract or agreement including, but not limited to, failing to perform contracted duties and responsibilities in the time or manner required by CalOptima Health;

   k. Failing to submit, remediate, or implement a CAP response, or take corrective action under any approved CAP response in the time or manner required by CalOptima Health; and

   l. Failing to comply with any other review of statutory, regulatory, contractual, CalOptima Health policy and other requirements related to a CalOptima Health policy.

B. Determining Sanction

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1. CalOptima Health's Delegation Oversight department and other business areas charged with oversight of Health Networks and FDRs shall monitor performance and compliance as required by the relevant CalOptima Health policies.

2. If areas of non-compliance or substandard performance are found through the monitoring process, the business unit shall exhaust appropriate escalation activities, including informal and formal communication, coordination with CalOptima Health's Provider Relations department and any other activities outlined in CalOptima Health policies HH.2005: Corrective Action Plan and HH.2003: Health Network and Delegated Entity Reporting.

3. If informal or formal escalation does not remedy the area of performance or non-compliance, the business area will recommend a sanction using the Health Network and FDR Sanction Request Form and include the recommended severity of Sanctions.

4. CalOptima Health's Compliance Committee shall record findings of a Health Network or FDR's deficient performance or non-compliance as provided by referring business unit or committee and in accordance with CalOptima Health Policy GG.1619: Delegation Oversight. The Compliance Committee shall record Sanctions that have been issued.

5. The Compliance Committee shall record the nature and severity of the Sanction as recommended by the referring committee or business area.

   a. Sanctions will vary in severity based on the extent and type of finding, including, but not limited to, findings in audits, investigations, contractual obligations, quality improvement system monitoring, routine monitoring, corrective action plan requirements, encounter and provider data submissions, grievances and appeals, network adequacy reviews, assessments of timely access requirements, reviews of utilization data, operational standards including the timely payment of claims, complaints from Members and other stakeholders, whistleblowers, and self-disclosures.

   b. Actions that are determined to endanger a Member or prevent access to Covered Services will be reviewed and acted upon immediately by the Office of Compliance.

   c. Sanctions shall be designed to correct the underlying issue and prevent future occurrence.

   d. Sanctions imposed may include, but not be limited to, termination of the contract between the Health Network or FDR and CalOptima Health.

6. The Compliance Committee shall consult with legal counsel on the imposition of Sanctions including, but not limited to, contract terminations, as necessary and appropriate.

C. Types of Sanctions

1. CalOptima Health may impose any one or a combination of the following Sanctions:

   a. Financial penalties defined in the contract;

   b. Enrollment freeze - Auto Assignment, Member selection, or both;

   c. Withholding quality or other incentive payments;

   d. Modification or de-delegation of delegated function(s);

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e. The requirement to engage and pay for an external auditor, or other consultant/monitor, acceptable to and approved by CalOptima Health, in order to correct the identified deficiency(ies), non-compliance, or FWA to CalOptima Health's satisfaction;

f. Termination of the contract, or agreement, with the non-compliant organization;

g. Forfeiture of FDR financial security;

h. Capitation deduction; and/or

i. Any other action CalOptima Health deems appropriate and reasonable.

2. Monetary Sanctions

a. Monetary Sanctions are imposed independently and are in addition to any other sums owed to CalOptima Health, such as refunding of Overpayments. Monetary Sanctions will be assessed and determined independently using the following guidelines:

i. Monetary Sanctions may be separately and independently assessed and may also be assessed for each day the Health Network or FDR fails to correct an identified deficiency.

ii. For deficiencies that impact Members, each impacted Member may constitute a separate violation. For example, CalOptima Health may calculate a violation, which directly impacts a Member's access to Covered Services, in the following terms:

1) Generally a sanction of at least $25,000 per occurrence with a a limit of $25,000 per Member in which the Health Network or FDR failed to provide Medically Necessary services that the Health Network FDR is required to provide, under law, or under its contract.

2) For deficiencies that remain uncured more than 30 days following the issuance of an original sanction, generally a sanction of $50,000 with an upper limit of $25,000 per member may apply. For deficiencies that continue to remain uncured after an additional 30 days (total of 60 days from original sanction), generally a sanction of $75,000 with an upper limit of $25,000 per member may apply.

3) Per Member penalties may be assessed when there is adverse impact to the Member for the following situations:

a) Inappropriate delay/denial of covered medical services/ drugs, and/or Appeal rights;

b) Incorrect premiums charged, or unnecessary out-of-pockets costs incurred; or

c) Inaccurate or untimely plan benefit information (e.g., wrong denial notices) provided.

b. Monetary Sanctions may also be applied in aggregate based on capitation on a per determination basis. For example, Monetary Sanctions can be calculated in the following terms:

i. 1% off the monthly capitation amount for a first violation.

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ii. 2% off the monthly capitation amount for a second violation.

iii. 3% off the monthly capitation amount for each subsequent violation.

iv. If CalOptima Health does not have the Member-specific data or the per Member impact cannot be clearly analyzed, it may calculate the penalty under the per determination basis. Please note that CalOptima Health may choose to impose a per determination penalty for a violation when the Health Network or FDR has provided CalOptima Health with an impact analysis and CalOptima Health determines that Members were adversely affected by the violation.

c. Parties with pending monetary Sanctions are responsible for paying monetary Sanctions in the time and manner required by CalOptima Health. Failure to render payments in the time and manner outlined by CalOptima Health may result in capitation deduction or payment withhold.

D. Notification of Sanction

1. CalOptima Health shall notify an Health Network or FDR, in writing. Such notice shall:

a. Detail the findings of non-compliance;

b. Reference the applicable statutory, regulatory, contractual, CalOptima Health policies, or other requirements that are the basis of the findings;

c. Provide detailed information describing the Sanction, including the effective date, duration of, and reason for each sanction proposed;

d. Identify time frames by which the FDR shall be required to achieve compliance, as applicable;

e. Inform the Health Network or FDR that CalOptima Health may impose additional Sanctions if compliance is not achieved in the manner and time frame specified; and

f. Provide notice of the Health Network or FDR's right to file a Complaint, in accordance with CalOptima Health policy.

2. In the event that CalOptima Health imposes a financial Sanction on an FDR as a direct consequence of an Immediate Corrective Action Plan (ICAP) and with respect to the CalOptima Health Medi-Cal Program, the Regulatory Affairs & Compliance Department shall consider reporting the issue to CalOptima Health's DHCS Contract Manager for Medi-Cal in a reasonably timely manner.

E. Provider Complaint Process

1. If an FDR disagrees with the Sanction, the FDR may file a rebuttal (or provider complaint) by submitting an email request to:

a. Health Network FDRs: Health Network Relations at healthnetworkdepartment@caloptima.org or the email address specified in the Notice of Sanction letter.

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b. All other FDRs: the email address specified in the Notice of Sanction letter.

F. The DOC or other assigned Committee shall oversee and monitor the FDR's response to the Sanctions letter and report status to the Compliance Committee.

IV. ATTACHMENT(S)

Health Network and FDR Sanction Request Form

V. REFERENCE(S)

A. CalOptima Health Code of Conduct
B. CalOptima Health Compliance Plan
C. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
D. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
E. CalOptima Health, Health Network Service Agreement, Delegation Agreement Exhibit F
F. CalOptima Health PACE Program Agreement
G. CalOptima Health Policy GG.1619: Delegation Oversight
H. CalOptima Health Policy HH.1101: CalOptima Health Provider Complaint
I. CalOptima Health Policy HH.1105: Fraud, Waste, and Abuse Detection
J. CalOptima Health Policy HH.2005: Corrective Action Plan
K. CalOptima Health Policy MA.9006: Contracted Provider Complaint Process
L. CMS Civil Monetary Penalty Calculation Methodology
M. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-006: Delegation and Subcontractor Network Certification (Supersedes APL 17-004)
N. Medicare Managed Care Manual, Chapter 21
O. Medicare Prescription Drug Benefit Manual, Chapter 9
P. Title 22, California Code of Regulations (CCR), §51301 et. seq.
Q. Title 42, Code of Federal Regulations (CFR), §455.2
R. Title 18, United States Code (USC), §1347
S. Welfare and Institutions Code, §14043.1(a)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
12/11/2013	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/06/2018	Regular Meeting of the CalOptima Board of Directors
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VIII. REVISION HISTORY

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Action	Date	Policy	Policy Title	Program(s)
Effective	10/01/1998	HH.2002	Health Network Sanctions	Medi-Cal
Revised	10/01/2002	HH.2002	Health Network Sanctions	Medi-Cal
Revised	07/01/2004	HH.2002	Health Network Sanctions	Medi-Cal
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IX. GLOSSARY

Term	Definition
Abuse	Medi-Cal: Practices that are inconsistent with sound fiscal and business practices or medical standards, and result in an unnecessary cost to the Medi-Cal program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to the Medi-Cal program. OneCare: A Provider practice that is inconsistent with sound fiscal, business, or medical practice, and results in an unnecessary cost to CalOptima Health and the OneCare program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to CalOptima Health and the OneCare program.
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.
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Compliance Program	Medi-Cal: The program including, without limitation, the Compliance Plan, Code of Conduct, and CalOptima Health policies, developed and adopted by CalOptima Health to promote, monitor, and ensure that CalOptima Health's operations and practices and the practices of its Board Members, employees, contractors, and providers comply with applicable law and ethical standards. OneCare: A comprehensive program that incorporates the fundamental elements identified by the state and federal governments and CalOptima Health as necessary to prevent and detect violations of ethical standards, contractual obligations, and applicable laws and the involvement of CalOptima Health's governing body and executive staff. Elements of the Compliance Program include standards, oversight, training, reporting, monitoring, enforcement, and remediation. The Compliance Program applies to CalOptima Health's Board of Directors, employees, and contractors including delegated entities, providers, and suppliers.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima Health, the Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima Health departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima Health and its regulators.
Delegation Oversight Committee (DOC)	A subcommittee of the Compliance Committee chaired by the Director(s) of Delegation Oversight to oversee CalOptima Health's delegated functions. The composition of the DOC includes representatives from CalOptima Health's departments as provided for in CalOptima Health Policy HH.4001: Delegation Oversight Committee.

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Encounter	Medi-Cal: An instance of direct Provider-to-Member interaction, regardless of the setting, between a Member and a Provider who is diagnosing, evaluating, or treating the Member's condition. OneCare: Any unit of Covered Service provided to a Member by a Health Network regardless of Health Network reimbursement methodology. These services include any Covered Services provided to a Member, regardless of the service location or Provider, including out-of-network Covered Services and sub-capitated and delegated Covered Services. Encounter data submitted to CalOptima Health should not include denied, adjusted, or duplicate claims.
First Tier, Downstream, and Related Entities (FDR)	First Tier, Downstream or Related Entity, as separately defined herein.
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Fraud	An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law, in accordance with Title 42 Code of Federal Regulations section 455.2, Welfare and Institutions Code section 14043.1(i).

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Term	Definition
Health Network	Health Network: A Physician Hospital Consortium (PHC), physician group under a shared risk contract, health care service plan, such as a Health Maintenance Organization (HMO), Subcontractor, or First Tier Entity, that contracts with CalOptima Health to provide Covered Services to Members.
Member	A beneficiary enrolled in a CalOptima Health Program.
Related Entity	Any entity that is related to the MAO or Part D program by common ownership or control and: 1. Performs some of the MAO or Part D program's management functions under contract or delegation; 2. Furnishes services to Medicare enrollees under an oral or written agreement; or 3. Leases real property or sells materials to the MAO or Part D program at a cost of more than two-thousand five-hundred dollars ($2,500) during a contract period.
Sanction	An action taken by CalOptima Health, including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on an FDR's or its agent's failure to comply with statutory, regulatory, contractual, and/or other requirements related to CalOptima Health Programs.
Waste	Medi-Cal: The overutilization or inappropriate utilization of services and misuse of resources. OneCare: The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Health Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

1

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Policy:	HH.2002
Title:	**Sanctions**
Department:	Office of Compliance
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	10/01/1998
Revised Date:	10/01/2025
Applicable to:	☐ Administrative ☐ Covered California [Effective 2027] ☒ Medi-Cal ☒ OneCare ☒ PACE

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I. PURPOSE

This policy describes the process by which CalOptima Health shall impose Sanctions on a First Tier, Downstream, or Related Entity (FDR), including a Health Network, to enforce effective correction of non-compliance with statutory, regulatory, contractual, or CalOptima Health policy requirements, Fraud, Waste, and Abuse, or the FDR's failure to satisfactorily implement corrective actions.

II. POLICY

A. CalOptima Health's Compliance Committee, Delegation Oversight Committee (DOC) or other CalOptima Health Committee may propose Sanctions against an FDR if it fails to comply with statutory, regulatory, contractual, CalOptima Health policy, and other requirements related to CalOptima Health programs. The applicable committee shall determine whether to impose any Sanction and submit the recommendation to the Compliance Committee. The Compliance Committee shall vote to approve all Sanctions.

B. CalOptima Health may impose Sanctions against a Health Network or FDR immediately following the entity's failure to comply with statutory, regulatory, contractual, CalOptima Health policy, or other requirements related to CalOptima Health programs, with or without a Corrective Action Plan (CAP) requirement.

C. If required by CalOptima Health, a Health Network or FDR must submit a CAP response to CalOptima Health, in accordance with CalOptima Health Policy HH.2005: Corrective Action Plan. CalOptima Health may also impose Sanctions if an Health Network or FDR fails to submit, remediate, or implement a CAP response, or take corrective action under any approved CAP in the time, or manner, required by CalOptima Health.

D. The extent of the Sanction shall be commensurate with the severity of the deficiency identified as it relates to the risk posed to the CalOptima Health Member(s), as well as other financial or accreditation exposure to CalOptima Health and designed to correct the underlying issue and prevent future recurrence.

E. Sanctions include, but are not limited to, financial penalties, suspension of membership enrollment, suspension of incentive or quality payments, de-delegation, and/or termination of contract.

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CalOptima Health retains the right to take termination action in addition to, and notwithstanding, the imposition of other Sanctions under this Policy.

F. In the event a Health Network or FDR fails to remediate its non-compliance in the time or manner required by CalOptima Health, CalOptima Health may impose additional and/or more severe Sanctions.

III. PROCEDURE

A. Basis for Sanctions

1. CalOptima Health may impose Sanctions or take any other action against a Health Network or FDR based on the identification of deficient performance or non-compliance of an FDR. Non-compliance may be established through and may include, but is not limited to:

   a. Findings from performance reviews and/or delegation oversight activities, in accordance with CalOptima Health Policy GG.1619: Delegation Oversight;

   b. Findings from regulatory reviews; including but not limited to the Department of Health Care Services (DHCS), the Department of Managed Health Care (DMHC), and the Centers for Medicare & Medicaid Services (CMS) audits;

   c. Findings from FDR annual contract performance reviews;

   d. Findings from Provider and Member complaints and surveys;

   e. Engaging in Fraud, Waste, or Abuse as specified in CalOptima Health Policy HH.1105: Fraud, Waste, and Abuse Detection;

   f. Failing to report data, or other information, in the time or manner required by CalOptima Health including, but not limited to, Encounter data;

   g. Engaging in any prohibited Marketing Activities, as outlined in CalOptima Health Policy MA.2001: Marketing Materials Standards;

   h. Failing to have the required amounts and types of financial reserves, or to meet financial solvency requirements;

   i. Failing to comply with the CalOptima Health Compliance Program and investigations including, but not limited to, CalOptima Health's Code of Conduct and policies;

   j. Breaching any covenant, condition, or term of the contract or agreement including, but not limited to, failing to perform contracted duties and responsibilities in the time or manner required by CalOptima Health;

   k. Failing to submit, remediate, or implement a CAP response, or take corrective action under any approved CAP response in the time or manner required by CalOptima Health; and

   l. Failing to comply with any other review of statutory, regulatory, contractual, CalOptima Health policy and other requirements related to a CalOptima Health policy.

B. Determining Sanction

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1. CalOptima Health's Delegation Oversight department and other business areas charged with oversight of Health Networks and FDRs shall monitor performance and compliance as required by the relevant CalOptima Health policies.

2. If areas of non-compliance or substandard performance are found through the monitoring process, the business unit shall exhaust appropriate escalation activities, including informal and formal communication, coordination with CalOptima Health's Provider Relations department and any other activities outlined in CalOptima Health policies HH.2005: Corrective Action Plan and HH.2003: Health Network and Delegated Entity Reporting.

3. If informal or formal escalation does not remedy the area of performance or non-compliance, the business area will recommend a sanction using the Health Network and FDR Sanction Request Form and include the recommended severity of Sanctions.

4. CalOptima Health's Compliance Committee shall record findings of a Health Network or FDR's deficient performance or non-compliance as provided by referring business unit or committee and in accordance with CalOptima Health Policy GG.1619: Delegation Oversight. The Compliance Committee shall record Sanctions that have been issued.

5. The Compliance Committee shall record the nature and severity of the Sanction as recommended by the referring committee or business area.

    a. Sanctions will vary in severity based on the extent and type of finding, including, but not limited to, findings in audits, investigations, contractual obligations, quality improvement system monitoring, routine monitoring, corrective action plan requirements, encounter and provider data submissions, grievances and appeals, network adequacy reviews, assessments of timely access requirements, reviews of utilization data, operational standards including the timely payment of claims, complaints from Members and other stakeholders, whistleblowers, and self-disclosures.

    b. Actions that are determined to endanger a Member or prevent access to Covered Services will be reviewed and acted upon immediately by the Office of Compliance.

    c. Sanctions shall be designed to correct the underlying issue and prevent future occurrence.

    d. Sanctions imposed may include, but not be limited to, termination of the contract between the Health Network or FDR and CalOptima Health.

6. The Compliance Committee shall consult with legal counsel on the imposition of Sanctions including, but not limited to, contract terminations, as necessary and appropriate.

C. Types of Sanctions

1. CalOptima Health may impose any one or a combination of the following Sanctions:

    a. Financial penalties defined in the contract;

    b. Enrollment freeze - Auto Assignment, Member selection, or both;

    c. Withholding quality or other incentive payments;

    d. Modification or de-delegation of delegated function(s);

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e. The requirement to engage and pay for an external auditor, or other consultant/monitor, acceptable to and approved by CalOptima Health, in order to correct the identified deficiency(ies), non-compliance, or FWA to CalOptima Health's satisfaction;

f. Termination of the contract, or agreement, with the non-compliant organization;

g. Forfeiture of FDR financial security;

h. Capitation deduction; and/or

i. Any other action CalOptima Health deems appropriate and reasonable.

2. Monetary Sanctions

a. Monetary Sanctions are imposed independently and are in addition to any other sums owed to CalOptima Health, such as refunding of Overpayments. Monetary Sanctions will be assessed and determined independently using the following guidelines:

i. Monetary Sanctions may be separately and independently assessed and may also be assessed for each day the Health Network or FDR fails to correct an identified deficiency.

ii. For deficiencies that impact Members, each impacted Member may constitute a separate violation. For example, CalOptima Health may calculate a violation, which directly impacts a Member's access to Covered Services, in the following terms:

1) Generally a sanction of at least $25,000 per occurrence with a a limit of $25,000 per Member in which the Health Network or FDR failed to provide Medically Necessary services that the Health Network FDR is required to provide, under law, or under its contract.

2) For deficiencies that remain uncured more than 30 days following the issuance of an original sanction, generally a sanction of $50,000 with an upper limit of $25,000 per member may apply. For deficiencies that continue to remain uncured after an additional 30 days (total of 60 days from original sanction), generally a sanction of $75,000 with an upper limit of $25,000 per member may apply.

3) Per Member penalties may be assessed when there is adverse impact to the Member for the following situations:

a) Inappropriate delay/denial of covered medical services/ drugs, and/or Appeal rights;

b) Incorrect premiums charged, or unnecessary out-of-pockets costs incurred; or

c) Inaccurate or untimely plan benefit information (e.g., wrong denial notices) provided.

b. Monetary Sanctions may also be applied in aggregate based on capitation on a per determination basis. For example, Monetary Sanctions can be calculated in the following terms:

i. 1% off the monthly capitation amount for a first violation.

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ii. 2% off the monthly capitation amount for a second violation.

iii. 3% off the monthly capitation amount for each subsequent violation.

iv. If CalOptima Health does not have the Member-specific data or the per Member impact cannot be clearly analyzed, it may calculate the penalty under the per determination basis. Please note that CalOptima Health may choose to impose a per determination penalty for a violation when the Health Network or FDR has provided CalOptima Health with an impact analysis and CalOptima Health determines that Members were adversely affected by the violation.

c. Parties with pending monetary Sanctions are responsible for paying monetary Sanctions in the time and manner required by CalOptima Health. Failure to render payments in the time and manner outlined by CalOptima Health may result in capitation deduction or payment withhold.

D. Notification of Sanction

1. CalOptima Health shall notify an Health Network or FDR, in writing. Such notice shall:

a. Detail the findings of non-compliance;

b. Reference the applicable statutory, regulatory, contractual, CalOptima Health policies, or other requirements that are the basis of the findings;

c. Provide detailed information describing the Sanction, including the effective date, duration of, and reason for each sanction proposed;

d. Identify time frames by which the FDR shall be required to achieve compliance, as applicable;

e. Inform the Health Network or FDR that CalOptima Health may impose additional Sanctions if compliance is not achieved in the manner and time frame specified; and

f. Provide notice of the Health Network or FDR's right to file a Complaint, in accordance with CalOptima Health policy.

2. In the event that CalOptima Health imposes a financial Sanction on an FDR as a direct consequence of an Immediate Corrective Action Plan (ICAP) and with respect to the CalOptima Health Medi-Cal Program, the Regulatory Affairs & Compliance Department shall consider reporting the issue to CalOptima Health's DHCS Contract Manager for Medi-Cal in a reasonably timely manner.

E. Provider Complaint Process

1. If an FDR disagrees with the Sanction, the FDR may file a rebuttal (or provider complaint) by submitting an email request to:

a. Health Network FDRs: Health Network Relations at healthnetworkdepartment@caloptima.org or the email address specified in the Notice of Sanction letter.

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F. The DOC or other assigned Committee shall oversee and monitor the FDR's response to the Sanctions letter and report status to the Compliance Committee.

IV. ATTACHMENT(S)

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Term	Definition
Health Network	Health Network: A Physician Hospital Consortium (PHC), physician group under a shared risk contract, health care service plan, such as a Health Maintenance Organization (HMO), Subcontractor, or First Tier Entity, that contracts with CalOptima Health to provide Covered Services to Members.
Member	A beneficiary enrolled in a CalOptima Health Program.
Related Entity	Any entity that is related to the MAO or Part D program by common ownership or control and: 1. Performs some of the MAO or Part D program's management functions under contract or delegation; 2. Furnishes services to Medicare enrollees under an oral or written agreement; or 3. Leases real property or sells materials to the MAO or Part D program at a cost of more than two-thousand five-hundred dollars ($2,500) during a contract period.
Sanction	An action taken by CalOptima Health, including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on an FDR's or its agent's failure to comply with statutory, regulatory, contractual, and/or other requirements related to CalOptima Health Programs.
Waste	Medi-Cal: The overutilization or inappropriate utilization of services and misuse of resources. OneCare: The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Health Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

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Health Network, Direct Network Provider and FDR Escalation, Corrective Action Plan and/or Sanction Request Form

INSTRUCTIONS

Please complete this form in its entirety. Be sure to attach all relevant documents (e.g., P&P, contract language excerpts, regulations etc.), and use concise explanations to support the basis of your request. Processing the request will be delayed if supporting documentation is not initially provided or if this form is incomplete.

Please submit the completed form via email at DelegationOversight@caloptima.org

Not all entity types are overseen by Delegation Oversight (DO) but DO will funnel the request to the appropriate owner.

Type and Name of Entity:

☐ Health Network: _____

☐ Delegate/Highest Risk FDR: _____

☐ Vendor: _____

☐ Direct Network Provider: _____

SECTION 1: REQUESTOR INFORMATION

DATE:	**ORGANIZATION/DEPT.:**
REQUESTOR'S NAME:	**PHONE / EMAIL:**

SECTION 2: TYPE OF REQUEST

☐ Outreach from Health Network Provider Relations/Provider Relations/Vendor Management	☐ Capitation Deduction
☐ Corrective Action Plan	☐ Monetary Sanction
☐ Enrollment Freeze – Auto Assignment, Member Selection or both	☐ Termination of Contract or Agreement
☐ Withholding of Quality, Shared Savings or Incentive Payments	☐ Notice of Pending Action Letter(s) ("warning of potential sanction letter")
☐ Require monitor at Health Network/Delegate/FDR Expense	☐ Other: Describe:
☐ Modification of Delegation or De-Delegation	

SECTION 3: DESCRIPTION OF NON-COMPLIANCE AND EVIDENCE

Evidence Attached: ☐ Prior CAPs ☐ Audit Results ☐ FDR Annual Review ☐ Regulatory Finding ☐ NCQA Finding ☐ Quality Performance Issue ☐ Contractual Performance Issue ☐ DO Dashboard Response Form ☐ Other

Description of non-compliance (use attachments as necessary):

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Health Network, Direct Network Provider and FDR
Escalation, Corrective Action Plan and/or Sanction Request Form

SECTION 3: BASIS OF NON-COMPLIANCE		
☐ Contract (attach) Sections(s)_____ ☐ NCQA Reference: _____ ☐ Quality Performance Reference: _____	☐ CalOptima Health Policy Policy #s: _____ Sections of the Policy:_____ Reference: _____ ☐ Business Associate Agreement Section: _____	☐ Regulatory Audit Regulator:_____ ☐ Statute or Regulation Section(s)_____ ☐ Sub-Regulatory Guidance Reference:_____

SECTION 5: PRIOR EFFORTS TO RESOLVE
Evidence Attached: ☐ Informal Notice ☐ Formal Notice ☐ CAP(s) ☐ ICAP ☐ Other
Description of prior steps taken to resolve non-compliance:

SECTION 6: RESOLUTION OR NEXT STEPS
Steps Implemented: ☐ Informal Outreach/Meeting ☐ CAP ☐ Freeze Enrollment ☐ Withholding Incentives ☐ Monitor ☐ Sanction ☐ Modification of Delegation ☐ Termination of Contract ☐ Other:
Description: .

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Policy:	HH.2005
Title:	**Corrective Action Plan**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance
CEO Approval:	*/s/*
Effective Date:	11/01/1998
Revised Date:	10/01/2025
Applicable to:	☐ Administrative ☐ Covered California [Effective 2027] ☒ Medi-Cal ☒ OneCare ☒ PACE

For 20251106 BOD Review Only

I. PURPOSE

This policy defines the requirements for CalOptima Health and its First Tier, Downstream, and Related Entities (FDRs) for development and submission of an Immediate Corrective Action Plan (ICAP) or Corrective Action Plan (CAP) for areas of non-compliant performance, as identified by CalOptima Health.

II. POLICY

A. CalOptima Health shall conduct Auditing, Monitoring, and investigations of internal CalOptima Health departments and its FDRs, as applicable, to ensure compliance with statutory, regulatory, contractual, CalOptima Health policy, and other requirements related to CalOptima Health programs.

B. CalOptima Health's Office of Compliance recognizes that issues of non-compliant performance may be identified by internal departments and FDRs that are outside of the Auditing, and operational Monitoring and investigations conducted by the Office of Compliance.

1. This policy does not restrict the internal departments and FDRs from performing their own routine monitoring, investigation and corrective action process. As an example, refer to CalOptima Health Policy GG.1615: Corrective Action Plan for Practitioners and Organizational Providers.

C. CalOptima Health's Delegation Oversight department has the authority to issue corrective actions in adherence with this policy and/or leveraging the requirements in this policy and in combination with GG.1619: Delegation Oversight.

D. CalOptima Health may require that an internal department or FDR develop an ICAP or CAP response based on the identified area(s) of non-compliance.

E. CalOptima Health shall require CalOptima Health internal departments and FDRs to bring their operations into full compliance with statutory, regulatory, contractual, CalOptima Health policy, and other requirements, which CalOptima Health or its regulators have identified as non-compliant, within time frames established by CalOptima Health.

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F. An internal department or FDR shall develop, submit, and take corrective action under an approved ICAP or CAP response in the time and manner required by CalOptima Health.

1. Failure by the internal department to respond accurately, timely, and in compliance with statutory, regulatory, contractual, CalOptima Health policy, or other requirements to CalOptima Health's Office of Compliance's ICAP or CAP request may lead to further action.

2. Failure by an FDR to respond accurately, timely, and in compliance with statutory, regulatory, contractual, CalOptima Health policy, or other requirements to CalOptima Health's ICAP or CAP request may lead to further action. CalOptima Health may impose Sanctions for the underlying non-compliant performance that gave rise to the ICAP or CAP request, or the failure to develop, submit, and meet the requirements of the ICAP or CAP request, in accordance with CalOptima Health Policy HH.2002: Sanctions.

III. PROCEDURE

A. Basis for an ICAP or CAP

1. CalOptima Health's Office of Compliance or responsible internal department shall routinely Monitor performance metrics, conduct routine, or focused, Audits, and conduct ongoing Monitoring and investigations of reported non-compliance for internal departments, or FDRs, through a variety of mechanisms.

a. CalOptima Health's Office of Compliance may issue an ICAP/CAP request as a result of Audits conducted by federal and state regulatory agencies, including, but not limited to the Department of Health Care Services (DHCS), the Centers for Medicare & Medicaid Services (CMS), and the Department of Managed Health Care (DMHC).

b. CalOptima Health's Office of Compliance may issue an ICAP/CAP request as a result of an ICAP/CAP request, or other corrective action, that CalOptima Health receives from a federal or state regulatory agency that is directly related to the operations of an internal department or FDR.

2. In the event that CalOptima Health determines an internal department, or FDR, has failed to comply with statutory, regulatory, contractual, CalOptima Health policy, or other requirements, an ICAP, or CAP request, may be issued to address the problem.

a. CalOptima Health's Office of Compliance shall coordinate its efforts with CalOptima Health's Human Resources Department in the event that an ICAP or CAP potentially warrants Employee disciplinary action.

B. ICAP and CAP Issuance and Requirements

1. CalOptima Health shall utilize standardized ICAP and CAP request template(s) that include, at minimum, the elements outlined in Section III.B.4 of this policy.

2. Non-compliance with specific requirements that have the potential to cause significant Member harm, or place CalOptima Health's accreditation, participation, and/or contractual status with regulatory agencies in jeopardy will require an ICAP response.

a. If the finding requires an ICAP request, as determined by CalOptima Health, the internal department or FDR must immediately take all reasonable action to stop or prevent further non-compliance. The internal department or FDR will have five (5) business days from the formal ICAP request to provide a plan, in writing, to address or remediate the deficiency.

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b. The internal department or FDR shall provide a written response within five (5) business days of receiving an ICAP request, detailing how it will mitigate and prevent further non-compliance. Following the acceptance of the ICAP response, the internal department or FDR is required to resolve the issue in a manner and time frame deemed appropriate by CalOptima Health.

3. A CAP request is the result of material non-compliance with specific requirements that does not rise to the level of an ICAP request.

   a. The internal department or FDR is required to respond to the CAP request within ten (10) business days. CalOptima Health's Chief Compliance Officer or Designee, or the applicable department leadership or their Designee, may authorize extensions to this timeline on a case-by-case basis. Following the acceptance of the CAP response, the internal department or FDR is required to resolve the issue in a manner and time frame deemed appropriate by CalOptima Health.

4. An ICAP or CAP response shall include the following elements:

   a. A root cause analysis of the deficiency which may include a description of the policies and procedures, staffing, training, and systems that failed;

   b. Steps taken to resolve the deficiency;

   c. Steps taken to avoid reoccurrence;

   d. Method for implementation and completion of ICAP response or CAP response;

   e. Individual(s) responsible for implementation of the ICAP response or CAP response;

   f. An attestation by the internal department's Executive Officer responsible for the area subject to the CAP, or their Designee, or FDR, conveying a plan to remedy its identified deficiencies; and

   g. ICAP response or CAP response completion date(s), as applicable.

C. Unacceptable Resolution to an ICAP or CAP

1. If the resolution to the deficiency is unacceptable or the internal department or FDR fails to respond, CalOptima Health shall issue a written notice to the internal department or the FDR, which shall include:

   a. A summary of previous outreach and required action(s);

   b. An explanation of why that the resolution was not acceptable, or why a response was not received;

   c. A revised response timeline of two (2) business days for an ICAP;

      i. Extensions to this timeline may be authorized on a case-by-case basis by CalOptima Health's Chief Compliance Officer or Designee, or the applicable department leadership or their Designee.

   d. A revised response timeline of five (5) business days for a CAP;

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i. Extensions to this timeline may be authorized on a case-by-case basis by CalOptima Health's Chief Compliance Officer or Designee, or the applicable department leadership or their Designee.

e. Explain the possible consequences, specific to the nature of the issue and degree of completeness in accordance with CalOptima Health Policy HH.2002: Sanctions;

f. Possibility of scheduling a required meeting with the internal department or the FDR to discuss the unacceptable response or the internal department or FDR's failure to respond.

g. Possibility of escalating to the department's Chief, or the FDR's Chief Executive Officer (CEO) or their Designee; and

h. Possibility of referral to the Delegation Oversight Committee (DOC) and the Compliance Committee.

D. Acceptable Resolution with ICAP or CAP Requirements

1. A response may be accepted once all requirements outlined in Section III.B.4 of this Policy are fulfilled. If an ICAP or CAP response requires Monitoring or a focused Audit, the ICAP or CAP response shall not be closed until the remediation(s) implemented has been validated and demonstrate that the issue will not recur.

a. A response may be accepted and closed simultaneously if Monitoring or a focused Audit is not required.

2. If the resolution to the deficiency is deemed acceptable by CalOptima Health's Chief Compliance Officer or Designee or the applicable department leadership or their Designee, CalOptima Health may issue a written notification of acceptance, which shall include:

a. An acknowledgement of acceptance;

b. A description of follow up actions which shall include, but is not limited to:

i. Submission of finalized documentation; and/or

ii. Focused Audit, as described in Section III.E. of this Policy; and/or

iii. Monitoring, as deemed appropriate by CalOptima Health, and as described in Section III.F. of this Policy.

3. If the resolution to the deficiency is accepted and deemed sufficient by CalOptima Health's Chief Compliance Officer or Designee or the applicable department leadership or their Designee, CalOptima Health shall issue a written notification of closure, which shall include:

a. An acknowledgement of closure;

b. The effective date of closure; and

c. Consequences of repeat deficiencies.

E. Focused Audits

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1. CalOptima Health may conduct a focused Audit of an internal department or FDR to confirm implementation of the accepted ICAP or CAP response.

2. CalOptima Health shall notify the internal department or FDR of the scope, Audit period, and Audit deliverables that shall be required to complete the focused Audit.

3. CalOptima Health may continue to Monitor and/or Audit an internal department or FDR for performance of issues and/or functions related to the ICAP or CAP request.

F. Monitoring Period

1. CalOptima Health may conduct Monitoring of the internal department's or FDR's resolution to confirm implementation of the accepted ICAP or CAP response.

2. CalOptima Health shall Monitor the resolution for a predetermined time frame for example, not more than 90 days after a "cure" has been affected to ensure ongoing compliance, as established by CalOptima Health.

3. CalOptima Health shall notify the internal department, or FDR, of the scope, Monitoring period, and deliverables that shall be required to complete the Monitoring.

4. CalOptima Health may continue to Monitor and/or Audit an internal department's or FDR's performance of issues and/or functions related to the ICAP or CAP request.

G. Failure to Maintain Adequate Resolution

1. If during the Monitoring period or the focused Audit the internal department or FDR fails to maintain the remedies in place, CalOptima Health may conduct an additional focused audit, extend the monitoring period, or re-assess the ICAP or CAP responses, including the implemented controls and monitoring efforts.

2. In the instance of an ICAP, the internal department or FDR shall be required to re-assess and resolve the issue within two (2) business days from the notification of failed focused audit or monitoring period.

   a. Extensions to this timeline may be authorized on a case-by-case basis by the Chief Compliance Officer or Designee, or the applicable department leadership or their Designee.

H. ICAP and CAP Tracking and Reporting

1. CalOptima Health's Office of Compliance or responsible department shall track all CAP and ICAP requests issued utilizing a standardized tool.

2. CalOptima Health's Office of Compliance shall report the status of all CAP/ICAP requests to the DOC and the Compliance Committee.

3. In the event that CalOptima Health's Office of Compliance makes a determination to self-disclose the ICAP or significant incident of noncompliance with respect to the CalOptima Health Medi-Cal or Medicare Program, the Regulatory Affairs & Compliance Department shall report the issue to CalOptima Health's DHCS Contract Manager and/or CMS Account Manager.

   a. The Office of Compliance will submit the Self-Disclosure report to the Chief Compliance Officer for review and sign off.

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b. Once the above step has been completed, and an accepted CAP (if applicable) has been submitted, the Chief Compliance Officer, or Designee, will submit the non-compliance incident to DHCS and/or CMS, including any steps taken to correct the non-compliance, immediately, but no later than the referenced time frame for Medicare in accordance with CalOptima Health Policy MA.9124: Self-Disclosure of Non-Compliance Issues, and three (3) business days for Medi-Cal.

c. CalOptima Health shall report the incident to DHCS and/or CMS as soon as possible after its discovery.

4. If CalOptima Health's internal department, or FDR, has repeated deficiencies, the issue(s) shall be reported to the DOC and the Compliance Committee for further action.

I. CalOptima Health shall maintain and publicly post its annual DHCS Medical Audit report, records of CAPs and the rectifying actions to close out the findings. If warranted, updates on the audit outcomes shall be available for detailed discussion, via the monthly report to the Board of Directors and/or its subcommittees, as necessary.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Compliance Plan
B. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima Health PACE Program Agreement
E. CalOptima Health Policy GG.1615: Corrective Action Plan for Practitioners and Organizational Providers
F. CalOptima Health Policy HH.2002: Sanctions
G. CalOptima Health Policy MA.9124: Self-Disclosure of Non-Compliance Issues
H. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-006: Delegation and Subcontractor Network Certification (Supersedes APL 17-004)
I. ICAP/CAP Request Template
J. Medicare Managed Care Manual, Chapter 21
K. Medicare Prescription Drug Benefit Manual, Chapter 9
L. Title 22, California Code of Regulations (CCR), §51301 et. seq.

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
06/08/2022	Department of Health Care Services (DHCS)	File and Use
10/23/2023	Department of Health Care Services (DHCS)	File and Use
02/21/2024	Department of Health Care Services (DHCS)	File and Use

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors

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08/02/2018	Regular Meeting of the CalOptima Board of Directors
12/06/2018	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
05/05/2022	Regular Meeting of the CalOptima Board of Directors
12/01/2022	Regular Meeting of the CalOptima Health Board of Directors
10/05/2023	Regular Meeting of the CalOptima Health Board of Directors
11/07/2024	Regular Meeting of the CalOptima Health Board of Directors
11/06/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	11/01/1998	HH.2005	Health Network Corrective Action Plan	Medi-Cal
Revised	10/01/2002	HH.2005	Health Network Corrective Action Plan	Medi-Cal
Revised	06/01/2007	HH.2005	Health Network Corrective Action Plan	Medi-Cal
Revised	04/01/2013	HH.2005	Corrective Action Plan	Medi-Cal OneCare
Revised	09/01/2015	HH.2005	Corrective Action Plan	Medi-Cal
Revised	12/01/2016	HH.2005	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE
Revised	12/07/2017	HH.2005	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE
Revised	08/02/2018	HH.2005	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.2005	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.2005	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE
Revised	12/03/2020	HH.2005	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE
Revised	12/20/2021	HH.2005	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE
Revised	05/05/2022	HH.2005	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE

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Action	Date	Policy	Policy Title	Program(s)
Revised	12/31/2022	HH.2005	Corrective Action Plan	Medi-Cal OneCare PACE
Revised	09/01/2023	HH.2005	Corrective Action Plan	Medi-Cal OneCare PACE
Revised	02/01/2024	HH.2005	Corrective Action Plan	Medi-Cal OneCare PACE
Revised	11/07/2024	HH.2005	Corrective Action Plan	Medi-Cal OneCare PACE
Revised	10/01/2025	HH.2005	Corrective Action Plan	Medi-Cal OneCare 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.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima Health, the Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima Health departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima Health and its regulators.
Delegation Oversight Committee (DOC)	Medi-Cal: A subcommittee of the Compliance Committee chaired by the Director(s) of Delegation Oversight to oversee CalOptima Health's delegated functions. The composition of the DOC includes representatives from CalOptima Health's departments as provided for in CalOptima Health Policy HH.4001: Delegation Oversight Committee. OneCare: A subcommittee of the Compliance Committee chaired by the Director of the Delegation Oversight department to oversee CalOptima Health's delegated functions. The composition of the DOC includes representatives from CalOptima Health's operational departments.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
DHCS Medical Audit	For the purpose of this policy, a DHCS Medical Audit refers to the annual evaluation conducted by DHCS in accordance with Welfare and Institutions Code 14456. The DHCS Medical audit is conducted to ascertain that medical services provided to CalOptima Health's members comply with federal and state laws, Medi-Cal regulations and guidelines and its contract with DHCS.
Downstream Entity	Medi-Cal: Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Health Program benefit, below the level of arrangement between CalOptima Health and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services. OneCare: Any party that enters into an acceptable written arrangement below the level of the arrangement between a Medicare Advantage Organization (MAO) (and contract applicant) and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.
Employee	For purposes of this policy, any and all employees of CalOptima Health, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary employees and volunteers.
First Tier, Downstream, and Related Entities (FDRs)	Means First Tier, Downstream or Related Entity, as separately defined herein.

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Term	Definition
First Tier Entity	Medi-Cal: Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima Health to provide administrative services or health care services to a Member under a CalOptima Health Program. OneCare: Any party that enters into a written arrangement, acceptable to CMS, with an MAO or Part D plan sponsor or applicant to provide administrative services or health care services to a Medicare eligible individual under the Medicare Advantage (MA) program or Part D program.
Immediate Corrective Action Plan (ICAP)	An ICAP is the result of non-compliance with specific requirements that has the potential to cause significant member harm. Significant member harm exists if the non-compliance resulted in the failure to provide medical items, services or prescription drugs, causing financial distress, or posing a threat to member's health and safety due to non-existent or inadequate policies and procedures, systems, operations or staffing.
Immediate Corrective Action Plan (ICAP) Request	The result of non-compliance with specific requirements that has the potential to cause significant Member harm. Significant Member harm exists if the noncompliance resulted in the failure to provide medical services or prescription drugs, causing financial distress, or posing a threat to Member's health and safety due to non-existent or inadequate policies and procedures, systems, operations or staffing.
Member	A beneficiary enrolled in a CalOptima Health 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.
Related Entity	Any entity that is related to the MAO or Part D program by common ownership or control and: 1. Performs some of the MAO or Part D program's management functions under contract or delegation; 2. Furnishes services to Medicare enrollees under an oral or written agreement; or 3. Leases real property or sells materials to the MAO or Part D Program at a cost of more than two thousand five hundred dollars ($2,500) during a contract period.
Sanction	An action taken by CalOptima Health, including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on an FDR's or its agent's failure to comply with statutory, regulatory, contractual, and/or other requirements related to CalOptima Health Programs.

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Policy:	HH.2005
Title:	**Corrective Action Plan**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance
CEO Approval:	*/s/*
Effective Date:	11/01/1998
Revised Date:	10/01/2025
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C. CalOptima Health's Delegation Oversight department has the authority to issue corrective actions in adherence with this policy and/or leveraging the requirements in this policy and in combination with GG.1619: Delegation Oversight.

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F. An internal department or FDR shall develop, submit, and take corrective action under an approved ICAP or CAP response in the time and manner required by CalOptima Health.

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2. Failure by an FDR to respond accurately, timely, and in compliance with statutory, regulatory, contractual, CalOptima Health policy, or other requirements to CalOptima Health's ICAP or CAP request may lead to further action. CalOptima Health may impose Sanctions for the underlying non-compliant performance that gave rise to the ICAP or CAP request, or the failure to develop, submit, and meet the requirements of the ICAP or CAP request, in accordance with CalOptima Health Policy HH.2002: Sanctions.

III. PROCEDURE

A. Basis for an ICAP or CAP

1. CalOptima Health's Office of Compliance or responsible internal department shall routinely Monitor performance metrics, conduct routine, or focused, Audits, and conduct ongoing Monitoring and investigations of reported non-compliance for internal departments, or FDRs, through a variety of mechanisms.

a. CalOptima Health's Office of Compliance may issue an ICAP/CAP request as a result of Audits conducted by federal and state regulatory agencies, including, but not limited to the Department of Health Care Services (DHCS), the Centers for Medicare & Medicaid Services (CMS), and the Department of Managed Health Care (DMHC).

b. CalOptima Health's Office of Compliance may issue an ICAP/CAP request as a result of an ICAP/CAP request, or other corrective action, that CalOptima Health receives from a federal or state regulatory agency that is directly related to the operations of an internal department or FDR.

2. In the event that CalOptima Health determines an internal department, or FDR, has failed to comply with statutory, regulatory, contractual, CalOptima Health policy, or other requirements, an ICAP, or CAP request, may be issued to address the problem.

a. CalOptima Health's Office of Compliance shall coordinate its efforts with CalOptima Health's Human Resources Department in the event that an ICAP or CAP potentially warrants Employee disciplinary action.

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1. CalOptima Health shall utilize standardized ICAP and CAP request template(s) that include, at minimum, the elements outlined in Section III.B.4 of this policy.

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a. If the finding requires an ICAP request, as determined by CalOptima Health, the internal department or FDR must immediately take all reasonable action to stop or prevent further non-compliance. The internal department or FDR will have five (5) business days from the formal ICAP request to provide a plan, in writing, to address or remediate the deficiency.

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b. The internal department or FDR shall provide a written response within five (5) business days of receiving an ICAP request, detailing how it will mitigate and prevent further non-compliance. Following the acceptance of the ICAP response, the internal department or FDR is required to resolve the issue in a manner and time frame deemed appropriate by CalOptima Health.

3. A CAP request is the result of material non-compliance with specific requirements that does not rise to the level of an ICAP request.

   a. The internal department or FDR is required to respond to the CAP request within ten (10) business days. CalOptima Health's Chief Compliance Officer or Designee, or the applicable department leadership or their Designee, may authorize extensions to this timeline on a case-by-case basis. Following the acceptance of the CAP response, the internal department or FDR is required to resolve the issue in a manner and time frame deemed appropriate by CalOptima Health.

4. An ICAP or CAP response shall include the following elements:

   a. A root cause analysis of the deficiency which may include a description of the policies and procedures, staffing, training, and systems that failed;

   b. Steps taken to resolve the deficiency;

   c. Steps taken to avoid reoccurrence;

   d. Method for implementation and completion of ICAP response or CAP response;

   e. Individual(s) responsible for implementation of the ICAP response or CAP response;

   f. An attestation by the internal department's Executive Officer responsible for the area subject to the CAP, or their Designee, or FDR, conveying a plan to remedy its identified deficiencies; and

   g. ICAP response or CAP response completion date(s), as applicable.

C. Unacceptable Resolution to an ICAP or CAP

1. If the resolution to the deficiency is unacceptable or the internal department or FDR fails to respond, CalOptima Health shall issue a written notice to the internal department or the FDR, which shall include:

   a. A summary of previous outreach and required action(s);

   b. An explanation of why that the resolution was not acceptable, or why a response was not received;

   c. A revised response timeline of two (2) business days for an ICAP;

      i. Extensions to this timeline may be authorized on a case-by-case basis by CalOptima Health's Chief Compliance Officer or Designee, or the applicable department leadership or their Designee.

   d. A revised response timeline of five (5) business days for a CAP;

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i. Extensions to this timeline may be authorized on a case-by-case basis by CalOptima Health's Chief Compliance Officer or Designee, or the applicable department leadership or their Designee.

e. Explain the possible consequences, specific to the nature of the issue and degree of completeness in accordance with CalOptima Health Policy HH.2002: Sanctions;

f. Possibility of scheduling a required meeting with the internal department or the FDR to discuss the unacceptable response or the internal department or FDR's failure to respond.

g. Possibility of escalating to the department's Chief, or the FDR's Chief Executive Officer (CEO) or their Designee; and

h. Possibility of referral to the Delegation Oversight Committee (DOC) and the Compliance Committee.

D. Acceptable Resolution with ICAP or CAP Requirements

1. A response may be accepted once all requirements outlined in Section III.B.4 of this Policy are fulfilled. If an ICAP or CAP response requires Monitoring or a focused Audit, the ICAP or CAP response shall not be closed until the remediation(s) implemented has been validated and demonstrate that the issue will not recur.

a. A response may be accepted and closed simultaneously if Monitoring or a focused Audit is not required.

2. If the resolution to the deficiency is deemed acceptable by CalOptima Health's Chief Compliance Officer or Designee or the applicable department leadership or their Designee, CalOptima Health may issue a written notification of acceptance, which shall include:

a. An acknowledgement of acceptance;

b. A description of follow up actions which shall include, but is not limited to:

i. Submission of finalized documentation; and/or

ii. Focused Audit, as described in Section III.E. of this Policy; and/or

iii. Monitoring, as deemed appropriate by CalOptima Health, and as described in Section III.F. of this Policy.

3. If the resolution to the deficiency is accepted and deemed sufficient by CalOptima Health's Chief Compliance Officer or Designee or the applicable department leadership or their Designee, CalOptima Health shall issue a written notification of closure, which shall include:

a. An acknowledgement of closure;

b. The effective date of closure; and

c. Consequences of repeat deficiencies.

E. Focused Audits

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1. CalOptima Health may conduct a focused Audit of an internal department or FDR to confirm implementation of the accepted ICAP or CAP response.

2. CalOptima Health shall notify the internal department or FDR of the scope, Audit period, and Audit deliverables that shall be required to complete the focused Audit.

3. CalOptima Health may continue to Monitor and/or Audit an internal department or FDR for performance of issues and/or functions related to the ICAP or CAP request.

F. Monitoring Period

1. CalOptima Health may conduct Monitoring of the internal department's or FDR's resolution to confirm implementation of the accepted ICAP or CAP response.

2. CalOptima Health shall Monitor the resolution for a predetermined time frame for example, not more than 90 days after a "cure" has been affected to ensure ongoing compliance, as established by CalOptima Health.

3. CalOptima Health shall notify the internal department, or FDR, of the scope, Monitoring period, and deliverables that shall be required to complete the Monitoring.

4. CalOptima Health may continue to Monitor and/or Audit an internal department's or FDR's performance of issues and/or functions related to the ICAP or CAP request.

G. Failure to Maintain Adequate Resolution

1. If during the Monitoring period or the focused Audit the internal department or FDR fails to maintain the remedies in place, CalOptima Health may conduct an additional focused audit, extend the monitoring period, or re-assess the ICAP or CAP responses, including the implemented controls and monitoring efforts.

2. In the instance of an ICAP, the internal department or FDR shall be required to re-assess and resolve the issue within two (2) business days from the notification of failed focused audit or monitoring period.

   a. Extensions to this timeline may be authorized on a case-by-case basis by the Chief Compliance Officer or Designee, or the applicable department leadership or their Designee.

H. ICAP and CAP Tracking and Reporting

1. CalOptima Health's Office of Compliance or responsible department shall track all CAP and ICAP requests issued utilizing a standardized tool.

2. CalOptima Health's Office of Compliance shall report the status of all CAP/ICAP requests to the DOC and the Compliance Committee.

3. In the event that CalOptima Health's Office of Compliance makes a determination to self-disclose the ICAP or significant incident of noncompliance with respect to the CalOptima Health Medi-Cal or Medicare Program, the Regulatory Affairs & Compliance Department shall report the issue to CalOptima Health's DHCS Contract Manager and/or CMS Account Manager.

   a. The Office of Compliance will submit the Self-Disclosure report to the Chief Compliance Officer for review and sign off.

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b. Once the above step has been completed, and an accepted CAP (if applicable) has been submitted, the Chief Compliance Officer, or Designee, will submit the non-compliance incident to DHCS and/or CMS, including any steps taken to correct the non-compliance, immediately, but no later than the referenced time frame for Medicare in accordance with CalOptima Health Policy MA.9124: Self-Disclosure of Non-Compliance Issues, and three (3) business days for Medi-Cal.

c. CalOptima Health shall report the incident to DHCS and/or CMS as soon as possible after its discovery.

4. If CalOptima Health's internal department, or FDR, has repeated deficiencies, the issue(s) shall be reported to the DOC and the Compliance Committee for further action.

I. CalOptima Health shall maintain and publicly post its annual DHCS Medical Audit report, records of CAPs and the rectifying actions to close out the findings. If warranted, updates on the audit outcomes shall be available for detailed discussion, via the monthly report to the Board of Directors and/or its subcommittees, as necessary.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Compliance Plan
B. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima Health PACE Program Agreement
E. CalOptima Health Policy GG.1615: Corrective Action Plan for Practitioners and Organizational Providers
F. CalOptima Health Policy HH.2002: Sanctions
G. CalOptima Health Policy MA.9124: Self-Disclosure of Non-Compliance Issues
H. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-006: Delegation and Subcontractor Network Certification (Supersedes APL 17-004)
I. ICAP/CAP Request Template
J. Medicare Managed Care Manual, Chapter 21
K. Medicare Prescription Drug Benefit Manual, Chapter 9
L. Title 22, California Code of Regulations (CCR), §51301 et. seq.

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
06/08/2022	Department of Health Care Services (DHCS)	File and Use
10/23/2023	Department of Health Care Services (DHCS)	File and Use
02/21/2024	Department of Health Care Services (DHCS)	File and Use

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors

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08/02/2018	Regular Meeting of the CalOptima Board of Directors
12/06/2018	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
05/05/2022	Regular Meeting of the CalOptima Board of Directors
12/01/2022	Regular Meeting of the CalOptima Health Board of Directors
10/05/2023	Regular Meeting of the CalOptima Health Board of Directors
11/07/2024	Regular Meeting of the CalOptima Health Board of Directors
11/06/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	11/01/1998	HH.2005	Health Network Corrective Action Plan	Medi-Cal
Revised	10/01/2002	HH.2005	Health Network Corrective Action Plan	Medi-Cal
Revised	06/01/2007	HH.2005	Health Network Corrective Action Plan	Medi-Cal
Revised	04/01/2013	HH.2005	Corrective Action Plan	Medi-Cal OneCare
Revised	09/01/2015	HH.2005	Corrective Action Plan	Medi-Cal
Revised	12/01/2016	HH.2005	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE
Revised	12/07/2017	HH.2005	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE
Revised	08/02/2018	HH.2005	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.2005	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.2005	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE
Revised	12/03/2020	HH.2005	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE
Revised	12/20/2021	HH.2005	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE
Revised	05/05/2022	HH.2005	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE

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Action	Date	Policy	Policy Title	Program(s)
Revised	12/31/2022	HH.2005	Corrective Action Plan	Medi-Cal OneCare PACE
Revised	09/01/2023	HH.2005	Corrective Action Plan	Medi-Cal OneCare PACE
Revised	02/01/2024	HH.2005	Corrective Action Plan	Medi-Cal OneCare PACE
Revised	11/07/2024	HH.2005	Corrective Action Plan	Medi-Cal OneCare PACE
Revised	10/01/2025	HH.2005	Corrective Action Plan	Medi-Cal OneCare 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.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima Health, the Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima Health departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima Health and its regulators.
Delegation Oversight Committee (DOC)	Medi-Cal: A subcommittee of the Compliance Committee chaired by the Director(s) of Delegation Oversight to oversee CalOptima Health's delegated functions. The composition of the DOC includes representatives from CalOptima Health's departments as provided for in CalOptima Health Policy HH.4001: Delegation Oversight Committee. OneCare: A subcommittee of the Compliance Committee chaired by the Director of the Delegation Oversight department to oversee CalOptima Health's delegated functions. The composition of the DOC includes representatives from CalOptima Health's operational departments.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
DHCS Medical Audit	For the purpose of this policy, a DHCS Medical Audit refers to the annual evaluation conducted by DHCS in accordance with Welfare and Institutions Code 14456. The DHCS Medical audit is conducted to ascertain that medical services provided to CalOptima Health's members comply with federal and state laws, Medi-Cal regulations and guidelines and its contract with DHCS.
Downstream Entity	Medi-Cal: Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Health Program benefit, below the level of arrangement between CalOptima Health and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services. OneCare: Any party that enters into an acceptable written arrangement below the level of the arrangement between a Medicare Advantage Organization (MAO) (and contract applicant) and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.
Employee	For purposes of this policy, any and all employees of CalOptima Health, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary employees and volunteers.
First Tier, Downstream, and Related Entities (FDRs)	Means First Tier, Downstream or Related Entity, as separately defined herein.

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Term	Definition
First Tier Entity	Medi-Cal: Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima Health to provide administrative services or health care services to a Member under a CalOptima Health Program. OneCare: Any party that enters into a written arrangement, acceptable to CMS, with an MAO or Part D plan sponsor or applicant to provide administrative services or health care services to a Medicare eligible individual under the Medicare Advantage (MA) program or Part D program.
Immediate Corrective Action Plan (ICAP)	An ICAP is the result of non-compliance with specific requirements that has the potential to cause significant member harm. Significant member harm exists if the non-compliance resulted in the failure to provide medical items, services or prescription drugs, causing financial distress, or posing a threat to member's health and safety due to non-existent or inadequate policies and procedures, systems, operations or staffing.
Immediate Corrective Action Plan (ICAP) Request	The result of non-compliance with specific requirements that has the potential to cause significant Member harm. Significant Member harm exists if the noncompliance resulted in the failure to provide medical services or prescription drugs, causing financial distress, or posing a threat to Member's health and safety due to non-existent or inadequate policies and procedures, systems, operations or staffing.
Member	A beneficiary enrolled in a CalOptima Health 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.
Related Entity	Any entity that is related to the MAO or Part D program by common ownership or control and: 1. Performs some of the MAO or Part D program's management functions under contract or delegation; 2. Furnishes services to Medicare enrollees under an oral or written agreement; or 3. Leases real property or sells materials to the MAO or Part D Program at a cost of more than two thousand five hundred dollars ($2,500) during a contract period.
Sanction	An action taken by CalOptima Health, including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on an FDR's or its agent's failure to comply with statutory, regulatory, contractual, and/or other requirements related to CalOptima Health Programs.

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Policy:	HH.2007
Title:	**Compliance Committee**
Department:	Office of Compliance
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	09/01/2015
Revised Date:	09/01/2025
Applicable to:	☐ Administrative ☐ Covered California [Effective 2027] ☒ Medi-Cal ☒ OneCare ☒ PACE

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I. PURPOSE

This policy describes the role and responsibilities of CalOptima Health's Compliance Committee in ensuring and enforcing compliance with ethical standards, regulatory requirements, contractual obligations, the Compliance Program, including the Compliance Plan, Code of Conduct, Anti-Fraud, Waste, and Abuse (FWA) Plan, HIPAA Privacy and Security Program, and all applicable CalOptima Health policies and procedures.

II. POLICY

A. For the purpose of CalOptima Health's Medi-Cal program, the Compliance Committee shall also serve as the Regulatory Compliance and Oversight Committee and will herein only be referred to as the Compliance Committee.

B. The Compliance Committee shall oversee compliance efforts in accordance with the Compliance Program, including the Compliance Plan, Code of Conduct, Anti-Fraud, Waste, and Abuse (FWA) Plan, HIPAA Privacy and Security Program, all applicable state and federal regulations, policies and procedures, and federal and state contracts.

C. The Compliance Committee shall recommend and monitor, in collaboration with the Office of Compliance, the development of internal processes and procedures to implement and support the Compliance Plan, Code of Conduct, the FWA Plan, HIPAA Privacy and Security Program, and adherence to relevant statutory, regulatory, and contractual obligations.

D. The Compliance Committee shall review the Compliance Plan on an annual basis.

E. The Office of Compliance shall provide summary updates of all issued Corrective Action Plan(s) (CAPs) to the Compliance Committee for review. The Compliance Committee shall Monitor and report on the effectiveness of issued CAPs.

F. The Director, Delegation Oversight shall report on behalf of the Delegation Oversight Committee (DOC) summary updates of all issued CAPs and the status of the CAPs.

III. PROCEDURE

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A. Compliance Committee Organization

1. The Chief Compliance Officer shall serve as chairperson of the Compliance Committee.

2. The Directors of Medicare Regulatory Affairs & Compliance and Medi-Cal Regulatory Affairs & Compliance shall serve as co-vice chairpersons and are considered the chairperson's Designees.

3. Members of the Compliance Committee are designated and/or selected from their senior level executives representing the various functional areas of the organization. The Compliance Committee shall consist of Executive staff that may include, but is not limited to, the: Chief Executive Officer; Chief Medical Officer; Chief Operating Officer; Chief Financial Officer; Chief Compliance Officer; and Chief Information Officer.

4. Each member of the Compliance Committee is a voting member. Voting members may appoint a Designee, when deemed appropriate. The Designee may serve as a subject matter expert at the Compliance Committee meeting; however, the Designee will not have voting rights unless approved in advance by the Chief Compliance Officer.

5. At the request of the chairperson of the Compliance Committee, CalOptima Health Employees may be requested to attend a Compliance Committee meeting on an ad-hoc basis. Attendance may be warranted to support discussion items at the Compliance Committee meeting and/or to provide clarification for the voting members.

6. Activities of the Compliance Committee, to the extent not deemed privileged and confidential, shall be disclosable.

B. Compliance Committee Meetings

1. The Compliance Committee shall meet at least on a quarterly basis, or more frequently, as significant non-compliant and/or FWA issues are identified outside of the quarterly time period, as determined by the Chief Compliance Officer. Annually, Compliance Committee members shall receive a calendar of meetings for the calendar year as well as a reporting matrix which includes all planned reports to be presented during scheduled Compliance Committee meetings.

2. A committee binder is distributed to all meeting attendees, electronically, prior to the Compliance Committee meeting. The committee binder shall include, but is not limited to:

   a. Current meeting agenda;

   b. Final draft meeting minutes from the previous Compliance Committee for approval;

   c. Listing of open action items;

   d. Submitted Compliance Committee reports;

   e. Scheduled audit reports;

   f. CAP monitoring;

   g. Notices of Non-Compliance; and

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h. Special reports, which may include, but not be limited to, any reports not regularly presented to the Compliance Committee that may be of interest or concern or is intermittent in nature.

3. Minutes of Compliance Committee meetings shall be maintained, electronically, by the Office of Compliance in the normal course of business.

4. Ad-hoc Compliance Committee meetings may be held at the discretion of the chairperson, as deemed appropriate.

C. Compliance Committee Responsibilities

1. The Compliance Committee responsibilities include, but are not limited to:

a. Determine the appropriate strategy and/or approach to promote compliance; to prevent, detect, and correct potential violations; and to advise the Chief Compliance Officer accordingly;

b. Review and approve training related to compliance and FWA and ensure that training and education are effective and appropriately completed;

c. Annually review, provide input and approve, Office of Compliance Annual Risk Assessment and Monitoring and Auditing work plan;

d. Review and Monitor the effectiveness of the Compliance Program, including Monitoring key performance reports and metrics, evaluating business and administrative operations, and overseeing the creation, implementation, and development of corrective and preventive action(s) to ensure they are prompt and effective;

e. Maintain and update the Compliance Plan and Code of Conduct consistent with regulatory requirements and/or operational changes, subject to the ultimate approval by the CalOptima Health Board of Directors;

f. Review overall effectiveness of the internal controls designed to ensure compliance with applicable regulations in daily operations;

g. Receive reports from the Chief Compliance Officer, on at least a quarterly basis, concerning the Compliance Program;

h. Review and approve recommendations of appropriate actions to ensure CalOptima Health is complying with the applicable laws, regulations, and ethical standards;

i. Ensure legal counsel is consulted as appropriate and all applicable rights are preserved, including the attorney-client privilege;

j. Ensure CalOptima Health has a Compliance & Ethics Hotline and an Office of Compliance email address for CalOptima Health Members, members of the Governing Body, Employees, and FDRs to ask compliance questions and report potential issues regarding any CalOptima Health program. Inquiries may include, but are not limited to, non-compliance and potential FWA. Information presented shall be handled confidentially (to the extent permitted by applicable law and circumstances) and may be submitted anonymously, if desired by the informant, without fear of retaliation, in accordance with CalOptima Health Policy HH.3012: Non-Retaliation for Reporting Violations;

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k. Ensure CalOptima Health has appropriate and current compliance policies and procedures;

l. Review and address reports of Monitoring and Auditing of areas in which CalOptima Health is at risk of program non-compliance and/or potential FWA, and ensure CAPs and ICAPs are implemented and Monitored for effectiveness;

m. Provide regular and ad-hoc status reports of compliance with recommendations to the CalOptima Health Board of Directors;

n. Maintain written notes, records, correspondence, or minutes (as appropriate) of Compliance Committee meetings reflecting reports made to the Compliance Committee and the Compliance Committee's decisions on the issues raised (subject to all applicable privileges).

o. Analyze applicable federal and state programs, including contractual, legal, and regulatory requirements, along with areas of risk, and coordinate with the Chief Compliance Officer to ensure the adequacy of the Compliance Program; and

p. Review the Office of Compliance's process for soliciting, evaluating, and responding to reports and disclosures within the Compliance Program.

2. The Compliance Committee, in collaboration with the DOC, shall evaluate the effectiveness of such corrective actions in collaboration with the appropriate CalOptima Health departments and shall make recommendations regarding ongoing Monitoring activities to ensure continuing compliance.

D. The Compliance Committee chairperson shall report to the CalOptima Health Board of Directors on at least a quarterly basis.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Code of Conduct
B. CalOptima Health Compliance Plan
C. CalOptima Health Compliance Committee Charter
D. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
E. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
F. CalOptima Health PACE Program Agreement
G. CalOptima Health Policy HH.2002: Sanctions
H. CalOptima Health Policy HH.2005: Corrective Action Plan
I. CalOptima Health Policy HH.2014: Compliance Program
J. CalOptima Health Policy HH.3012: Non-Retaliation for Reporting Violations
K. Medicare Managed Care Manual, Chapter 21
L. Medicare Prescription Drug Benefit Manual, Chapter 9
M. Title 42, Code of Federal Regulations (CFR), §455.2
N. Welfare and Institutions Code, §14043.1(a)

VI. REGULATORY AGENCY APPROVAL(S)

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None to Date

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/06/2018	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
11/07/2024	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	09/01/2015	HH.2007	Compliance Committee	Medi-Cal
Revised	12/01/2016	HH.2007	Compliance Committee	Medi-Cal OneCare OneCare Connect PACE
Revised	12/07/2017	HH.2007	Compliance Committee	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.2007	Compliance Committee	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.2007	Compliance Committee	Medi-Cal OneCare OneCare Connect PACE
Revised	12/03/2020	HH.2007	Compliance Committee	Medi-Cal OneCare OneCare Connect PACE
Revised	12/20/2021	HH.2007	Compliance Committee	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	HH.2007	Compliance Committee	Medi-Cal OneCare PACE
Revised	09/01/2023	HH.2007	Compliance Committee	Medi-Cal OneCare PACE
Revised	11/07/2024	HH.2007	Compliance Committee	Medi-Cal OneCare PACE

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Action	Date	Policy	Policy Title	Program(s)
Revised	09/01/2025	HH.2007	Compliance Committee	Medi-Cal OneCare PACE

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IX. GLOSSARY

Term	Definition
Abuse	Medi-Cal: Practices that are inconsistent with sound fiscal and business practices or medical standards, and result in an unnecessary cost to the Medi-Cal program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to the Medi-Cal program. OneCare: A Provider practice that is inconsistent with sound fiscal, business, or medical practice, and results in an unnecessary cost to CalOptima Health and the OneCare program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to CalOptima Health and the OneCare program.
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.
Code of Conduct	The statement setting forth the principles and standards governing CalOptima Health's activities to which CalOptima Health's Board of Directors, employees, contractors, and agents are required to adhere.
Compliance Committee	This CalOptima Health committee consists of executive officers, managers of key operating divisions, and legal counsel and oversees the implementation of CalOptima Health's Compliance Program.
Compliance Program	Medi-Cal: The program including, without limitation, the Compliance Plan, Code of Conduct, and CalOptima Health policies, developed and adopted by CalOptima Health to promote, monitor, and ensure that CalOptima Health's operations and practices and the practices of its Board Members, employees, contractors, and providers comply with applicable law and ethical standards. OneCare: A comprehensive program that incorporates the fundamental elements identified by the state and federal governments and CalOptima Health as necessary to prevent and detect violations of ethical standards, contractual obligations, and applicable laws and the involvement of CalOptima Health's governing body and executive staff. Elements of the Compliance Program include standards, oversight, training, reporting, monitoring, enforcement, and remediation. The Compliance Program applies to CalOptima Health's Board of Directors, employees, and contractors including delegated entities, providers, and suppliers.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima Health, the Centers of Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima Health departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima Health and its regulators.

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Term	Definition
Delegation Oversight Committee (DOC)	Medi-Cal: A subcommittee of the Compliance Committee chaired by the Director(s) of Delegation Oversight to oversee CalOptima Health's delegated functions. The composition of the DOC includes representatives from CalOptima Health's departments as provided for in CalOptima Health Policy HH.4001: Delegation Oversight Committee. OneCare: A subcommittee of the Compliance Committee chaired by the Director of the Delegation Oversight department to oversee CalOptima Health's delegated functions. The composition of the DOC includes representatives from CalOptima Health's operational departments.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Downstream Entity	Medi-Cal: Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Health Program benefit, below the level of arrangement between CalOptima Health and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services. OneCare: Any party that enters into an acceptable written arrangement below the level of the arrangement between a Medicare Advantage Organization (MAO) (and contract applicant) and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.
Employee	For purposes of this policy, any and all employees of CalOptima Health, including all permanent and temporary employees, volunteers, and other employed personnel.
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, Health Maintenance Organizations, suppliers and consultants, including those that contract with CalOptima Health as well as those that are Downstream or Related Entities.
First Tier Entity	Medi-Cal: Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima Health to provide administrative services or health care services to a Member under a CalOptima Health Program. OneCare: Any party that enters into a written arrangement, acceptable to CMS, with an MAO or Part D plan sponsor or applicant to provide administrative services or health care services to a Medicare eligible individual under the Medicare Advantage (MA) program or Part D program.
Fraud	An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law, in accordance with Title 42 Code of Federal Regulations section 455.2, Welfare and Institutions Code section 14043.1(i).
Governing Body	The Board of Directors of CalOptima Health.

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Term	Definition
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.
Related Entity	Any entity that is related to the MAO or Part D program by common ownership or control and: 1. Performs some of the MAO or Part D program's management functions under contract or delegation; 2. Furnishes services to Medicare enrollees under an oral or written agreement; or 3. Leases real property or sells materials to the MAO or Part D program at a cost of more than two thousand five hundred dollars ($2,500) during a contract period.
Waste	Medi-Cal: The overutilization or inappropriate utilization of services and misuse of resources. OneCare: The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Health Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

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Policy:	HH.2007
Title:	**Compliance Committee**
Department:	Office of Compliance
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	09/01/2015
Revised Date:	09/01/2025
Applicable to:	☐ Administrative ☐ Covered California [Effective 2027] ☒ Medi-Cal ☒ OneCare ☒ PACE

For 2025 106 BOD Review Only

I. PURPOSE

This policy describes the role and responsibilities of CalOptima Health's Compliance Committee in ensuring and enforcing compliance with ethical standards, regulatory requirements, contractual obligations, the Compliance Program, including the Compliance Plan, Code of Conduct, Anti-Fraud, Waste, and Abuse (FWA) Plan, HIPAA Privacy and Security Program, and all applicable CalOptima Health policies and procedures.

II. POLICY

A. For the purpose of CalOptima Health's Medi-Cal program, the Compliance Committee shall also serve as the Regulatory Compliance and Oversight Committee and will herein only be referred to as the Compliance Committee.

B. The Compliance Committee shall oversee compliance efforts in accordance with the Compliance Program, including the Compliance Plan, Code of Conduct, Anti-Fraud, Waste, and Abuse (FWA) Plan, HIPAA Privacy and Security Program, all applicable state and federal regulations, policies and procedures, and federal and state contracts.

C. The Compliance Committee shall recommend and monitor, in collaboration with the Office of Compliance, the development of internal processes and procedures to implement and support the Compliance Plan, Code of Conduct, the FWA Plan, HIPAA Privacy and Security Program, and adherence to relevant statutory, regulatory, and contractual obligations.

D. The Compliance Committee shall review the Compliance Plan on an annual basis.

E. The Office of Compliance shall provide summary updates of all issued Corrective Action Plan(s) (CAPs) to the Compliance Committee for review. The Compliance Committee shall Monitor and report on the effectiveness of issued CAPs.

F. The Director, Delegation Oversight shall report on behalf of the Delegation Oversight Committee (DOC) summary updates of all issued CAPs and the status of the CAPs.

III. PROCEDURE

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A. Compliance Committee Organization

1. The Chief Compliance Officer shall serve as chairperson of the Compliance Committee.

2. The Directors of Medicare Regulatory Affairs & Compliance and Medi-Cal Regulatory Affairs & Compliance shall serve as co-vice chairpersons and are considered the chairperson's Designees.

3. Members of the Compliance Committee are designated and/or selected from their senior level executives representing the various functional areas of the organization. The Compliance Committee shall consist of Executive staff that may include, but is not limited to, the: Chief Executive Officer; Chief Medical Officer; Chief Operating Officer; Chief Financial Officer; Chief Compliance Officer; and Chief Information Officer.

4. Each member of the Compliance Committee is a voting member. Voting members may appoint a Designee, when deemed appropriate. The Designee may serve as a subject matter expert at the Compliance Committee meeting; however, the Designee will not have voting rights unless approved in advance by the Chief Compliance Officer.

5. At the request of the chairperson of the Compliance Committee, CalOptima Health Employees may be requested to attend a Compliance Committee meeting on an ad-hoc basis. Attendance may be warranted to support discussion items at the Compliance Committee meeting and/or to provide clarification for the voting members.

6. Activities of the Compliance Committee, to the extent not deemed privileged and confidential, shall be disclosable.

B. Compliance Committee Meetings

1. The Compliance Committee shall meet at least on a quarterly basis, or more frequently, as significant non-compliant and/or FWA issues are identified outside of the quarterly time period, as determined by the Chief Compliance Officer. Annually, Compliance Committee members shall receive a calendar of meetings for the calendar year as well as a reporting matrix which includes all planned reports to be presented during scheduled Compliance Committee meetings.

2. A committee binder is distributed to all meeting attendees, electronically, prior to the Compliance Committee meeting. The committee binder shall include, but is not limited to:

   a. Current meeting agenda;

   b. Final draft meeting minutes from the previous Compliance Committee for approval;

   c. Listing of open action items;

   d. Submitted Compliance Committee reports;

   e. Scheduled audit reports;

   f. CAP monitoring;

   g. Notices of Non-Compliance; and

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h. Special reports, which may include, but not be limited to, any reports not regularly presented to the Compliance Committee that may be of interest or concern or is intermittent in nature.

3. Minutes of Compliance Committee meetings shall be maintained, electronically, by the Office of Compliance in the normal course of business.

4. Ad-hoc Compliance Committee meetings may be held at the discretion of the chairperson, as deemed appropriate.

C. Compliance Committee Responsibilities

1. The Compliance Committee responsibilities include, but are not limited to:

a. Determine the appropriate strategy and/or approach to promote compliance; to prevent, detect, and correct potential violations; and to advise the Chief Compliance Officer accordingly;

b. Review and approve training related to compliance and FWA and ensure that training and education are effective and appropriately completed;

c. Annually review, provide input and approve, Office of Compliance Annual Risk Assessment and Monitoring and Auditing work plan;

d. Review and Monitor the effectiveness of the Compliance Program, including Monitoring key performance reports and metrics, evaluating business and administrative operations, and overseeing the creation, implementation, and development of corrective and preventive action(s) to ensure they are prompt and effective;

e. Maintain and update the Compliance Plan and Code of Conduct consistent with regulatory requirements and/or operational changes, subject to the ultimate approval by the CalOptima Health Board of Directors;

f. Review overall effectiveness of the internal controls designed to ensure compliance with applicable regulations in daily operations;

g. Receive reports from the Chief Compliance Officer, on at least a quarterly basis, concerning the Compliance Program;

h. Review and approve recommendations of appropriate actions to ensure CalOptima Health is complying with the applicable laws, regulations, and ethical standards;

i. Ensure legal counsel is consulted as appropriate and all applicable rights are preserved, including the attorney-client privilege;

j. Ensure CalOptima Health has a Compliance & Ethics Hotline and an Office of Compliance email address for CalOptima Health Members, members of the Governing Body, Employees, and FDRs to ask compliance questions and report potential issues regarding any CalOptima Health program. Inquiries may include, but are not limited to, non-compliance and potential FWA. Information presented shall be handled confidentially (to the extent permitted by applicable law and circumstances) and may be submitted anonymously, if desired by the informant, without fear of retaliation, in accordance with CalOptima Health Policy HH.3012: Non-Retaliation for Reporting Violations;

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k. Ensure CalOptima Health has appropriate and current compliance policies and procedures;

l. Review and address reports of Monitoring and Auditing of areas in which CalOptima Health is at risk of program non-compliance and/or potential FWA, and ensure CAPs and ICAPs are implemented and Monitored for effectiveness;

m. Provide regular and ad-hoc status reports of compliance with recommendations to the CalOptima Health Board of Directors;

n. Maintain written notes, records, correspondence, or minutes (as appropriate) of Compliance Committee meetings reflecting reports made to the Compliance Committee and the Compliance Committee's decisions on the issues raised (subject to all applicable privileges).

o. Analyze applicable federal and state programs, including contractual, legal, and regulatory requirements, along with areas of risk, and coordinate with the Chief Compliance Officer to ensure the adequacy of the Compliance Program; and

p. Review the Office of Compliance's process for soliciting, evaluating, and responding to reports and disclosures within the Compliance Program.

2. The Compliance Committee, in collaboration with the DOC, shall evaluate the effectiveness of such corrective actions in collaboration with the appropriate CalOptima Health departments and shall make recommendations regarding ongoing Monitoring activities to ensure continuing compliance.

D. The Compliance Committee chairperson shall report to the CalOptima Health Board of Directors on at least a quarterly basis.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Code of Conduct
B. CalOptima Health Compliance Plan
C. CalOptima Health Compliance Committee Charter
D. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
E. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
F. CalOptima Health PACE Program Agreement
G. CalOptima Health Policy HH.2002: Sanctions
H. CalOptima Health Policy HH.2005: Corrective Action Plan
I. CalOptima Health Policy HH.2014: Compliance Program
J. CalOptima Health Policy HH.3012: Non-Retaliation for Reporting Violations
K. Medicare Managed Care Manual, Chapter 21
L. Medicare Prescription Drug Benefit Manual, Chapter 9
M. Title 42, Code of Federal Regulations (CFR), §455.2
N. Welfare and Institutions Code, §14043.1(a)

VI. REGULATORY AGENCY APPROVAL(S)

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None to Date

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/06/2018	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
11/07/2024	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	09/01/2015	HH.2007	Compliance Committee	Medi-Cal
Revised	12/01/2016	HH.2007	Compliance Committee	Medi-Cal OneCare OneCare Connect PACE
Revised	12/07/2017	HH.2007	Compliance Committee	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.2007	Compliance Committee	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.2007	Compliance Committee	Medi-Cal OneCare OneCare Connect PACE
Revised	12/03/2020	HH.2007	Compliance Committee	Medi-Cal OneCare OneCare Connect PACE
Revised	12/20/2021	HH.2007	Compliance Committee	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	HH.2007	Compliance Committee	Medi-Cal OneCare PACE
Revised	09/01/2023	HH.2007	Compliance Committee	Medi-Cal OneCare PACE
Revised	11/07/2024	HH.2007	Compliance Committee	Medi-Cal OneCare PACE

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Action	Date	Policy	Policy Title	Program(s)
Revised	09/01/2025	HH.2007	Compliance Committee	Medi-Cal OneCare PACE

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IX. GLOSSARY

Term	Definition
Abuse	Medi-Cal: Practices that are inconsistent with sound fiscal and business practices or medical standards, and result in an unnecessary cost to the Medi-Cal program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to the Medi-Cal program. OneCare: A Provider practice that is inconsistent with sound fiscal, business, or medical practice, and results in an unnecessary cost to CalOptima Health and the OneCare program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to CalOptima Health and the OneCare program.
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.
Code of Conduct	The statement setting forth the principles and standards governing CalOptima Health's activities to which CalOptima Health's Board of Directors, employees, contractors, and agents are required to adhere.
Compliance Committee	This CalOptima Health committee consists of executive officers, managers of key operating divisions, and legal counsel and oversees the implementation of CalOptima Health's Compliance Program.
Compliance Program	Medi-Cal: The program including, without limitation, the Compliance Plan, Code of Conduct, and CalOptima Health policies, developed and adopted by CalOptima Health to promote, monitor, and ensure that CalOptima Health's operations and practices and the practices of its Board Members, employees, contractors, and providers comply with applicable law and ethical standards. OneCare: A comprehensive program that incorporates the fundamental elements identified by the state and federal governments and CalOptima Health as necessary to prevent and detect violations of ethical standards, contractual obligations, and applicable laws and the involvement of CalOptima Health's governing body and executive staff. Elements of the Compliance Program include standards, oversight, training, reporting, monitoring, enforcement, and remediation. The Compliance Program applies to CalOptima Health's Board of Directors, employees, and contractors including delegated entities, providers, and suppliers.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima Health, the Centers of Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima Health departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima Health and its regulators.

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Term	Definition
Delegation Oversight Committee (DOC)	Medi-Cal: A subcommittee of the Compliance Committee chaired by the Director(s) of Delegation Oversight to oversee CalOptima Health's delegated functions. The composition of the DOC includes representatives from CalOptima Health's departments as provided for in CalOptima Health Policy HH.4001: Delegation Oversight Committee. OneCare: A subcommittee of the Compliance Committee chaired by the Director of the Delegation Oversight department to oversee CalOptima Health's delegated functions. The composition of the DOC includes representatives from CalOptima Health's operational departments.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Downstream Entity	Medi-Cal: Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Health Program benefit, below the level of arrangement between CalOptima Health and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services. OneCare: Any party that enters into an acceptable written arrangement below the level of the arrangement between a Medicare Advantage Organization (MAO) (and contract applicant) and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.
Employee	For purposes of this policy, any and all employees of CalOptima Health, including all permanent and temporary employees, volunteers, and other employed personnel.
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, Health Maintenance Organizations, suppliers and consultants, including those that contract with CalOptima Health as well as those that are Downstream or Related Entities.
First Tier Entity	Medi-Cal: Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima Health to provide administrative services or health care services to a Member under a CalOptima Health Program. OneCare: Any party that enters into a written arrangement, acceptable to CMS, with an MAO or Part D plan sponsor or applicant to provide administrative services or health care services to a Medicare eligible individual under the Medicare Advantage (MA) program or Part D program.
Fraud	An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law, in accordance with Title 42 Code of Federal Regulations section 455.2, Welfare and Institutions Code section 14043.1(i).
Governing Body	The Board of Directors of CalOptima Health.

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Term	Definition
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.
Related Entity	Any entity that is related to the MAO or Part D program by common ownership or control and: 1. Performs some of the MAO or Part D program's management functions under contract or delegation; 2. Furnishes services to Medicare enrollees under an oral or written agreement; or 3. Leases real property or sells materials to the MAO or Part D program at a cost of more than two thousand five hundred dollars ($2,500) during a contract period.
Waste	Medi-Cal: The overutilization or inappropriate utilization of services and misuse of resources. OneCare: The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Health Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

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Policy:	HH.2022
Title:	**Record Retention and Access**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance
CEO Approval:	*/s/*
Effective Date:	06/01/2013
Revised Date:	09/01/2025
Applicable to:	☐ Administrative ☐ Covered California [Effective 2027] ☒ Medi-Cal ☒ OneCare ☒ PACE

For 20251106 POD Review Only

I. PURPOSE

This policy establishes the requirements for CalOptima Health and its First Tier, Downstream, and Related Entities (FDRs) to retain and make available premises, contracts, books, documents, records, financial statements, equipment, computers, or other electronic systems, in accordance with federal and state regulations for the purpose of any audit, or investigation, of a CalOptima Health program.

II. POLICY

A. CalOptima Health and its FDRs shall retain and make available contracts, books, documents, records, and financial statements, in accordance with the provisions of this Policy. These documents include, but are not limited to, the following:

1. Data relating to Medi-Cal and Medicare utilization and costs;
2. Reinsurance costs;
3. Low-income subsidy payments;
4. Risk corridor costs;
5. Bid calculations;
6. Rebate information;
7. Medical Records;
8. Medical charts and prescription files;
9. Records related to/supporting Health Network Medical Loss Ratio (MLR) calculations;
10. Hierarchical Condition Categories (HCC) and risk adjustment records;
11. Encounter data;

12. Member Grievance and Appeal records;
13. Base data as defined in Title 42, Code of Federal Regulations (C.F.R.), Section 438.5(c);

14. Data, information, and documentation specified in Title 42, C.F.R., Sections 438.604, 606, 608, and 610; and

15. Other documentation pertaining to medical and non-medical services rendered to Members.

16. Documentation of disciplinary actions for a period of ten (10) years at a minimum, including date of and description of violation, date of investigation, findings and date and description of disciplinary action.

B. An FDR shall retain and make available all of its premises, facilities, equipment, contracts, books, documents, records, encounter data (for a period of at least ten (10) years), computers and other electronic systems pertaining to the Covered Services ordered, referred, or rendered under the terms of the Network Provider Agreement, available to CalOptima Health and any authorized state and federal agencies or contractors, as described in Section II.C. 1-9 of this Policy, or their designees, for inspections, evaluations, examinations, copying, monitoring and auditing.

1. If the Department of Health Care Services (DHCS), the Centers for Medicare & Medicaid Services (CMS),or the U.S. Department of Health and Human Services (HHS) Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the HHS Inspector General may inspect, evaluate, and audit an FDR at any time.

2. Upon resolution of a full investigation of Fraud, DHCS reserves the right to suspend or terminate the FDR from participation in the Medi-Cal program; seek recovery of payments made to the FDR; impose other Sanctions provided under the State Plan, and direct CalOptima Health to terminate its agreement with the FDR due to Fraud.

C. Authorized state and federal agencies reserve the right to monitor all aspects of CalOptima Health's operations, including its FDRs, for compliance with the provisions of the CalOptima Health Contracts with DHCS for Medi-Cal and with CMS for Medicare, and applicable federal and state laws and regulations. Monitoring activities will include, but are not limited to, inspection and auditing of facilities, management systems and procedures, and books and records as deemed appropriate by the Director of DHCS, at any time, pursuant to 42 CFR 438.3(h). The monitoring activities will be either announced or unannounced.

III. PROCEDURE

A. CalOptima Health and its FDRs shall provide an authorized entity with the requested and required access to premises, contracts, books, documents, records, financial statements, equipment, computers, or other electronic systems at any time during normal business hours for audit, monitoring, and other investigative activities.

B. CalOptima Health and its FDRs shall maintain and make available all records and documents for a minimum of ten (10) years from the final date of the Contract Period, or from completion of any audit or investigation, whichever is later.

1. If there is a termination, dispute, or allegation of Fraud, or similar fault, document retention requirements for CalOptima Health and its FDRs may be extended to ten (10) years from the date of any resulting final resolution of the termination, dispute, or allegation of Fraud, or similar fault.

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C. CalOptima Health shall retain and make available all of its premises, facilities, equipment, contracts, books, documents, records, encounter data (for a period of at least ten (10) years and in accordance with CalOptima Health's Document Retention Schedule), computers and other electronic systems pertaining to the goods and services provided to Members, to any authorized state and federal agencies or contractors for inspections, evaluations, examinations or copying, monitoring and auditing including, but not limited to:

a. Centers for Medicare & Medicaid Services (CMS);

b. Department of Managed Health Care (DMHC);

c. Department of Health Care Services (DHCS);

d. The U.S. Department of Health and Human Services (HHS) Office of the Inspector General;

e. The Bureau of Medi-Cal Fraud

f. The Comptroller General;

g. Department of Justice;

h. The U.S. Government Accountability Office (GAO)

i. Authorized State agencies, or their duly authorized representatives or designees, including DHCS's External Quality Review Organization (EQRO) contractor; and

j. Any Quality Improvement Organization (QIO) or accrediting organizations, including NCQA, their designees and other representatives of regulatory or accrediting organizations.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Compliance Plan
B. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima Health's Document Retention Schedule
E. CalOptima Health PACE Program Agreement
F. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-006: Delegation and Subcontractor Network Certification (Supersedes APL 17-004)
G. Medicare Managed Care Manual, Chapter 21
H. Medicare Prescription Drug Benefit Manual, Chapter 9
I. Title 42, Code of Federal Regulations (C.F.R.), §422.504(d-e), §423.505(d-e), §438.230(c), §438.3(h), §438.604, §606, §608, §438.3(u); and §610

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
07/12/2013	Department of Health Care Services (DHCS)	Approved as Submitted
01/19/2022	Department of Health Care Services (DHCS)	File and Use

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VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/06/2018	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
11/07/2024	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	06/01/2013	HH.2022	Record Retention and Access	Medi-Cal OneCare
Revised	09/01/2015	HH.2022	Record Retention and Access	Medi-Cal
Revised	12/01/2016	HH.2022	Record Retention and Access	Medi-Cal OneCare OneCare Connect PACE
Revised	12/07/2017	HH.2022	Record Retention and Access	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.2022	Record Retention and Access	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.2022	Record Retention and Access	Medi-Cal OneCare OneCare Connect PACE
Revised	12/03/2020	HH.2022	Record Retention and Access	Medi-Cal OneCare OneCare Connect PACE
Revised	12/20/2021	HH.2022	Record Retention and Access	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	HH.2022	Record Retention and Access	Medi-Cal OneCare PACE
Revised	09/01/2023	HH.2022	Record Retention and Access	Medi-Cal OneCare PACE
Revised	11/07/2024	HH.2022	Record Retention and Access	Medi-Cal OneCare PACE

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Action	Date	Policy	Policy Title	Program(s)
Revised	09/01/2025	HH.2022	Record Retention and Access	Medi-Cal OneCare PACE

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IX. GLOSSARY

Term	Definition
Appeal	Medi-Cal: A review by CalOptima Health of an adverse benefit determination, which includes one of the following actions: 1. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a 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: As defined at 42 CFR §422.561 and §423.560, the procedures that deal with the review of adverse initial determinations made by the plan on health care services or benefits under Part C or D the enrollee believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the enrollee) or on any amounts the enrollee must pay for a service or drug as defined in 42 CFR §422.566(b) and §423.566(b). These appeal procedures include a plan reconsideration or redetermination (also referred to as a level 1 appeal), a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (Council), and judicial review. PACE: A Member's action taken with respect to the PACE organization's noncoverage of, modification of, or nonpayment for, a service including denials, reductions or termination of services, as defined by federal PACE regulation 42 CFR Section 460.122.
Contract Period	For purposes of this policy, this timeframe is the First Tier, Downstream, and Related Entities' (FDR's) contract duration with the Department of Health Care Services (DHCS).
Covered Service	Medi-Cal: Those health care services, set forth in W&I sections 14000 et seq. and 14131 et seq., 22 CCR section 51301 et seq., 17 CCR section 6800 et seq., the Medi-Cal Provider Manual, the California Medicaid State Plan, the California Section 1115 Medicaid Demonstration Project, the contract with DHCS for Medi-Cal, and DHCS APLs that are made the responsibility of CalOptima Health pursuant to the California Section 1915(b) Medicaid Waiver authorizing the Medi-Cal managed care program or other federally approved managed care authorities maintained by DHCS. Covered Services do not include: 1. Home and Community-Based Services (HCBS) program as specified in the DHCS contract for Medi-Cal Exhibit A, Attachment III, Subsections 4.3.15 (Services for Persons with Developmental Disabilities), 4.3.20 (Home and Community-Based Services Programs) regarding waiver programs, 4.3.21 (In-Home Supportive Services), and Department of Developmental Services (DDS) Administered Medicaid Home and

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Term	Definition
	Community-Based Services Waiver. HCBS programs do not include services that are available as an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) service, as described in 22 CCR sections 51184, 51340 and 51340.1. EPSDT services are covered under the DHCS contract for Medi-Cal, as specified in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services), Subsection F4 regarding services for Members less than twenty-one (21) years of age. CalOptima Health is financially responsible for the payment of all EPSDT services; 2. California Children's Services (CCS) as specified in Exhibit A, Attachment III, Subsection 4.3.14 (California Children's Services), except for Contractors providing Whole Child Model (WCM) services; 3. Specialty Mental Health Services as specified in Exhibit A, Attachment III, Subsection 4.3.12 (Mental Health Services); 4. Alcohol and SUD treatment services, and outpatient heroin and other opioid detoxification, except for medications for addiction treatment as specified in Exhibit A, Attachment III, Subsection 4.3.13 (Alcohol and Substance Use Disorder Treatment Services); 5. Fabrication of optical lenses except as specified in Exhibit A, Attachment III, Subsection 5.3.7 (Services for All Members); 6. Direct Observed Therapy for Treatment of Tuberculosis (TB) as specified in Exhibit A, Attachment III, Subsection 4.3.18 (Direct Observed Therapy for Treatment of Tuberculosis); 7. Dental services as specified in W&I sections 14131.10, 14132(h), 14132.22, 14132.23, and 14132.88, and EPSDT dental services as described in 22 CCR section 51340.1(b). However, CalOptima Health is responsible for all Covered Services as specified in Exhibit A, Attachment III, Subsection 4.3.17 (Dental) regarding dental services; 8. Prayer or spiritual healing as specified in 22 CCR section 51312; 9. Educationally Necessary Behavioral Health Services that are covered by a Local Education Agency (LEA) and provided pursuant to a Member's Individualized Education Plan (IEP) as set forth in Education Code section 56340 et seq., Individualized Family Service Plan (IFSP) as set forth in California Government Code (GC) section 95020, or Individualized Health and Support Plan (IHSP). However, CalOptima Health is responsible for all Medically Necessary Behavioral Health Services as specified in Exhibit A, Attachment III Subsection 4.3.16 (School-Based Services); 10. Laboratory services provided under the State serum alpha-feto-protein-testing program administered by the Genetic Disease Branch of California Department of Public Health (CDPH); 11. Pediatric Day Health Care, except for Contractors providing Whole Child Model (WCM) services; 12. State Supported Services; 13. Targeted Case Management (TCM) services as set forth in 42 USC section 1396n(g), W&I sections 14132.48 and 14021.3, 22 CCR sections 51185 and 51351, and as described in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services). However, if Members less than twenty-one (21) years of age are not eligible for or accepted by a Regional Center (RC) or a local government health program for TCM services, CalOptima Health must ensure access to

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Department of Health Care Services (DHCS)	Medi-Cal: The single State department responsible for the administration of the Medi-Cal Program, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), and other health related programs as provided by statute and/or regulation. OneCare: 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. PACE: The single State Department responsible for administration of the federal Medicaid (referred to as Medi-Cal in California) Program.
Department of Managed Health Care (DMHC)	The State agency responsible for administering the Knox-Keene Health Care Service Plan Act of 1975.
Downstream Entity	Medi-Cal: Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Health Program benefit, below the level of arrangement between CalOptima Health and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services. OneCare: Any party that enters into an acceptable written arrangement below the level of the arrangement between a Medicare Advantage Organization (MAO) (and contract applicant) and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.

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External Quality Review	The analysis and review by the External Quality Review Organization (EQRO) of aggregated information on quality, timeliness, and access to the health care services that CalOptima Health, its Subcontractor, its Downstream Subcontractor, or its Network Provider furnishes to Members.
External Quality Review Organization (EQRO)	An organization that meets the competence and independence requirements set forth in 42 CFR section 438.354, and performs EQR and other EQR–related activities as set forth in 42 CFR section 438.358 pursuant to its contract with DHCS.
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	Medi-Cal: Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima Health to provide administrative services or health care services to a Member under a CalOptima Health Program. OneCare: Any party that enters into a written arrangement, acceptable to CMS, with an MAO or Part D plan sponsor or applicant to provide administrative services or health care services to a Medicare eligible individual under the MA program or Part D program.
Fraud	An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law, in accordance with Title 42 Code of Federal Regulations section 455.2, Welfare and Institutions Code section 14043.1(i).
Grievance	Medi-Cal: Any expression of dissatisfaction about any matter other than an Adverse Benefit Determination (ABD), and may include, but is not limited to the Quality of Care or services provided, aspects of interpersonal relationships with a Provider or CalOptima Health's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by CalOptima Health to make an authorization decision. A complaint is the same as Grievance. An inquiry is a request for more information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other CalOptima Health processes. If CalOptima Health is unable to distinguish between a Grievance and an inquiry, it must be considered a Grievance. OneCare: An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. A grievance does not include, and is distinct from, a dispute of the appeal of an organization determination or coverage determination or an LEP determination. PACE: A complaint, either written or oral, expressing dissatisfaction with service delivery or the quality of care furnished, as defined by the federal PACE regulation 42 CFR Section 460.120.
Hierarchical Coding Categories (HCC)	A risk-adjusted model developed by CMS to adjust Medicare payments to health care plans for the health expenditure risk of Members.

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Medical Loss Ratio (MLR)	Medi-Cal: The percentage calculated by dividing the Health Network's total medical costs paid on behalf of CalOptima Health Members by the total revenue received from CalOptima Health. Health Network medical costs would include payments to physicians (i.e., capitation, fee-for-service, or salary), medical groups/Independent Practice Associations (IPAs), hospitals, labs, ambulance companies, and other providers of service. PACE: The Allowed Medical Expenses for the covered services provided to enrollees under the Contract divided by the amount of Medi-Cal managed care Net Capitation Payments or revenues recorded by CalOptima Health PACE, by county.
Medically Necessary or Medical Necessity	Medi-Cal: Reasonable and necessary Covered Services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services shall include Covered Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members under twenty-one (21) years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard of medical necessity set forth in Section 1396dI(5) of Title 42 of the United States Code, as required by W&I Code 14059.5(b) and W&I Code Section 14132(v). Without limitation, Medically Necessary services for Members under twenty-one (21) years of age include Covered Services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support or maintain the Member's current health condition. CalOptima Health shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child. OneCare: Reasonable and necessary medical services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services includes Medi-Cal Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. PACE: 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.
Medical Record	Medi-Cal: The record of a Member's medical information including but not limited to, medical history, care or treatments received, test results, diagnoses, and prescribed medications. OneCare: A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal

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Term	Definition
	documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal. PACE: Written documentary evidence of treatments rendered to plan Members.
Member	Medi-Cal: A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima Health program. OneCare: A beneficiary enrolled in a CalOptima Health OneCare Program. PACE: Any Eligible Medi-Cal Beneficiary who has enrolled in CalOptima Health PACE's plan in accordance with the provisions of California Code of Regulations title 22, section 53420.
National Committee for Quality Assurance (NCQA)	Medi-Cal: An organization responsible for the accreditation of managed care plans and other health care entities and for developing and managing health care measures that assess the Quality of Care and services that Members receive. OneCare: An independent, not-for-profit organization dedicated to assessing and reporting on the quality of managed care plans, managed behavioral healthcare organizations, preferred provider organizations, new health plans, physician organizations, credentials verification organizations, disease management programs and other health-related programs. PACE: A non-profit organization committed to evaluating and publicly reporting on the quality of managed care plans.
Quality Improvement Organization (QIO)	An organization comprised of practicing doctors and other health care experts under contract to the federal government to monitor and improve the care given to Medicare enrollees. A QIO reviews Complaints raised by enrollees about the quality of care provided by physicians, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Medicare managed care plans, and ambulatory surgical centers. A QIO also reviews continued stay denials for enrollees receiving care in acute inpatient hospital facilities as well as coverage terminations in Skilled Nursing Facilities, Home Health Agencies, and Comprehensive Outpatient Rehabilitation Facilities.
Related Entity	Any entity that is related to the MAO or Part D program by common ownership or control and: 1. Performs some of the MAO or Part D program's management functions under contract or delegation; 2. Furnishes services to Medicare enrollees under an oral or written agreement; or 3. Leases real property or sells materials to the MAO or Part D program at a cost of more than two thousand five hundred dollars ($2,500) during a contract period.

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Policy:	HH.2022
Title:	**Record Retention and Access**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance
CEO Approval:	*/s/*
Effective Date:	06/01/2013
Revised Date:	09/01/2025
Applicable to:	☐ Administrative ☐ Covered California [Effective 2027] ☒ Medi-Cal ☒ OneCare ☒ PACE

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I. PURPOSE

This policy establishes the requirements for CalOptima Health and its First Tier, Downstream, and Related Entities (FDRs) to retain and make available premises, contracts, books, documents, records, financial statements, equipment, computers, or other electronic systems, in accordance with federal and state regulations for the purpose of any audit, or investigation, of a CalOptima Health program.

II. POLICY

A. CalOptima Health and its FDRs shall retain and make available contracts, books, documents, records, and financial statements, in accordance with the provisions of this Policy. These documents include, but are not limited to, the following:

1. Data relating to Medi-Cal and Medicare utilization and costs;
2. Reinsurance costs;
3. Low-income subsidy payments;
4. Risk corridor costs;
5. Bid calculations;
6. Rebate information;
7. Medical Records;
8. Medical charts and prescription files;
9. Records related to/supporting Health Network Medical Loss Ratio (MLR) calculations;
10. Hierarchical Condition Categories (HCC) and risk adjustment records;
11. Encounter data;

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12. Member Grievance and Appeal records;
13. Base data as defined in Title 42, Code of Federal Regulations (C.F.R.), Section 438.5(c);

14. Data, information, and documentation specified in Title 42, C.F.R., Sections 438.604, 606, 608, and 610; and

15. Other documentation pertaining to medical and non-medical services rendered to Members.

16. Documentation of disciplinary actions for a period of ten (10) years at a minimum, including date of and description of violation, date of investigation, findings and date and description of disciplinary action.

B. An FDR shall retain and make available all of its premises, facilities, equipment, contracts, books, documents, records, encounter data (for a period of at least ten (10) years), computers and other electronic systems pertaining to the Covered Services ordered, referred, or rendered under the terms of the Network Provider Agreement, available to CalOptima Health and any authorized state and federal agencies or contractors, as described in Section II.C. 1-9 of this Policy, or their designees, for inspections, evaluations, examinations, copying, monitoring and auditing.

1. If the Department of Health Care Services (DHCS), the Centers for Medicare & Medicaid Services (CMS),or the U.S. Department of Health and Human Services (HHS) Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the HHS Inspector General may inspect, evaluate, and audit an FDR at any time.

2. Upon resolution of a full investigation of Fraud, DHCS reserves the right to suspend or terminate the FDR from participation in the Medi-Cal program; seek recovery of payments made to the FDR; impose other Sanctions provided under the State Plan, and direct CalOptima Health to terminate its agreement with the FDR due to Fraud.

C. Authorized state and federal agencies reserve the right to monitor all aspects of CalOptima Health's operations, including its FDRs, for compliance with the provisions of the CalOptima Health Contracts with DHCS for Medi-Cal and with CMS for Medicare, and applicable federal and state laws and regulations. Monitoring activities will include, but are not limited to, inspection and auditing of facilities, management systems and procedures, and books and records as deemed appropriate by the Director of DHCS, at any time, pursuant to 42 CFR 438.3(h). The monitoring activities will be either announced or unannounced.

III. PROCEDURE

A. CalOptima Health and its FDRs shall provide an authorized entity with the requested and required access to premises, contracts, books, documents, records, financial statements, equipment, computers, or other electronic systems at any time during normal business hours for audit, monitoring, and other investigative activities.

B. CalOptima Health and its FDRs shall maintain and make available all records and documents for a minimum of ten (10) years from the final date of the Contract Period, or from completion of any audit or investigation, whichever is later.

1. If there is a termination, dispute, or allegation of Fraud, or similar fault, document retention requirements for CalOptima Health and its FDRs may be extended to ten (10) years from the date of any resulting final resolution of the termination, dispute, or allegation of Fraud, or similar fault.

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C. CalOptima Health shall retain and make available all of its premises, facilities, equipment, contracts, books, documents, records, encounter data (for a period of at least ten (10) years and in accordance with CalOptima Health's Document Retention Schedule), computers and other electronic systems pertaining to the goods and services provided to Members, to any authorized state and federal agencies or contractors for inspections, evaluations, examinations or copying, monitoring and auditing including, but not limited to:

a. Centers for Medicare & Medicaid Services (CMS);

b. Department of Managed Health Care (DMHC);

c. Department of Health Care Services (DHCS);

d. The U.S. Department of Health and Human Services (HHS) Office of the Inspector General;

e. The Bureau of Medi-Cal Fraud

f. The Comptroller General;

g. Department of Justice;

h. The U.S. Government Accountability Office (GAO)

i. Authorized State agencies, or their duly authorized representatives or designees, including DHCS's External Quality Review Organization (EQRO) contractor; and

j. Any Quality Improvement Organization (QIO) or accrediting organizations, including NCQA, their designees and other representatives of regulatory or accrediting organizations.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Compliance Plan
B. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima Health's Document Retention Schedule
E. CalOptima Health PACE Program Agreement
F. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-006: Delegation and Subcontractor Network Certification (Supersedes APL 17-004)
G. Medicare Managed Care Manual, Chapter 21
H. Medicare Prescription Drug Benefit Manual, Chapter 9
I. Title 42, Code of Federal Regulations (C.F.R.), §422.504(d-e), §423.505(d-e), §438.230(c), §438.3(h), §438.604, §606, §608, §438.3(u); and §610

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
07/12/2013	Department of Health Care Services (DHCS)	Approved as Submitted
01/19/2022	Department of Health Care Services (DHCS)	File and Use

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VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/06/2018	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
11/07/2024	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	06/01/2013	HH.2022	Record Retention and Access	Medi-Cal OneCare
Revised	09/01/2015	HH.2022	Record Retention and Access	Medi-Cal
Revised	12/01/2016	HH.2022	Record Retention and Access	Medi-Cal OneCare OneCare Connect PACE
Revised	12/07/2017	HH.2022	Record Retention and Access	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.2022	Record Retention and Access	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.2022	Record Retention and Access	Medi-Cal OneCare OneCare Connect PACE
Revised	12/03/2020	HH.2022	Record Retention and Access	Medi-Cal OneCare OneCare Connect PACE
Revised	12/20/2021	HH.2022	Record Retention and Access	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	HH.2022	Record Retention and Access	Medi-Cal OneCare PACE
Revised	09/01/2023	HH.2022	Record Retention and Access	Medi-Cal OneCare PACE
Revised	11/07/2024	HH.2022	Record Retention and Access	Medi-Cal OneCare PACE

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Action	Date	Policy	Policy Title	Program(s)
Revised	09/01/2025	HH.2022	Record Retention and Access	Medi-Cal OneCare PACE

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IX. GLOSSARY

Term	Definition
Appeal	Medi-Cal: A review by CalOptima Health of an adverse benefit determination, which includes one of the following actions: 1. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a 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: As defined at 42 CFR §422.561 and §423.560, the procedures that deal with the review of adverse initial determinations made by the plan on health care services or benefits under Part C or D the enrollee believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the enrollee) or on any amounts the enrollee must pay for a service or drug as defined in 42 CFR §422.566(b) and §423.566(b). These appeal procedures include a plan reconsideration or redetermination (also referred to as a level 1 appeal), a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (Council), and judicial review. PACE: A Member's action taken with respect to the PACE organization's noncoverage of, modification of, or nonpayment for, a service including denials, reductions or termination of services, as defined by federal PACE regulation 42 CFR Section 460.122.
Contract Period	For purposes of this policy, this timeframe is the First Tier, Downstream, and Related Entities' (FDR's) contract duration with the Department of Health Care Services (DHCS).
Covered Service	Medi-Cal: Those health care services, set forth in W&I sections 14000 et seq. and 14131 et seq., 22 CCR section 51301 et seq., 17 CCR section 6800 et seq., the Medi-Cal Provider Manual, the California Medicaid State Plan, the California Section 1115 Medicaid Demonstration Project, the contract with DHCS for Medi-Cal, and DHCS APLs that are made the responsibility of CalOptima Health pursuant to the California Section 1915(b) Medicaid Waiver authorizing the Medi-Cal managed care program or other federally approved managed care authorities maintained by DHCS. Covered Services do not include: 1. Home and Community-Based Services (HCBS) program as specified in the DHCS contract for Medi-Cal Exhibit A, Attachment III, Subsections 4.3.15 (Services for Persons with Developmental Disabilities), 4.3.20 (Home and Community-Based Services Programs) regarding waiver programs, 4.3.21 (In-Home Supportive Services), and Department of Developmental Services (DDS) Administered Medicaid Home and

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First Tier Entity	Medi-Cal: Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima Health to provide administrative services or health care services to a Member under a CalOptima Health Program. OneCare: Any party that enters into a written arrangement, acceptable to CMS, with an MAO or Part D plan sponsor or applicant to provide administrative services or health care services to a Medicare eligible individual under the MA program or Part D program.
Fraud	An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law, in accordance with Title 42 Code of Federal Regulations section 455.2, Welfare and Institutions Code section 14043.1(i).
Grievance	Medi-Cal: Any expression of dissatisfaction about any matter other than an Adverse Benefit Determination (ABD), and may include, but is not limited to the Quality of Care or services provided, aspects of interpersonal relationships with a Provider or CalOptima Health's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by CalOptima Health to make an authorization decision. A complaint is the same as Grievance. An inquiry is a request for more information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other CalOptima Health processes. If CalOptima Health is unable to distinguish between a Grievance and an inquiry, it must be considered a Grievance. OneCare: An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. A grievance does not include, and is distinct from, a dispute of the appeal of an organization determination or coverage determination or an LEP determination. PACE: A complaint, either written or oral, expressing dissatisfaction with service delivery or the quality of care furnished, as defined by the federal PACE regulation 42 CFR Section 460.120.
Hierarchical Coding Categories (HCC)	A risk-adjusted model developed by CMS to adjust Medicare payments to health care plans for the health expenditure risk of Members.

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Term	Definition
Medical Loss Ratio (MLR)	Medi-Cal: The percentage calculated by dividing the Health Network's total medical costs paid on behalf of CalOptima Health Members by the total revenue received from CalOptima Health. Health Network medical costs would include payments to physicians (i.e., capitation, fee-for-service, or salary), medical groups/Independent Practice Associations (IPAs), hospitals, labs, ambulance companies, and other providers of service. PACE: The Allowed Medical Expenses for the covered services provided to enrollees under the Contract divided by the amount of Medi-Cal managed care Net Capitation Payments or revenues recorded by CalOptima Health PACE, by county.
Medically Necessary or Medical Necessity	Medi-Cal: Reasonable and necessary Covered Services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services shall include Covered Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members under twenty-one (21) years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard of medical necessity set forth in Section 1396dI(5) of Title 42 of the United States Code, as required by W&I Code 14059.5(b) and W&I Code Section 14132(v). Without limitation, Medically Necessary services for Members under twenty-one (21) years of age include Covered Services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support or maintain the Member's current health condition. CalOptima Health shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child. OneCare: Reasonable and necessary medical services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services includes Medi-Cal Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. PACE: 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.
Medical Record	Medi-Cal: The record of a Member's medical information including but not limited to, medical history, care or treatments received, test results, diagnoses, and prescribed medications. OneCare: A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal

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Term	Definition
	documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal. PACE: Written documentary evidence of treatments rendered to plan Members.
Member	Medi-Cal: A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima Health program. OneCare: A beneficiary enrolled in a CalOptima Health OneCare Program. PACE: Any Eligible Medi-Cal Beneficiary who has enrolled in CalOptima Health PACE's plan in accordance with the provisions of California Code of Regulations title 22, section 53420.
National Committee for Quality Assurance (NCQA)	Medi-Cal: An organization responsible for the accreditation of managed care plans and other health care entities and for developing and managing health care measures that assess the Quality of Care and services that Members receive. OneCare: An independent, not-for-profit organization dedicated to assessing and reporting on the quality of managed care plans, managed behavioral healthcare organizations, preferred provider organizations, new health plans, physician organizations, credentials verification organizations, disease management programs and other health-related programs. PACE: A non-profit organization committed to evaluating and publicly reporting on the quality of managed care plans.
Quality Improvement Organization (QIO)	An organization comprised of practicing doctors and other health care experts under contract to the federal government to monitor and improve the care given to Medicare enrollees. A QIO reviews Complaints raised by enrollees about the quality of care provided by physicians, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Medicare managed care plans, and ambulatory surgical centers. A QIO also reviews continued stay denials for enrollees receiving care in acute inpatient hospital facilities as well as coverage terminations in Skilled Nursing Facilities, Home Health Agencies, and Comprehensive Outpatient Rehabilitation Facilities.
Related Entity	Any entity that is related to the MAO or Part D program by common ownership or control and: 1. Performs some of the MAO or Part D program's management functions under contract or delegation; 2. Furnishes services to Medicare enrollees under an oral or written agreement; or 3. Leases real property or sells materials to the MAO or Part D program at a cost of more than two thousand five hundred dollars ($2,500) during a contract period.

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1

Policy:	HH.3000
Title:	**Notice of Privacy Practices**
Department:	Office of Compliance
Section:	Privacy
CEO Approval:	*/s/*
Effective Date:	04/01/2003
Revised Date:	09/01/2025
Applicable to:	☐ Administrative ☐ Covered California [Effective 2027] ☒ Medi-Cal ☒ OneCare ☒ PACE

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I. PURPOSE

This policy identifies the required content of CalOptima Health's Notice of Privacy Practices (NPP) and the process by which the NPP is distributed to CalOptima Health Members. It outlines the controls for physical and electronic access to Member data which includes Protected Health Information (PHI) and Personally Identifiable Information (PII). The NPP also outlines the impermissible and permissible uses of Member data, including PHI/PII.

II. POLICY

A. CalOptima Health Members have the right to adequate notice of the Uses and Disclosures of Protected Health Information (PHI) and Personally Identifiable Information (PII) data, that may be made by CalOptima Health and of the Members' rights and CalOptima Health's legal duties with respect to PHI/PII data.

B. CalOptima Health shall provide information that directs Members on the process to file complaints with CalOptima Health and its regulators and will not retaliate against Members who file complaints when the Member believes their privacy rights have been violated, in accordance with CalOptima Health Policy HH.3012: Non-Retaliation for Reporting Violations.

C. CalOptima Health shall provide the NPP to Members and former Members as required by law and accreditation standards, including providing the NPP upon enrollment and providing notice upon material revisions of the NPP in an easily accessible location on CalOptima Health's public website.

D. The CalOptima Health NPP shall describe steps Members may consider taking to help protect the privacy and security of their PHI/PII.

III. PROCEDURE

A. The content of the NPP shall be written in plain language and contain the following elements:

1. Mandated header;

2. Description and one (1) example each, of the types of Use and Disclosures that CalOptima Health is permitted under state and federal regulations for the purposes of Treatment, Payment,

and Health Care Operations. If a Use or Disclosure for any purpose described at 45 CFR Section 164.520(b)(1)(ii)(A) or (B) is prohibited or materially limited by other applicable law, for example 42 CFR Part 2, the description of such Use or Disclosure must reflect the more stringent law as defined in 45 CFR Section 160.202;

3. A description of each of the types of Uses or Disclosures, other than for purposes of Treatment, Payment, and Health Care Operations, that CalOptima Health is permitted or required by 45 CFR Part 164, Subpart E, to make without the Member's written consent.

4. A description of the types of Uses and Disclosures that require an authorization under 45 CFR Section 164.508(a)(2)-(a)(4), and Title 42 Code of Federal Regulations Part 2, a statement that other Uses and Disclosures not described in the NPP will be made only with the Member's written authorization, and a statement that the Member may revoke such authorization as provided by 45 CFR Section 164.508(b)(5);

5. A description and one (1) example each of the types of Uses and Disclosures of PHI related to lawful Reproductive Health Care for the following prohibited purposes under 45 CFR Section 164.502(a)(5)(iii): (i) conducting a criminal, civil, or administrative investigation into any person for the mere act of seeking, obtaining, providing, or facilitating Reproductive Health Care; (ii) imposing criminal, civil, or administrative liability on any person for the mere act of seeking, obtaining, providing, or facilitating Reproductive Health Care; (iii) or to identify any person for any purpose previously described

6. A description and one (1) example each of the following the Uses and Disclosures for which an attestation is required under 45 CFR Section 164.509: (i) health oversight activities under 45 CFR Section 164.512(d); (ii) judicial or administrative proceedings under 45 CFR Section 164.512(e); (iii) disclosures for law enforcement purposes under 45 CFR Section 164.512(f); and (iv) disclosures about decedents to coroners and medical examiners under 45 CFR Section 164.512(g)(1);

7. A statement adequate to put the Member on notice of the potential for information disclosed by CalOptima Health pursuant to the NPP to be subject to redisclosure by the recipient and no longer protected by applicable privacy laws;

8. Statement to describe the Member's rights concerning his or her PHI/PII, how to exercise these rights, and restrictions on such rights, which shall include information on:

   a. Right to request restrictions on certain Uses and Disclosures of PHI/PII, and provision that CalOptima Health is not required to agree to those restrictions, except in case of a Disclosure restricted under 45 CFR Section 164.522(a)(1)(iv) and in accordance with CalOptima Health Policy HH.3007: Member Rights to Request Restrictions on Use and Disclosure of Protected Health Information;

   b. Right to receive confidential communications of PHI/PII, in accordance with CalOptima Health Policy HH.3008: Member Right to Request Confidential Communications;

   c. Right to inspect and copy PHI/PII , in accordance with CalOptima Health Policy HH.3001: Member Access to Designated Record Set;

   d. Right to request amendment to PHI/PII, in accordance with CalOptima Health Policy HH.3004: Member Request to Amend Records;

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e. Right to receive accounting of Disclosures, with certain exceptions, in accordance with CalOptima Health Policy HH.3005: Member Request for Accounting of Disclosures; and

f. Right to receive a paper copy of the NPP, in accordance with this Policy.

9. Statement specifically describing CalOptima Health's duties and rights under the privacy rule, including:

a. A statement that CalOptima Health is required by law to maintain the privacy of the Member's PHI, to provide individuals with notice of its legal duties and privacy practices with respect to PHI/PII, and to notify affected Members following a breach of unsecured PHI/PII, and in accordance with CalOptima Health policies, which shall include processes to ensure internal protection of verbal (i.e., when talking to individuals on the telephone or in person about a Member), and written information, in accordance with CalOptima Health Policies HH.3003: Verification of Identity for Disclosures of Protected Health Information (PHI), HH.3009: Access by Member's Personal Representative, HH.3016: Guidelines for Handling Protected Health Information (PHI) Off-site, and HH.3019: De-identification of Protected Health Information (PHI).

b. The responsibility to abide by the terms of the NPP currently in effect;

c. CalOptima Health's right to make changes to the terms of the NPP when it makes changes to its privacy practices; and

d. A description of how CalOptima Health provides Members with a revised NPP.

10. Statement that the Member may file a complaint as part of their privacy rights, and without retaliation, to CalOptima Health's Customer Service Department or Privacy Officer, the California Department of Health Care Services (DHCS), and/or the United States Department of Health and Human Services (HHS), if the Member believes his or her privacy rights have been violated, and include contact title and telephone number for filing the complaint with CalOptima Health, or to get further information concerning the notice. The contact information should include:

a. **CalOptima Health**
Privacy Officer
CalOptima Health
505 City Parkway West
Orange CA 92868

Or call:

CalOptima Health Customer Service Department
Telephone: 1-714-246-8500
Toll-free: 1-888-587-8088
TTY: 711

b. **Department of Health Care Services**
Privacy Officer
Office of HIPAA Compliance
PO Box 997413 MS 4722
Sacramento CA 95899-7413

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Email: privacyofficer@dhcs.ca.gov
Telephone: 1-916-445-4646
Fax: 1-916-440-7680

c. **U.S. Department of Health and Human Services**
Regional Manager
Office for Civil Rights
90 7th Street Suite 4-100
San Francisco CA 94103

Phone: 1-800-368-1019
Fax: 1-415-437-8329
TDD: 1-800-537-7697
Email: OCRComplaint@hhs.gov

11. Effective date of the notice.

B. The NPP shall be made available to anyone, upon request, by calling or writing to the CalOptima Health Customer Service Department. CalOptima Health's Customer Service Department shall make the NPP available in Threshold Languages to anyone by mail, in person, or through the CalOptima Health website. CalOptima Health shall distribute the NPP by:

1. Including copies in all new enrollment packets.

2. Posting a copy in the Customer Service Department lobby in Threshold Languages.

3. Posting the NPP on the CalOptima Health website.

   a. Upon a material change to the NPP, CalOptima Health shall prominently post the change, or the revised NPP, on the CalOptima Health website by the effective date of the material change to the notice.

4. Providing a revised NPP, or information about the material change and how to obtain the revised NPP, in the next annual mailing to Members.

5. Notifying all Members at least once every three (3) years that a copy of the NPP is available upon request or may be obtained on the CalOptima Health website at www.CalOptima Health.org.

6. Ensuring all mailings of the NPP comply with CalOptima Health's Cultural and Linguistic Services guidelines, in accordance with CalOptima Health Policies DD.2002: Cultural and Linguistic Services.

7. PACE Member materials shall include a statement of non-discrimination acknowledging that CalOptima Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex and taglines informing members of the availability of language assistance services.

C. Sensitive Services:

1. CalOptima Health shall accommodate reasonable Member requests for alternate communication methods (e.g., email, mail, or phone) regarding sensitive services in accordance with CalOptima Health Policy HH.3008: Member Right to Request Confidential Information.

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2. CalOptima Health shall not disclose sensitive service information to any individual or entity without the Member's expressed consent in accordance with CalOptima Health Policy HH.3015: Member Authorization for the Use and Disclosure of Protected Health Information (PHI).

D. Documentation and Retention:

1. CalOptima Health shall document compliance with this Policy and retain copies of the notices issued for a period of ten (10) years from the effective date of the notice.

IV. ATTACHMENT(S)

A. Notice of Privacy Practices (NPP)

V. REFERENCE(S)

A. CalOptima Health Compliance Plan
B. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima Health PACE Program Agreement
E. CalOptima Health Policy DD.2002: Cultural and Linguistic Services
F. CalOptima Health Policy HH.3001: Member Access to Designated Record Set
G. CalOptima Health Policy HH.3003: Verification of Identity for Disclosures of Protected Health Information (PHI)
H. CalOptima Health Policy HH.3004: Member Request to Amend Records
I. CalOptima Health Policy HH.3005: Member Request for Accounting of Disclosures
J. CalOptima Health Policy HH.3007: Member Rights to Request Restrictions on Use and Disclosure of Protected Health Information (PHI)
K. CalOptima Health Policy HH.3008: Member Right to Request Confidential Communications
L. CalOptima Health Policy HH.3009: Access by Member's Personal Representative
M. CalOptima Health Policy HH.3012: Non-Retaliation for Reporting Violations
N. CalOptima Health Policy HH.3014: Use of Electronic Mail with Protected Health Information
O. CalOptima Health Policy 3015: Member Authorization for the Use and Disclosure of Protected Health Information (PHI)
P. CalOptima Health Policy HH.3016: Guidelines for Handling Protected Health Information (PHI) Off-site
Q. CalOptima Health Policy HH.3019: De-identification of Protected Health Information (PHI)
R. Department of Health Care Services (DHCS) All Plan Letter (APL) 06-001: Notice of Privacy Practices and Notification of Breaches
S. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-026: Inoperability and Patient Access Final Rule
T. NCQA Standard MED5 Privacy and Confidentiality: Element A: Adopting Written Policies, Factor 1-2017
U. Patient Protection and Affordable Care Act §1557
V. 45 CFR Part 2
W. 45CFR §160.202
X. 45 CFR §164.105(c)(2)
Y. 45 CFR §164.504(a)(2)-(a)(4)
Z. 45 CFR §164.508(b)(5)
AA. 45 CFR §164.520(b)(1)(ii)(A) or (B)
BB. 45 CFR §164.530(g)

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VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
01/19/2022	Department of Health Care Services (DHCS)	Approved as Submitted
05/02/2023	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/06/2018	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
11/07/2024	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	04/01/2003	HH.3000	Notice of Privacy Practices	Medi-Cal
Revised	07/01/2007	HH.3000	Notice of Privacy Practices	Medi-Cal
Revised	04/01/2009	HH.3000	Notice of Privacy Practices	Medi-Cal
Revised	01/01/2011	HH.3000	Notice of Privacy Practices	Medi-Cal
Revised	01/01/2013	HH.3000	Notice of Privacy Practices	Medi-Cal OneCare
Revised	01/01/2014	HH.3000	Notice of Privacy Practices	Medi-Cal
Revised	09/01/2015	HH.3000	Notice of Privacy Practices	Medi-Cal
Revised	12/01/2016	HH.3000	Notice of Privacy Practices	Medi-Cal OneCare OneCare Connect PACE
Reviewed	03/01/2017	HH.3000	Notice of Privacy Practices	Medi-Cal OneCare OneCare Connect PACE
Revised	12/07/2017	HH.3000	Notice of Privacy Practices	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.3000	Notice of Privacy Practices	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.3000	Notice of Privacy Practices	Medi-Cal OneCare OneCare Connect PACE

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Action	Date	Policy	Policy Title	Program(s)
Revised	12/03/2020	HH.3000	Notice of Privacy Practices	Medi-Cal OneCare OneCare Connect PACE
Revised	12/20/2021	HH.3000	Notice of Privacy Practices	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	HH.3000	Notice of Privacy Practices	Medi-Cal OneCare PACE
Revised	03/01/2023	HH.3000	Notice of Privacy Practices	Medi-Cal OneCare PACE
Revised	11/07/2024	HH.3000	Notice of Privacy Practices	Medi-Cal OneCare PACE
Revised	09/01/2025	HH.3000	Notice of Privacy Practices	Medi-Cal OneCare PACE

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IX. GLOSSARY

Term	Definition
CFR	Means the Code of Federal Regulations.
Disclosure	Has the meaning in 45 CFR Section 160.103, including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.
Health Care Operations	Has the meaning given such term in 45 CFR Section 164.501, including activities including quality assessment and improvement activities, care management, professional review, compliance and audits, health insurance underwriting, premium rating and other activities related to a contract and health benefits, management and administration activities, customer services, resolution of internal grievances, business planning, and development and activities related to compliance with the privacy rule.
Member	A beneficiary enrolled in a CalOptima Health program.
Notice of Privacy Practices (NPP)	Notice provided to a Member that describes Cal Optima's practices in the Use and Disclosure of Protected Health Information, Member rights, and CalOptima Health legal duties with respect to Protected Health Information.
Payment	Has the meaning in 45 CFR Section 164.501, including: activities carried out by CalOptima Health including: 1. Determination of eligibility, risk adjustments based on Member health status and demographics, billing claims management, and collection activities; 2. Review of health care services regarding medical necessity, coverage under a health plan, appropriateness of care, or justification of charges; and, 3. Utilization review activities including pre-certification, preauthorization, concurrent, or retrospective review of services.
Personally Identifiable Information (PII)	Any information about an individual maintained by an agency, including (1) any information that can be Used to distinguish or trace an individual's identity, such as name, social security number, date and place of birth, mother's maiden name, biometric records, race, ethnicity, language (REL), sexual orientation and gender identity (SOGI); and (2) any other information that is linked or linkable to an individual, such as medical, educational, financial, and employment information.
Protected Health Information (PHI)	Has the meaning in 45 CFR Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be Used to identify the individual. The information was created or received by CalOptima Health or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.

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Term	Definition
Reproductive Health Care	Means health care, as defined at 45 CFR § 160.103, that affects the health of a Member in all matters relating to the reproductive system and to its functions and processes.
Threshold Languages	Medi-Cal: The non-English threshold and concentration standard languages in which Contractor is required to provide written translations of Member Information, as determined by DHCS. OneCare: A threshold language is defined by CMS as the native language of a group who compromises five percent (5%) or more of the people served by the CMS Program.
Treatment	Has the meaning in 45 CFR Section 164.501, including: activities undertaken on behalf of a Member including the provision, coordination, or management of health care and related services; the referral to, and consultation between, health care providers; and coordination with third parties for services related to the management of the Member's health care benefits.
Use	Has the meaning in 45 CFR Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.

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Policy:	HH.3000
Title:	**Notice of Privacy Practices**
Department:	Office of Compliance
Section:	Privacy
CEO Approval:	*/s/*
Effective Date:	04/01/2003
Revised Date:	09/01/2025
Applicable to:	☐ Administrative ☐ Covered California [Effective 2027] ☒ Medi-Cal ☒ OneCare ☒ PACE

For 2025 1106 BOD Review Only

I. PURPOSE

This policy identifies the required content of CalOptima Health's Notice of Privacy Practices (NPP) and the process by which the NPP is distributed to CalOptima Health Members. It outlines the controls for physical and electronic access to Member data which includes Protected Health Information (PHI) and Personally Identifiable Information (PII). The NPP also outlines the impermissible and permissible uses of Member data, including PHI/PII.

II. POLICY

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B. CalOptima Health shall provide information that directs Members on the process to file complaints with CalOptima Health and its regulators and will not retaliate against Members who file complaints when the Member believes their privacy rights have been violated, in accordance with CalOptima Health Policy HH.3012: Non-Retaliation for Reporting Violations.

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and Health Care Operations. If a Use or Disclosure for any purpose described at 45 CFR Section 164.520(b)(1)(ii)(A) or (B) is prohibited or materially limited by other applicable law, for example 42 CFR Part 2, the description of such Use or Disclosure must reflect the more stringent law as defined in 45 CFR Section 160.202;

3. A description of each of the types of Uses or Disclosures, other than for purposes of Treatment, Payment, and Health Care Operations, that CalOptima Health is permitted or required by 45 CFR Part 164, Subpart E, to make without the Member's written consent.

4. A description of the types of Uses and Disclosures that require an authorization under 45 CFR Section 164.508(a)(2)-(a)(4), and Title 42 Code of Federal Regulations Part 2, a statement that other Uses and Disclosures not described in the NPP will be made only with the Member's written authorization, and a statement that the Member may revoke such authorization as provided by 45 CFR Section 164.508(b)(5);

5. A description and one (1) example each of the types of Uses and Disclosures of PHI related to lawful Reproductive Health Care for the following prohibited purposes under 45 CFR Section 164.502(a)(5)(iii): (i) conducting a criminal, civil, or administrative investigation into any person for the mere act of seeking, obtaining, providing, or facilitating Reproductive Health Care; (ii) imposing criminal, civil, or administrative liability on any person for the mere act of seeking, obtaining, providing, or facilitating Reproductive Health Care; (iii) or to identify any person for any purpose previously described

6. A description and one (1) example each of the following the Uses and Disclosures for which an attestation is required under 45 CFR Section 164.509: (i) health oversight activities under 45 CFR Section 164.512(d); (ii) judicial or administrative proceedings under 45 CFR Section 164.512(e); (iii) disclosures for law enforcement purposes under 45 CFR Section 164.512(f); and (iv) disclosures about decedents to coroners and medical examiners under 45 CFR Section 164.512(g)(1);

7. A statement adequate to put the Member on notice of the potential for information disclosed by CalOptima Health pursuant to the NPP to be subject to redisclosure by the recipient and no longer protected by applicable privacy laws;

8. Statement to describe the Member's rights concerning his or her PHI/PII, how to exercise these rights, and restrictions on such rights, which shall include information on:

   a. Right to request restrictions on certain Uses and Disclosures of PHI/PII, and provision that CalOptima Health is not required to agree to those restrictions, except in case of a Disclosure restricted under 45 CFR Section 164.522(a)(1)(iv) and in accordance with CalOptima Health Policy HH.3007: Member Rights to Request Restrictions on Use and Disclosure of Protected Health Information;

   b. Right to receive confidential communications of PHI/PII, in accordance with CalOptima Health Policy HH.3008: Member Right to Request Confidential Communications;

   c. Right to inspect and copy PHI/PII , in accordance with CalOptima Health Policy HH.3001: Member Access to Designated Record Set;

   d. Right to request amendment to PHI/PII, in accordance with CalOptima Health Policy HH.3004: Member Request to Amend Records;

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e. Right to receive accounting of Disclosures, with certain exceptions, in accordance with CalOptima Health Policy HH.3005: Member Request for Accounting of Disclosures; and

f. Right to receive a paper copy of the NPP, in accordance with this Policy.

9. Statement specifically describing CalOptima Health's duties and rights under the privacy rule, including:

   a. A statement that CalOptima Health is required by law to maintain the privacy of the Member's PHI, to provide individuals with notice of its legal duties and privacy practices with respect to PHI/PII, and to notify affected Members following a breach of unsecured PHI/PII, and in accordance with CalOptima Health policies, which shall include processes to ensure internal protection of verbal (i.e., when talking to individuals on the telephone or in person about a Member), and written information, in accordance with CalOptima Health Policies HH.3003: Verification of Identity for Disclosures of Protected Health Information (PHI), HH.3009: Access by Member's Personal Representative, HH.3016: Guidelines for Handling Protected Health Information (PHI) Off-site, and HH.3019: De-identification of Protected Health Information (PHI).

   b. The responsibility to abide by the terms of the NPP currently in effect;

   c. CalOptima Health's right to make changes to the terms of the NPP when it makes changes to its privacy practices; and

   d. A description of how CalOptima Health provides Members with a revised NPP.

10. Statement that the Member may file a complaint as part of their privacy rights, and without retaliation, to CalOptima Health's Customer Service Department or Privacy Officer, the California Department of Health Care Services (DHCS), and/or the United States Department of Health and Human Services (HHS), if the Member believes his or her privacy rights have been violated, and include contact title and telephone number for filing the complaint with CalOptima Health, or to get further information concerning the notice. The contact information should include:

    a. **CalOptima Health**
    Privacy Officer
    CalOptima Health
    505 City Parkway West
    Orange CA 92868

    Or call:

    CalOptima Health Customer Service Department
    Telephone: 1-714-246-8500
    Toll-free: 1-888-587-8088
    TTY: 711

    b. **Department of Health Care Services**
    Privacy Officer
    Office of HIPAA Compliance
    PO Box 997413 MS 4722
    Sacramento CA 95899-7413

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Email: privacyofficer@dhcs.ca.gov
Telephone: 1-916-445-4646
Fax: 1-916-440-7680

c. **U.S. Department of Health and Human Services**
Regional Manager
Office for Civil Rights
90 7th Street Suite 4-100
San Francisco CA 94103

Phone: 1-800-368-1019
Fax: 1-415-437-8329
TDD: 1-800-537-7697
Email: OCRComplaint@hhs.gov

11. Effective date of the notice.

B. The NPP shall be made available to anyone, upon request, by calling or writing to the CalOptima Health Customer Service Department. CalOptima Health's Customer Service Department shall make the NPP available in Threshold Languages to anyone by mail, in person, or through the CalOptima Health website. CalOptima Health shall distribute the NPP by:

1. Including copies in all new enrollment packets.

2. Posting a copy in the Customer Service Department lobby in Threshold Languages.

3. Posting the NPP on the CalOptima Health website.

   a. Upon a material change to the NPP, CalOptima Health shall prominently post the change, or the revised NPP, on the CalOptima Health website by the effective date of the material change to the notice.

4. Providing a revised NPP, or information about the material change and how to obtain the revised NPP, in the next annual mailing to Members.

5. Notifying all Members at least once every three (3) years that a copy of the NPP is available upon request or may be obtained on the CalOptima Health website at www.CalOptima Health.org.

6. Ensuring all mailings of the NPP comply with CalOptima Health's Cultural and Linguistic Services guidelines, in accordance with CalOptima Health Policies DD.2002: Cultural and Linguistic Services.

7. PACE Member materials shall include a statement of non-discrimination acknowledging that CalOptima Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex and taglines informing members of the availability of language assistance services.

C. Sensitive Services:

1. CalOptima Health shall accommodate reasonable Member requests for alternate communication methods (e.g., email, mail, or phone) regarding sensitive services in accordance with CalOptima Health Policy HH.3008: Member Right to Request Confidential Information.

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2. CalOptima Health shall not disclose sensitive service information to any individual or entity without the Member's expressed consent in accordance with CalOptima Health Policy HH.3015: Member Authorization for the Use and Disclosure of Protected Health Information (PHI).

D. Documentation and Retention:

1. CalOptima Health shall document compliance with this Policy and retain copies of the notices issued for a period of ten (10) years from the effective date of the notice.

IV. ATTACHMENT(S)

A. Notice of Privacy Practices (NPP)

V. REFERENCE(S)

A. CalOptima Health Compliance Plan
B. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima Health PACE Program Agreement
E. CalOptima Health Policy DD.2002: Cultural and Linguistic Services
F. CalOptima Health Policy HH.3001: Member Access to Designated Record Set
G. CalOptima Health Policy HH.3003: Verification of Identity for Disclosures of Protected Health Information (PHI)
H. CalOptima Health Policy HH.3004: Member Request to Amend Records
I. CalOptima Health Policy HH.3005: Member Request for Accounting of Disclosures
J. CalOptima Health Policy HH.3007: Member Rights to Request Restrictions on Use and Disclosure of Protected Health Information (PHI)
K. CalOptima Health Policy HH.3008: Member Right to Request Confidential Communications
L. CalOptima Health Policy HH.3009: Access by Member's Personal Representative
M. CalOptima Health Policy HH.3012: Non-Retaliation for Reporting Violations
N. CalOptima Health Policy HH.3014: Use of Electronic Mail with Protected Health Information
O. CalOptima Health Policy 3015: Member Authorization for the Use and Disclosure of Protected Health Information (PHI)
P. CalOptima Health Policy HH.3016: Guidelines for Handling Protected Health Information (PHI) Off-site
Q. CalOptima Health Policy HH.3019: De-identification of Protected Health Information (PHI)
R. Department of Health Care Services (DHCS) All Plan Letter (APL) 06-001: Notice of Privacy Practices and Notification of Breaches
S. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-026: Inoperability and Patient Access Final Rule
T. NCQA Standard MED5 Privacy and Confidentiality: Element A: Adopting Written Policies, Factor 1-2017
U. Patient Protection and Affordable Care Act §1557
V. 45 CFR Part 2
W. 45CFR §160.202
X. 45 CFR §164.105(c)(2)
Y. 45 CFR §164.504(a)(2)-(a)(4)
Z. 45 CFR §164.508(b)(5)
AA. 45 CFR §164.520(b)(1)(ii)(A) or (B)
BB. 45 CFR §164.530(g)

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VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
01/19/2022	Department of Health Care Services (DHCS)	Approved as Submitted
05/02/2023	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/06/2018	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
11/07/2024	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	04/01/2003	HH.3000	Notice of Privacy Practices	Medi-Cal
Revised	07/01/2007	HH.3000	Notice of Privacy Practices	Medi-Cal
Revised	04/01/2009	HH.3000	Notice of Privacy Practices	Medi-Cal
Revised	01/01/2011	HH.3000	Notice of Privacy Practices	Medi-Cal
Revised	01/01/2013	HH.3000	Notice of Privacy Practices	Medi-Cal OneCare
Revised	01/01/2014	HH.3000	Notice of Privacy Practices	Medi-Cal
Revised	09/01/2015	HH.3000	Notice of Privacy Practices	Medi-Cal
Revised	12/01/2016	HH.3000	Notice of Privacy Practices	Medi-Cal OneCare OneCare Connect PACE
Reviewed	03/01/2017	HH.3000	Notice of Privacy Practices	Medi-Cal OneCare OneCare Connect PACE
Revised	12/07/2017	HH.3000	Notice of Privacy Practices	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.3000	Notice of Privacy Practices	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.3000	Notice of Privacy Practices	Medi-Cal OneCare OneCare Connect PACE

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Action	Date	Policy	Policy Title	Program(s)
Revised	12/03/2020	HH.3000	Notice of Privacy Practices	Medi-Cal OneCare OneCare Connect PACE
Revised	12/20/2021	HH.3000	Notice of Privacy Practices	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	HH.3000	Notice of Privacy Practices	Medi-Cal OneCare PACE
Revised	03/01/2023	HH.3000	Notice of Privacy Practices	Medi-Cal OneCare PACE
Revised	11/07/2024	HH.3000	Notice of Privacy Practices	Medi-Cal OneCare PACE
Revised	09/01/2025	HH.3000	Notice of Privacy Practices	Medi-Cal OneCare PACE

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IX. GLOSSARY

Term	Definition
CFR	Means the Code of Federal Regulations.
Disclosure	Has the meaning in 45 CFR Section 160.103, including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.
Health Care Operations	Has the meaning given such term in 45 CFR Section 164.501, including activities including quality assessment and improvement activities, care management, professional review, compliance and audits, health insurance underwriting, premium rating and other activities related to a contract and health benefits, management and administration activities, customer services, resolution of internal grievances, business planning, and development and activities related to compliance with the privacy rule.
Member	A beneficiary enrolled in a CalOptima Health program.
Notice of Privacy Practices (NPP)	Notice provided to a Member that describes Cal Optima's practices in the Use and Disclosure of Protected Health Information, Member rights, and CalOptima Health legal duties with respect to Protected Health Information.
Payment	Has the meaning in 45 CFR Section 164.501, including: activities carried out by CalOptima Health including: 1. Determination of eligibility, risk adjustments based on Member health status and demographics, billing claims management, and collection activities; 2. Review of health care services regarding medical necessity, coverage under a health plan, appropriateness of care, or justification of charges; and, 3. Utilization review activities including pre-certification, preauthorization, concurrent, or retrospective review of services.
Personally Identifiable Information (PII)	Any information about an individual maintained by an agency, including (1) any information that can be Used to distinguish or trace an individual's identity, such as name, social security number, date and place of birth, mother's maiden name, biometric records, race, ethnicity, language (REL), sexual orientation and gender identity (SOGI); and (2) any other information that is linked or linkable to an individual, such as medical, educational, financial, and employment information.
Protected Health Information (PHI)	Has the meaning in 45 CFR Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be Used to identify the individual. The information was created or received by CalOptima Health or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.

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Term	Definition
Reproductive Health Care	Means health care, as defined at 45 CFR § 160.103, that affects the health of a Member in all matters relating to the reproductive system and to its functions and processes.
Threshold Languages	Medi-Cal: The non-English threshold and concentration standard languages in which Contractor is required to provide written translations of Member Information, as determined by DHCS. OneCare: A threshold language is defined by CMS as the native language of a group who compromises five percent (5%) or more of the people served by the CMS Program.
Treatment	Has the meaning in 45 CFR Section 164.501, including: activities undertaken on behalf of a Member including the provision, coordination, or management of health care and related services; the referral to, and consultation between, health care providers; and coordination with third parties for services related to the management of the Member's health care benefits.
Use	Has the meaning in 45 CFR Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.

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For 20251106 BOD Review Only

Notice of Privacy Practices

Effective: April 14, 2003 | Updated: July 22, 2025

CalOptima Health offers you access to health care through our Medi-Cal plan, our One Care (HMO D-SNP) Medicare Advantage Special Needs Plan and our Program of All-Inclusive Care for the Elderly (PACE). We are required by state and federal law to protect your health information. After you become eligible and enroll in one of our health plans, Medicare or Medi-Cal sends your information to us. We also get medical information from your doctors, clinics, labs and hospitals to approve and pay for your health care.

This notice explains how medical information about you may be used and shared, and how you can get access to this information. **Please review it carefully.**

Your rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

How we protect your information	• We have controls in place for physical and electronic access to your information, which include race, ethnicity, language, gender identity and sexual orientation. • Our policies and procedures outline what is allowed and what is not allowed when using your personal health information, including race, ethnicity, language, gender identity and sexual orientation. • Electronic access may include media formats, devices and hardware, and data storage. • We do not discriminate against members based on any sensitive information.

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Notice of Privacy Practices

Get a copy of your health and claims records	• You can ask to see or get a copy of your health and claims records and other health information we have about you. You must make this request in writing. We will send you a form to fill out, and we may charge a fair fee for the costs of copying and mailing records. You must provide a valid form of ID to view or get a copy of your health records. • We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. • We may keep you from seeing certain parts of your records for reasons allowed by law. • **CalOptima Health does not have complete copies of your medical records. If you want to look at, get a copy of, or change your medical records, please contact your doctor or clinic.**
Ask us to correct health and claims records	• You have the right to send a written request to change information in your records if it's not correct or complete. You must make your request in writing. • We may refuse your request if the information is not created or kept by CalOptima Health, or if we believe it is correct and complete, but we will tell you why in writing within 60 days. • If we don't make the changes you asked for, you may ask us to review our decision. You may also send a statement saying why you disagree with our records, and your statement will be kept with your records.
Request confidential communications	• You can ask us to contact you by your preferred method of contact (for example, home or work phone) or to send mail to a different address. • We will consider all fair requests. We must say "yes" if you tell us you would be in danger if we do not.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment or our health care operations. • We are not required to agree to your request, and we may say "no" if it would affect your care.

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Notice of Privacy Practices

Get a list of who we shared information with	• You can ask for a list of the times we shared your health information during the past 6 years before the date you asked. • You have the right to request a list of what information was shared, who it was shared with, when it was shared and why. • We will include all disclosures, except for those about your treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make).
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to accept the notice electronically. We will offer you a paper copy in good time. • You can also find this notice on our website at www.caloptimahealth.org.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, this person can use your rights and make choices about your health information. • We will make sure this person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• If you feel we have violated your rights, you can complain by contacting us using the information in this notice. • We will not retaliate against you for filing a complaint.
Use a self-pay restriction	• If you pay the whole bill for a service, you can ask your doctor not to share the information about that service with us. If you or your provider submits a claim to CalOptima Health, we do not have to agree to a restriction. If a law requires the disclosure, CalOptima Health does not have to agree to your restriction.

For certain health information, you can tell us your choices about what we share.
If you have a preference for how we share your information in the situations below, please contact us. In most cases, if we use or share your Protected Health Information (PHI) outside of treatment, payment or health care operations, we must get your written permission first. If you give us your permission, you may take it back in writing at any time. We cannot take back what we used or shared when we had your written permission, but we will stop using or sharing your PHI in the future.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends or others involved in payment for your care. • Share information in a disaster-relief situation.
In these cases, we *never* share your information unless you give us	• Substance use disorder (SUD) information: We must get your permission for any use or disclosure of SUD information. • Psychotherapy notes: We must get your permission for any use or

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written permission:	disclosure of psychotherapy notes, except to carry out certain treatment, payment or health care operations. • Your race, ethnicity, language, gender identity and sexual orientation information, except to carry out treatment, payment or health care operations. • Your race, ethnicity, language, gender identity and sexual orientation information for underwriting, denial of services and coverage, or for benefit determinations. • Marketing needs. • Sale of your information.

Our responsibilities

- We are required by law to maintain the privacy and security of your PHI.
- We will let you know as soon as possible if a breach happens that may have affected the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

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Our uses and disclosures

Your information may be used or shared by CalOptima Health only for treatment, payment and health care operations related to the Medi-Cal, Medicare (OneCare) or PACE programs in which you are enrolled. We may use and share your information in health information exchanges with providers involved in the care you receive. The information we use and share includes, but is not limited to:

- Your name
- Address
- History of care and treatment given to you
- Cost or payment for care

Some examples of how we share your information with those involved with your care:

Help manage the health care treatment you receive	• We can use your health information and share it with professionals who are treating you. This may include your race, ethnicity, language, gender identity and sexual orientation to provide services that best fit your needs.	**Example:** A doctor sends us information about your diagnosis and treatment plan so we can set up additional services. We will share this information with doctors, hospitals and others to get you the care you need.
Run our organization (health care operations)	• We can use and share your information to run our organization and contact you when needed. • **We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage.**	**Example:** We use your health information to develop better services for you, which may include reviewing the quality of care and services you receive. We may also use this information in audits and fraud investigations.
Pay for your health services	• We can use and share your health information as we pay for your health services.	**Example:** We share information with the doctors, clinics and others who bill us for your care. We may also forward bills to other health plans or organizations for payment.

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Administer your plan	• We may share your health information with the Department of Health Care Services (DHCS) or the Centers for Medicare & Medicaid Services (CMS) for plan administration.	**Example:** DHCS contracts with us to provide a health plan, and we provide DHCS with certain information.

How else can we use or share your health information?

We are allowed or required to share your information in other ways, usually to promote the public good, like public health and research. We have to meet many conditions in the law before we can share your information for these reasons.

Help with public health and safety issues	We can share health information about you for certain situations like: • Preventing disease. • Helping with product recalls. • Reporting adverse reactions to medicines. • Reporting suspected abuse, neglect or domestic violence. • Preventing or reducing a serious threat to anyone's health or safety.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy law.
Respond to organ and tissue donation requests and work with a medical examiner or funeral director	• We can share health information about you with organ procurement organizations. • We can share health information with a coroner, medical examiner or funeral director when an individual dies.
Address workers' compensation, law enforcement and other government requests	We can use or share health information about you: • For workers' compensation claims. • For law enforcement reasons or with a law enforcement official. • With health oversight agencies for activities authorized by law. • For special government functions, such as military, national security and presidential protective services.
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

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Comply with special laws	• There are special laws that protect some types of health information, such as mental health services, treatment for substance use disorders and HIV/AIDS testing and treatment. We will obey these laws when they are stricter than this notice. • There are also laws that limit our use and disclosure to reasons directly connected to the administration of CalOptima Health's programs.

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Notice of Privacy Practices

Confidentiality of sensitive services

CalOptima Health is committed to protecting the privacy and confidentiality of information related to sensitive services you receive. Sensitive services are any health care services related to mental or behavioral health care; substance use disorder; gender-affirming care; sexual and reproductive health; sexually transmitted infections; rape or sexual assault; infectious, contagious, or communicable diseases; HIV/AIDs-related care; or intimate partner violence, as defined in California Civil Code § 56.05(s).

CalOptima Health will send communications about sensitive services to a mailing address, email address or phone number of your choice, or we will use the mailing address, phone number, or email address on file if you did not give us a different one. CalOptima Health will not share medical information about your sensitive services with any other person without your written approval. CalOptima Health will honor your requests for confidential communication in the form and format you want if it can be done in your requested form and format. Your request for confidential communication related to sensitive services will be valid until you take back the request or make a new request for confidential communications. Please call us toll-free at **1-888-587-8088** (TTY **711**), or write to us to find out how to request sensitive services information. You will need to submit your request in writing and give us certain information. We can send you the form(s) for the request. We will carry out your request within 7 calendar days after we receive your phone call or within 14 calendar days after we get your request by first-class mail.

Changes to the terms of this notice

CalOptima Health reserves the right to change its privacy notice and the ways we keep your PHI safe. If this happens, we will update the notice and notify you. We will also post the updated notice on our website.

Potential for redisclosure

Information disclosed by CalOptima Health, either authorized by you (or your personal representative) or permitted by applicable privacy laws, may be redisclosed by the person receiving your information if they are not required by law to protect your information.

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Notice of Privacy Practices

How to contact us to use your rights

If you want to use any of the privacy rights explained in this notice, please write to us at:

CalOptima Health
Privacy Officer
505 City Parkway West
Orange, CA 92868
1-888-587-8088 (TTY **711**)

Or call CalOptima Health Customer Service **toll-free at**
1-888-587-8088 (TTY **711**). We have staff who speak your language.

If you believe that we have not protected your privacy and wish to file a complaint or grievance, you may write or call CalOptima Health at the address and phone number above. You may also contact these agencies:

California Department of Health Care Services
Privacy Officer
C/O: Office of HIPAA Compliance
P.O. Box 997413 MS 4722
Sacramento, CA 95899-7413
Email: privacyofficer@dhcs.ca.gov
Phone: 1-916-445-4646
Fax: 1-916-440-7680

U.S. Department of Health and Human Services
Office for Civil Rights
Regional Manager
90 Seventh Street, Suite 4-100
San Francisco, CA 94103
Email: OCRComplaint@hhs.gov
Phone: 1-800-368-1019
Fax: 1-415-437-8329
TDD: 1-800-537-7697

Use your rights without fear

CalOptima Health cannot take away your health care benefits, nor do anything to hurt you in any way, if you choose to file a complaint or use any of the privacy rights in this notice. This notice applies to all CalOptima Health's health care programs.

For 20251106 BOD Review Only

Policy:	HH.3011
Title:	**Use and Disclosure of PHI for Treatment, Payment, and Health Care Operations**
Department:	Office of Compliance
Section:	Privacy
CEO Approval:	*/s/*
Effective Date:	04/01/2003
Revised Date:	09/01/2025
Applicable to:	☐ Administrative ☐ Covered California [Effective 2027] ☒ Medi-Cal ☒ OneCare ☒ PACE

For 20251106 BOD Review Only

I. PURPOSE

This policy describes the requirements for the Use and Disclosure of Member Protected Health Information (PHI) for Treatment, Payment, and Health Care Operations.

II. POLICY

A. CalOptima Health shall maintain the privacy of PHI in compliance with all federal and state laws when Using, or Disclosing, PHI for Treatment, Payment, and Health Care Operations, including applying the Minimum Necessary standard, when applicable.

B. Unless otherwise prohibited by other state or federal law, CalOptima Health may Use or Disclose PHI pertaining to a Member to perform functions, activities, or services for the purposes directly related to the administration of CalOptima Health programs.

C. CalOptima Health may Use and Disclose a Member's PHI without a Member's Authorization for Treatment, Payment, or Health Care Operations in compliance with the Health Insurance Portability and Accountability Act (HIPAA) and other federal and state laws to the extent that they are more protective of the Member's privacy.

D. Uses and Disclosures pursuant to a valid Member Authorization do not need to be tracked pursuant to CalOptima Health Policy HH.3006: Tracking and Reporting Disclosures of Protected Health Information.

III. PROCEDURE

A. CalOptima Health may Use and Disclose PHI for its own Treatment purposes and may Disclose PHI for the Treatment purposes of a health care Provider:

1. Treatment

a. Activities undertaken by designated staff on behalf of a Member that includes:

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i. Direct and indirect provision of health care;

ii. Coordination and management of health care and related services;
iii. Referral to and consultation between health care Providers; and

iv. Coordination with third parties for services related to the management of the Member's health care benefits.

b. Examples of Treatment activities include, but are not limited to:

i. Disclosing a Member's PHI to facilitate Long Term Care (LTC) placement;

ii. Referral for home health care, physical therapy, obtaining Durable Medical Equipment (DME) or medical supplies; and

iii. Providing medical information when referring the Member for consultations with other Providers.

c. CalOptima Health may only Use PHI regarding mental health Treatment for its own Treatment purposes.

2. Health Care Operations

a. CalOptima Health may Use and Disclose PHI for its own Health Care Operations. CalOptima Health may only Disclose PHI to another Covered Entity for the Health Care Operations of the other Covered Entity if:

i. Each party has or had a relationship with the Member who is the subject of the PHI being requested;

ii. The PHI pertains to such relationship;

iii. The Disclosure is for the following limited purposes:

a) Quality assessment and improvement activities;

b) Patient safety activities;

c) Population-based activities;

d) Credentialing and peer review;

e) Evaluations of health care performance training programs; and

f) Health care fraud and abuse detection and compliance as described in Title 45, Code of Federal Regulations, Section 164.506(c)(4) and where consistent with the administration of the Medi-Cal program.

b. The Minimum Necessary Rule applies to Uses and Disclosures for Health Care Operations.

3. Payment

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a. CalOptima Health may Use and Disclose PHI for its own Payment activities and may Disclose PHI to another Covered Entity, or health care Provider, for the Payment activities of the entity that receives the information for CalOptima Health's health care programs. The Minimum Necessary rule applies to Uses and Discloses for Payment activities:

i. Determination of eligibility and to fulfill responsibility for coverage and provision of health benefits under agency programs;

ii. Reimbursement for provision of health care services and coordination of benefits with other health coverage;

iii. Risk adjustments based on Member health status and demographics, billing, claims management, and collection activities;

iv. Review of health care services regarding Medical Necessity, coverage under a health plan and appropriateness of care or justification of charges;

v. Utilization review activities including precertification, preauthorization, and concurrent and retrospective review of services;

vi. Disclosure to consumer reporting agencies of any of the following PHI relating to collection of premiums, or reimbursement:

a) Name and address;

b) Date of birth;

c) Social Security Number;

d) Payment History;

e) Account number; or

f) Name and address of CalOptima Health.

B. With respect to PHI regarding mental health Treatment that is protected by Section 5328 of the Welfare & Institutions Code, CalOptima Health may Disclose such information and records as follows:

1. Communications between qualified professional persons in the provision of services or appropriate referrals, or in the course of conservatorship proceedings. The consent of the Member, or his or her Personal Representative, shall be obtained before information or records may be Disclosed by a professional person employed by CalOptima Health to a professional person not employed by CalOptima Health who does not have the medical or psychological responsibility for the patient's care.

2. To the extent necessary for a Member to make a claim, or for a claim to be made on behalf of a Member for aid, insurance, or medical assistance to which he or she may be entitled.

3. To CalOptima Health's Business Associate or for Health Care Operations purpose, in accordance with Parts 160 and 164 of Subchapter C of Subtitle A of Title 45 of the Code of Federal Regulations.

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C. CalOptima Health may use or disclose Member PHI to family, friends, caregivers, or others involved with the Member's care in certain circumstances if the individual does not object or if the health plan can reasonably conclude that the individual does not object.

1. Uses and Disclosures when the Member is present:

a. Member provides verbal consent for disclosure.

2. Uses and Disclosures when the Member is not present:

a. When verbal consent or permission cannot be given due to a Member's incapacitation or in the event of an emergency situation, CalOptima Health may, in the exercise of professional judgment, disclose Member PHI limited to the individual's involvement with the Member's healthcare if it is believed to be in the best interest of the Member.

D. CalOptima Health may use or disclose member PHI to a public or private organization authorized by law or by their charters to assist in disaster relief efforts, if obtaining Member permission would interfere with the organization's emergency response.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Health PACE Program Agreement
D. CalOptima Health Compliance Plan
E. CalOptima Health Privacy Program
F. CalOptima Health Policy HH.3006: Tracking and Reporting Disclosures of Protected Health Information
G. CalOptima Health Policy HH.3019: De-identification of Protected Health Information
H. Title 22, California Code of Regulations, §51009
I. Title 42, Code of Federal Regulations, §431.00 et seq.
J. Title 45, Code of Federal Regulations, §§160, 164.501, 164.502(b), 164.506, 164.510(b)(2), 164.510(b)(3), and 164.510(b)(4).
K. Welfare and Institutions Code, §§5328 and 14100.2 (a)

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/06/2018	Regular Meeting of the CalOptima Board of Directors
12/05/2019	Regular Meeting of the CalOptima Board of Directors

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Date	Meeting
12/03/2020	Regular Meeting of the CalOptima Board of Directors
12/20/2021	Special Meeting of the CalOptima Board of Directors
11/07/2024	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	04/01/2003	HH.3011	Use and Disclosure for Treatment, Payment, and Health Care Operations	Medi-Cal
Revised	04/01/2007	HH.3011	Use and Disclosure for Treatment, Payment, and Health Care Operations	Medi-Cal
Revised	01/01/2010	HH.3011	Use and Disclosure for Treatment, Payment, and Health Care Operations	Medi-Cal
Revised	04/01/2013	HH.3011	Use and Disclosure for Treatment, Payment, and Health Care Operations	Medi-Cal
Revised	09/01/2014	HH.3011	Use and Disclosure for Treatment, Payment, and Health Care Operations	Medi-Cal
Revised	09/01/2015	HH.3011	Use and Disclosure for Treatment, Payment, and Health Care Operations	Medi-Cal
Revised	12/01/2016	HH.3011	Use and Disclosure for Treatment, Payment, and Health Care Operations	Medi-Cal OneCare OneCare Connect PACE
Revised	12/07/2017	HH.3011	Use and Disclosure of PHI for Treatment, Payment, and Health Care Operations	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.3011	Use and Disclosure of PHI for Treatment, Payment, and Health Care Operations	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.3011	Use and Disclosure of PHI for Treatment, Payment, and Health Care Operations	Medi-Cal OneCare OneCare Connect PACE
Revised	12/03/2020	HH.3011	Use and Disclosure of PHI for Treatment, Payment, and Health Care Operations	Medi-Cal OneCare OneCare Connect PACE
Revised	12/20/2021	HH.3011	Use and Disclosure of PHI for Treatment, Payment, and Health Care Operations	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2021	HH.3011	Use and Disclosure of PHI for Treatment, Payment, and Health Care Operations	Medi-Cal OneCare PACE
Revised	09/01/2023	HH.3011	Use and Disclosure of PHI for Treatment, Payment, and Health Care Operations	Medi-Cal OneCare PACE

For 20251106 BOD Review Only

Action	Date	Policy	Policy Title	Program(s)
Revised	11/07/2024	HH.3011	Use and Disclosure of PHI for Treatment, Payment, and Health Care Operations	Medi-Cal OneCare PACE
Revised	09/01/2025	HH.3011	Use and Disclosure of PHI for Treatment, Payment, and Health Care Operations	Medi-Cal OneCare PACE

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IX. GLOSSARY

Term	Definition
Authorization	Has the meaning given such term in 45 CFR Section 164.508 and other federal and state laws imposing more stringent Authorization requirements for the Use and Disclosure of Member PHI e.g. Welfare & Institution Code section 14100.2.
Covered Entity	A health plan, a health care clearinghouse, or a health care provider who transmits any health information in electronic form in connection with a transaction covered by Title 45, Code of Federal Regulations, Part 160.
Covered Service	Medi-Cal: Those health care services, set forth in W&I sections 14000 et seq. and 14131 et seq., 22 CCR section 51301 et seq., 17 CCR section 6800 et seq., the Medi-Cal Provider Manual, the California Medicaid State Plan, the California Section 1115 Medicaid Demonstration Project, the contract with DHCS for Medi-Cal, and DHCS APLs that are made the responsibility of CalOptima Health pursuant to the California Section 1915(b) Medicaid Waiver authorizing the Medi-Cal managed care program or other federally approved managed care authorities maintained by DHCS. Covered Services do not include: 1. Home and Community-Based Services (HCBS) program as specified in the DHCS contract for Medi-Cal Exhibit A, Attachment III, Subsections 4.3.15 (Services for Persons with Developmental Disabilities), 4.3.20 (Home and Community-Based Services Programs) regarding waiver programs, 4.3.21 (In-Home Supportive Services), and Department of Developmental Services (DDS) Administered Medicaid Home and Community-Based Services Waiver. HCBS programs do not include services that are available as an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) service, as described in 22 CCR sections 51184, 51340 and 51340.1. EPSDT services are covered under the DHCS contract for Medi-Cal, as specified in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services), Subsection F4 regarding services for Members less than twenty-one (21) years of age. CalOptima Health is financially responsible for the payment of all EPSDT services; 2. California Children's Services (CCS) as specified in Exhibit A, Attachment III, Subsection 4.3.14 (California Children's Services), except for Contractors providing Whole Child Model (WCM) services; 3. Specialty Mental Health Services as specified in Exhibit A, Attachment III, Subsection 4.3.12 (Mental Health Services); 4. Alcohol and SUD treatment services, and outpatient heroin and other opioid detoxification, except for medications for addiction treatment as specified in Exhibit A, Attachment III, Subsection 4.3.13 (Alcohol and Substance Use Disorder Treatment Services); 5. Fabrication of optical lenses except as specified in Exhibit A, Attachment III, Subsection 5.3.7 (Services for All Members); 6. Direct Observed Therapy for Treatment of Tuberculosis (TB) as specified in Exhibit A, Attachment III, Subsection 4.3.18 (Direct Observed Therapy for Treatment of Tuberculosis); 7. Dental services as specified in W&I sections 14131.10, 14132(h), 14132.22, 14132.23, and 14132.88, and EPSDT dental services as described in 22 CCR section 51340.1(b). However, CalOptima Health is

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Term	Definition
	responsible for all Covered Services as specified in Exhibit A, Attachment III, Subsection 4.3.17 (Dental) regarding dental services; 8. Prayer or spiritual healing as specified in 22 CCR section 51312; 9. Educationally Necessary Behavioral Health Services that are covered by a Local Education Agency (LEA) and provided pursuant to a Member's Individualized Education Plan (IEP) as set forth in Education Code section 56340 et seq., Individualized Family Service Plan (IFSP) as set forth in California Government Code (GC) section 95020, or Individualized Health and Support Plan (IHSP). However, CalOptima Health is responsible for all Medically Necessary Behavioral Health Services as specified in Exhibit A, Attachment III Subsection 4.3.16 (School-Based Services); 10. Laboratory services provided under the State serum alpha-feto-protein-testing program administered by the Genetic Disease Branch of California Department of Public Health (CDPH); 11. Pediatric Day Health Care, except for Contractors providing Whole Child Model (WCM) services; 12. State Supported Services; 13. Targeted Case Management (TCM) services as set forth in 42 USC section 1396n(g), W&I sections 14132.48 and 14021.3, 22 CCR sections 51185 and 51351, and as described in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services). However, if Members less than twenty-one (21) years of age are not eligible for or accepted by a Regional Center (RC) or a local government health program for TCM services, CalOptima Health must ensure access to comparable services under the EPSDT benefit in accordance with DHCS APL 23-005; 14. Childhood lead poisoning case management provided by county health departments; 15. Non-medical services provided by Regional Centers (RC) to individuals with Developmental Disabilities, including but not limited to respite, out-of-home placement, and supportive living; 16. End of life services as stated in Health and Safety Code (H&S) section 443 et seq., and DHCS APL 16-006; and 17. Prescribed and covered outpatient drugs, medical supplies, and enteral nutritional products when appropriately billed by a pharmacy on a pharmacy claim, in accordance with DHCS APL 22-012. OneCare: Those medical services, equipment, or supplies that CalOptima Health is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract. PACE: Those items and services provided by CalOptima Health under the provisions of Welfare and Institutions Code, section 14132 and the California State Plan, except those services specifically excluded under Exhibit E, Attachment 1 of the CalOptima Health PACE contract, state law, or the California State Plan.

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Term	Definition
Credentialing	Medi-Cal: The process of determining a Provider or an entity's professional or technical competence, and may include registration, certification, licensure and professional association membership. OneCare: The process of obtaining, verifying, assessing, and monitoring the qualifications of a Practitioner to provide quality and safe patient care services. PACE: The recognition of professional or technical competence. The process involved may include registration, certification, licensure and professional association membership.
De-identified Information	Health information that does not identify a Member and does not provide a reasonable basis to believe that the information can be Used to identify a Member.
Department of Health Care Services (DHCS)	Medi-Cal: The single State department responsible for the administration of the Medi-Cal Program, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), and other health related programs as provided by statute and/or regulation. OneCare: 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. PACE: The single State Department responsible for administration of the federal Medicaid (referred to as Medi-Cal in California) Program.
Disclosure	Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations including the following: the release, transfer, provision of access to, or divulging in any other manner of information outside of the entity holding the information.
Durable Medical Equipment (DME)	Medi-Cal: Medically Necessary medical equipment as defined by 22 CCR section 51160 that a Provider prescribes for a Member that the Member uses in the home, in the community, or in a facility that is used as a home. OneCare & PACE: Durable medical equipment means equipment prescribed by a licensed practitioner to meet medical equipment needs of the Member that: 1. Can withstand repeated use. 2. Is used to serve a medical purpose. 3. Is not useful to an individual in the absence of an illness, injury, functional impairment, or congenital anomaly. 4. Is appropriate for use in or out of the patient's home.
Grievance	Medi-Cal: Any expression of dissatisfaction about any matter other than an Adverse Benefit Determination (ABD), and may include, but is not limited to the Quality of Care or services provided, aspects of interpersonal relationships with a Provider or CalOptima Health's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by CalOptima Health to make an authorization decision. A complaint is the same as Grievance. An inquiry is a request for more information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions

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Term	Definition
	pertaining to eligibility, benefits, or other CalOptima Health processes. If CalOptima Health is unable to distinguish between a Grievance and an inquiry, it must be considered a Grievance. OneCare: An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. A grievance does not include, and is distinct from, a dispute of the appeal of an organization determination or coverage determination or an LEP determination. PACE: A complaint, either written or oral, expressing dissatisfaction with service delivery or the quality of care furnished, as defined by the federal PACE regulation 42 CFR Section 460.120.
Health Care Operations	Has the meaning given such term in Section 164.501 of Title 45, Code of Federal Regulations including: activities including quality assessment and improvement activities, care management, professional review, compliance and audits, health insurance underwriting, premium rating and other activities related to a contract and health benefits, management and administration activities customer services, resolution of internal Grievances, business planning, and development activities related to compliance with the privacy rule.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO), Subcontractor, or First Tier Entity that contracts with CalOptima Health to provide Covered Services to Members.
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information, and as subsequently amended.
Limited Data Set	Protected Health Information (PHI) that Uses the indirect identifiers (State, town or city, zip codes, dates of service, birth, and death) and excludes direct identifiers of the Member or the Member's relatives, employers, or household members.
Long Term Care (LTC)	Medi-Cal: Specialized rehabilitative services and care provided in a Skilled Nursing Facility (SNF), subacute facility, pediatric subacute facility, Intermediate Care Facility/Developmentally Disabled (ICF/DD), ICF/DD-Habilitative (ICF/DD-H), or ICF/DD-Nursing (ICF/DD-N) homes. OneCare: A variety of services that help Members with health or personal needs and activities of daily living over a period of time. Long Term Care (LTC) may be provided at home, in the community, or in various types of facilities, including nursing homes and assisted living facilities.
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.

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Term	Definition
	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 Health shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child. OneCare: Reasonable and necessary medical services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services includes Medi-Cal Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. PACE: 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.
Medical Record	Medi-Cal: The record of a Member's medical information including but not limited to, medical history, care or treatments received, test results, diagnoses, and prescribed medications. OneCare: A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal. PACE: Written documentary evidence of treatments rendered to plan Members.
Member	A beneficiary enrolled in a CalOptima Health program.
Minimum Necessary	The principle that a covered entity must make reasonable efforts to Use, Disclose, and request only the minimum amount of protected health information needed to accomplish the intended purpose of the Use, Disclosure, or request for Treatment, Payment or Health Care Operations.
Payment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities carried out by CalOptima Health including: 1. Determination of eligibility, risk adjustments based on Member health status and demographics, billing claims management, and collection activities; 2. Review of health care services regarding medical necessity, coverage under a health plan, appropriateness of care, or justification of charges; and 3. Utilization review activities including pre-certification, preauthorization, concurrent, or retrospective review of services.

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Term	Definition
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 a reasonable basis to believe the information can be Used to identify the individual. The information was created or received by CalOptima Health or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Provider	Medi-Cal: Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so. OneCare: Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier, etc.) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of Covered Services under Medicare Part B.
Treatment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities undertaken on behalf of a Member including the provision, coordination, or management of health care and related services; the referral to, and consultation between, health care Providers; and coordination with third parties for services related to the management of the Member's health care benefits.
Use	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.

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Policy:	HH.3011
Title:	**Use and Disclosure of PHI for Treatment, Payment, and Health Care Operations**
Department:	Office of Compliance
Section:	Privacy
CEO Approval:	*/s/*
Effective Date:	04/01/2003
Revised Date:	09/01/2025
Applicable to:	☐ Administrative ☐ Covered California [Effective 2027] ☒ Medi-Cal ☒ OneCare ☒ PACE

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I. PURPOSE

This policy describes the requirements for the Use and Disclosure of Member Protected Health Information (PHI) for Treatment, Payment, and Health Care Operations.

II. POLICY

A. CalOptima Health shall maintain the privacy of PHI in compliance with all federal and state laws when Using, or Disclosing, PHI for Treatment, Payment, and Health Care Operations, including applying the Minimum Necessary standard, when applicable.

B. Unless otherwise prohibited by other state or federal law, CalOptima Health may Use or Disclose PHI pertaining to a Member to perform functions, activities, or services for the purposes directly related to the administration of CalOptima Health programs.

C. CalOptima Health may Use and Disclose a Member's PHI without a Member's Authorization for Treatment, Payment, or Health Care Operations in compliance with the Health Insurance Portability and Accountability Act (HIPAA) and other federal and state laws to the extent that they are more protective of the Member's privacy.

D. Uses and Disclosures pursuant to a valid Member Authorization do not need to be tracked pursuant to CalOptima Health Policy HH.3006: Tracking and Reporting Disclosures of Protected Health Information.

III. PROCEDURE

A. CalOptima Health may Use and Disclose PHI for its own Treatment purposes and may Disclose PHI for the Treatment purposes of a health care Provider:

1. Treatment

a. Activities undertaken by designated staff on behalf of a Member that includes:

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i. Direct and indirect provision of health care;

ii. Coordination and management of health care and related services;
iii. Referral to and consultation between health care Providers; and

iv. Coordination with third parties for services related to the management of the Member's health care benefits.

b. Examples of Treatment activities include, but are not limited to:

i. Disclosing a Member's PHI to facilitate Long Term Care (LTC) placement;

ii. Referral for home health care, physical therapy, obtaining Durable Medical Equipment (DME) or medical supplies; and

iii. Providing medical information when referring the Member for consultations with other Providers.

c. CalOptima Health may only Use PHI regarding mental health Treatment for its own Treatment purposes.

2. Health Care Operations

a. CalOptima Health may Use and Disclose PHI for its own Health Care Operations. CalOptima Health may only Disclose PHI to another Covered Entity for the Health Care Operations of the other Covered Entity if:

i. Each party has or had a relationship with the Member who is the subject of the PHI being requested;

ii. The PHI pertains to such relationship;

iii. The Disclosure is for the following limited purposes:

a) Quality assessment and improvement activities;

b) Patient safety activities;

c) Population-based activities;

d) Credentialing and peer review;

e) Evaluations of health care performance training programs; and

f) Health care fraud and abuse detection and compliance as described in Title 45, Code of Federal Regulations, Section 164.506(c)(4) and where consistent with the administration of the Medi-Cal program.

b. The Minimum Necessary Rule applies to Uses and Disclosures for Health Care Operations.

3. Payment

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a. CalOptima Health may Use and Disclose PHI for its own Payment activities and may Disclose PHI to another Covered Entity, or health care Provider, for the Payment activities of the entity that receives the information for CalOptima Health's health care programs. The Minimum Necessary rule applies to Uses and Discloses for Payment activities:

i. Determination of eligibility and to fulfill responsibility for coverage and provision of health benefits under agency programs;

ii. Reimbursement for provision of health care services and coordination of benefits with other health coverage;

iii. Risk adjustments based on Member health status and demographics, billing, claims management, and collection activities;

iv. Review of health care services regarding Medical Necessity, coverage under a health plan and appropriateness of care or justification of charges;

v. Utilization review activities including precertification, preauthorization, and concurrent and retrospective review of services;

vi. Disclosure to consumer reporting agencies of any of the following PHI relating to collection of premiums, or reimbursement:

a) Name and address;

b) Date of birth;

c) Social Security Number;

d) Payment History;

e) Account number; or

f) Name and address of CalOptima Health.

B. With respect to PHI regarding mental health Treatment that is protected by Section 5328 of the Welfare & Institutions Code, CalOptima Health may Disclose such information and records as follows:

1. Communications between qualified professional persons in the provision of services or appropriate referrals, or in the course of conservatorship proceedings. The consent of the Member, or his or her Personal Representative, shall be obtained before information or records may be Disclosed by a professional person employed by CalOptima Health to a professional person not employed by CalOptima Health who does not have the medical or psychological responsibility for the patient's care.

2. To the extent necessary for a Member to make a claim, or for a claim to be made on behalf of a Member for aid, insurance, or medical assistance to which he or she may be entitled.

3. To CalOptima Health's Business Associate or for Health Care Operations purpose, in accordance with Parts 160 and 164 of Subchapter C of Subtitle A of Title 45 of the Code of Federal Regulations.

For 20251106 BOD Review Only

C. CalOptima Health may use or disclose Member PHI to family, friends, caregivers, or others involved with the Member's care in certain circumstances if the individual does not object or if the health plan can reasonably conclude that the individual does not object.

1. Uses and Disclosures when the Member is present:

a. Member provides verbal consent for disclosure.

2. Uses and Disclosures when the Member is not present:

a. When verbal consent or permission cannot be given due to a Member's incapacitation or in the event of an emergency situation, CalOptima Health may, in the exercise of professional judgment, disclose Member PHI limited to the individual's involvement with the Member's healthcare if it is believed to be in the best interest of the Member.

D. CalOptima Health may use or disclose member PHI to a public or private organization authorized by law or by their charters to assist in disaster relief efforts, if obtaining Member permission would interfere with the organization's emergency response.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Health PACE Program Agreement
D. CalOptima Health Compliance Plan
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F. CalOptima Health Policy HH.3006: Tracking and Reporting Disclosures of Protected Health Information
G. CalOptima Health Policy HH.3019: De-identification of Protected Health Information
H. Title 22, California Code of Regulations, §51009
I. Title 42, Code of Federal Regulations, §431.00 et seq.
J. Title 45, Code of Federal Regulations, §§160, 164.501, 164.502(b), 164.506, 164.510(b)(2), 164.510(b)(3), and 164.510(b)(4).
K. Welfare and Institutions Code, §§5328 and 14100.2 (a)

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/06/2018	Regular Meeting of the CalOptima Board of Directors
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For 20251106 BOD Review Only

Date	Meeting
12/03/2020	Regular Meeting of the CalOptima Board of Directors
12/20/2021	Special Meeting of the CalOptima Board of Directors
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VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	04/01/2003	HH.3011	Use and Disclosure for Treatment, Payment, and Health Care Operations	Medi-Cal
Revised	04/01/2007	HH.3011	Use and Disclosure for Treatment, Payment, and Health Care Operations	Medi-Cal
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Revised	12/01/2016	HH.3011	Use and Disclosure for Treatment, Payment, and Health Care Operations	Medi-Cal OneCare OneCare Connect PACE
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Revised	09/01/2023	HH.3011	Use and Disclosure of PHI for Treatment, Payment, and Health Care Operations	Medi-Cal OneCare PACE

For 20251106 BOD Review Only

Action	Date	Policy	Policy Title	Program(s)
Revised	11/07/2024	HH.3011	Use and Disclosure of PHI for Treatment, Payment, and Health Care Operations	Medi-Cal OneCare PACE
Revised	09/01/2025	HH.3011	Use and Disclosure of PHI for Treatment, Payment, and Health Care Operations	Medi-Cal OneCare PACE

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IX. GLOSSARY

Term	Definition
Authorization	Has the meaning given such term in 45 CFR Section 164.508 and other federal and state laws imposing more stringent Authorization requirements for the Use and Disclosure of Member PHI e.g. Welfare & Institution Code section 14100.2.
Covered Entity	A health plan, a health care clearinghouse, or a health care provider who transmits any health information in electronic form in connection with a transaction covered by Title 45, Code of Federal Regulations, Part 160.
Covered Service	Medi-Cal: Those health care services, set forth in W&I sections 14000 et seq. and 14131 et seq., 22 CCR section 51301 et seq., 17 CCR section 6800 et seq., the Medi-Cal Provider Manual, the California Medicaid State Plan, the California Section 1115 Medicaid Demonstration Project, the contract with DHCS for Medi-Cal, and DHCS APLs that are made the responsibility of CalOptima Health pursuant to the California Section 1915(b) Medicaid Waiver authorizing the Medi-Cal managed care program or other federally approved managed care authorities maintained by DHCS. Covered Services do not include: 1. Home and Community-Based Services (HCBS) program as specified in the DHCS contract for Medi-Cal Exhibit A, Attachment III, Subsections 4.3.15 (Services for Persons with Developmental Disabilities), 4.3.20 (Home and Community-Based Services Programs) regarding waiver programs, 4.3.21 (In-Home Supportive Services), and Department of Developmental Services (DDS) Administered Medicaid Home and Community-Based Services Waiver. HCBS programs do not include services that are available as an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) service, as described in 22 CCR sections 51184, 51340 and 51340.1. EPSDT services are covered under the DHCS contract for Medi-Cal, as specified in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services), Subsection F4 regarding services for Members less than twenty-one (21) years of age. CalOptima Health is financially responsible for the payment of all EPSDT services; 2. California Children's Services (CCS) as specified in Exhibit A, Attachment III, Subsection 4.3.14 (California Children's Services), except for Contractors providing Whole Child Model (WCM) services; 3. Specialty Mental Health Services as specified in Exhibit A, Attachment III, Subsection 4.3.12 (Mental Health Services); 4. Alcohol and SUD treatment services, and outpatient heroin and other opioid detoxification, except for medications for addiction treatment as specified in Exhibit A, Attachment III, Subsection 4.3.13 (Alcohol and Substance Use Disorder Treatment Services); 5. Fabrication of optical lenses except as specified in Exhibit A, Attachment III, Subsection 5.3.7 (Services for All Members); 6. Direct Observed Therapy for Treatment of Tuberculosis (TB) as specified in Exhibit A, Attachment III, Subsection 4.3.18 (Direct Observed Therapy for Treatment of Tuberculosis); 7. Dental services as specified in W&I sections 14131.10, 14132(h), 14132.22, 14132.23, and 14132.88, and EPSDT dental services as described in 22 CCR section 51340.1(b). However, CalOptima Health is

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Term	Definition
	responsible for all Covered Services as specified in Exhibit A, Attachment III, Subsection 4.3.17 (Dental) regarding dental services; 8. Prayer or spiritual healing as specified in 22 CCR section 51312; 9. Educationally Necessary Behavioral Health Services that are covered by a Local Education Agency (LEA) and provided pursuant to a Member's Individualized Education Plan (IEP) as set forth in Education Code section 56340 et seq., Individualized Family Service Plan (IFSP) as set forth in California Government Code (GC) section 95020, or Individualized Health and Support Plan (IHSP). However, CalOptima Health is responsible for all Medically Necessary Behavioral Health Services as specified in Exhibit A, Attachment III Subsection 4.3.16 (School-Based Services); 10. Laboratory services provided under the State serum alpha-feto-protein-testing program administered by the Genetic Disease Branch of California Department of Public Health (CDPH); 11. Pediatric Day Health Care, except for Contractors providing Whole Child Model (WCM) services; 12. State Supported Services; 13. Targeted Case Management (TCM) services as set forth in 42 USC section 1396n(g), W&I sections 14132.48 and 14021.3, 22 CCR sections 51185 and 51351, and as described in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services). However, if Members less than twenty-one (21) years of age are not eligible for or accepted by a Regional Center (RC) or a local government health program for TCM services, CalOptima Health must ensure access to comparable services under the EPSDT benefit in accordance with DHCS APL 23-005; 14. Childhood lead poisoning case management provided by county health departments; 15. Non-medical services provided by Regional Centers (RC) to individuals with Developmental Disabilities, including but not limited to respite, out-of-home placement, and supportive living; 16. End of life services as stated in Health and Safety Code (H&S) section 443 et seq., and DHCS APL 16-006; and 17. Prescribed and covered outpatient drugs, medical supplies, and enteral nutritional products when appropriately billed by a pharmacy on a pharmacy claim, in accordance with DHCS APL 22-012. OneCare: Those medical services, equipment, or supplies that CalOptima Health is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract. PACE: Those items and services provided by CalOptima Health under the provisions of Welfare and Institutions Code, section 14132 and the California State Plan, except those services specifically excluded under Exhibit E, Attachment 1 of the CalOptima Health PACE contract, state law, or the California State Plan.

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Term	Definition
Credentialing	Medi-Cal: The process of determining a Provider or an entity's professional or technical competence, and may include registration, certification, licensure and professional association membership. OneCare: The process of obtaining, verifying, assessing, and monitoring the qualifications of a Practitioner to provide quality and safe patient care services. PACE: The recognition of professional or technical competence. The process involved may include registration, certification, licensure and professional association membership.
De-identified Information	Health information that does not identify a Member and does not provide a reasonable basis to believe that the information can be Used to identify a Member.
Department of Health Care Services (DHCS)	Medi-Cal: The single State department responsible for the administration of the Medi-Cal Program, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), and other health related programs as provided by statute and/or regulation. OneCare: 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. PACE: The single State Department responsible for administration of the federal Medicaid (referred to as Medi-Cal in California) Program.
Disclosure	Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations including the following: the release, transfer, provision of access to, or divulging in any other manner of information outside of the entity holding the information.
Durable Medical Equipment (DME)	Medi-Cal: Medically Necessary medical equipment as defined by 22 CCR section 51160 that a Provider prescribes for a Member that the Member uses in the home, in the community, or in a facility that is used as a home. OneCare & PACE: Durable medical equipment means equipment prescribed by a licensed practitioner to meet medical equipment needs of the Member that: 1. Can withstand repeated use. 2. Is used to serve a medical purpose. 3. Is not useful to an individual in the absence of an illness, injury, functional impairment, or congenital anomaly. 4. Is appropriate for use in or out of the patient's home.
Grievance	Medi-Cal: Any expression of dissatisfaction about any matter other than an Adverse Benefit Determination (ABD), and may include, but is not limited to the Quality of Care or services provided, aspects of interpersonal relationships with a Provider or CalOptima Health's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by CalOptima Health to make an authorization decision. A complaint is the same as Grievance. An inquiry is a request for more information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions

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Term	Definition
	pertaining to eligibility, benefits, or other CalOptima Health processes. If CalOptima Health is unable to distinguish between a Grievance and an inquiry, it must be considered a Grievance. OneCare: An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. A grievance does not include, and is distinct from, a dispute of the appeal of an organization determination or coverage determination or an LEP determination. PACE: A complaint, either written or oral, expressing dissatisfaction with service delivery or the quality of care furnished, as defined by the federal PACE regulation 42 CFR Section 460.120.
Health Care Operations	Has the meaning given such term in Section 164.501 of Title 45, Code of Federal Regulations including: activities including quality assessment and improvement activities, care management, professional review, compliance and audits, health insurance underwriting, premium rating and other activities related to a contract and health benefits, management and administration activities customer services, resolution of internal Grievances, business planning, and development activities related to compliance with the privacy rule.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO), Subcontractor, or First Tier Entity that contracts with CalOptima Health to provide Covered Services to Members.
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information, and as subsequently amended.
Limited Data Set	Protected Health Information (PHI) that Uses the indirect identifiers (State, town or city, zip codes, dates of service, birth, and death) and excludes direct identifiers of the Member or the Member's relatives, employers, or household members.
Long Term Care (LTC)	Medi-Cal: Specialized rehabilitative services and care provided in a Skilled Nursing Facility (SNF), subacute facility, pediatric subacute facility, Intermediate Care Facility/Developmentally Disabled (ICF/DD), ICF/DD-Habilitative (ICF/DD-H), or ICF/DD-Nursing (ICF/DD-N) homes. OneCare: A variety of services that help Members with health or personal needs and activities of daily living over a period of time. Long Term Care (LTC) may be provided at home, in the community, or in various types of facilities, including nursing homes and assisted living facilities.
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.

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Term	Definition
	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 Health shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child. OneCare: Reasonable and necessary medical services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services includes Medi-Cal Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. PACE: 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.
Medical Record	Medi-Cal: The record of a Member's medical information including but not limited to, medical history, care or treatments received, test results, diagnoses, and prescribed medications. OneCare: A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal. PACE: Written documentary evidence of treatments rendered to plan Members.
Member	A beneficiary enrolled in a CalOptima Health program.
Minimum Necessary	The principle that a covered entity must make reasonable efforts to Use, Disclose, and request only the minimum amount of protected health information needed to accomplish the intended purpose of the Use, Disclosure, or request for Treatment, Payment or Health Care Operations.
Payment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities carried out by CalOptima Health including: 1. Determination of eligibility, risk adjustments based on Member health status and demographics, billing claims management, and collection activities; 2. Review of health care services regarding medical necessity, coverage under a health plan, appropriateness of care, or justification of charges; and 3. Utilization review activities including pre-certification, preauthorization, concurrent, or retrospective review of services.

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Term	Definition
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 a reasonable basis to believe the information can be Used to identify the individual. The information was created or received by CalOptima Health or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Provider	Medi-Cal: Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so. OneCare: Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier, etc.) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of Covered Services under Medicare Part B.
Treatment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities undertaken on behalf of a Member including the provision, coordination, or management of health care and related services; the referral to, and consultation between, health care Providers; and coordination with third parties for services related to the management of the Member's health care benefits.
Use	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.

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Policy:	HH.3014
Title:	**Use of Electronic Mail with Protected Health Information (PHI) and Personally Identifiable Information (PII)**
Department:	Office of Compliance
Section:	Privacy
CEO Approval:	*/s/*
Effective Date:	04/01/2003
Revised Date:	09/01/2025
Applicable to:	☐ Administrative ☐ Covered California [Effective 2027] ☒ Medi-Cal ☒ OneCare ☒ PACE

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I. PURPOSE

This policy describes CalOptima Health's procedures related to the Use of electronic mail (email) to send information containing Protected Health Information (PHI) and Personally Identifiable Information (PII).

II. POLICY

A. CalOptima Health, its Business Associates, and First Tier, Downstream, and Related Entities (FDRs) shall send email containing PHI/PII as follows:

1. Internal email

   a. Email sent within CalOptima Health's mail system may contain PHI/PII that is limited to the Use and Disclosure of the Minimum Necessary data to complete the required message, in accordance with CalOptima Health Policy HH.3002: Minimum Necessary Uses and Disclosure of Protected Health Information (PHI) and Document Controls.

   b. PHI/PII (e.g., Member name, Social Security Number, Client Index Number [CIN]) shall not be included in the subject line of the email.

2. External email sent on the Internet

   a. Email that CalOptima Health or a Business Associate sends to an external entity via the open Internet shall not contain PHI/PII unless the email, or attachment, has been encrypted to prevent anyone, other than the intended receiver, from reading the contents.

   b. Email that CalOptima Health or a Business Associate sends to an outside entity may contain PHI/PII that is limited to the Use and Disclosure of the Minimum Necessary data to complete the required message, in accordance with CalOptima Health Policy HH.3002: Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls.

   c. PHI/PII (e.g., Member name, Social Security Number, Client Index Number [CIN]) shall not be included in the subject line of the email.

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B. CalOptima Health staff shall appropriately use information and Information Technology (IT) resources and security of those resources when performing procedures related to the Use of email to send information containing PHI/PII, in accordance with CalOptima Health Policy GA.5005a: Acceptable Use of Technology Resources.

C. CalOptima Health staff shall follow instructions for Use of email, as set forth in CalOptima Health Policy GA.5005b: Email and Internet Use.

III. PROCEDURE

A. Communications via email sent through the open Internet requires Encryption to prevent unauthorized access to PHI/PII, in accordance with CalOptima Health Policy IT.1202: Technical Safeguards – Data Controls. CalOptima Health employees shall encrypt external emails by utilizing Microsoft Outlook Send Secure encryption, Transport Layer Security (TLS) encryption technology, or other encryption technologies established by IT.

B. CalOptima Health employees and Business Associates shall immediately report any suspected or known Security Incidents, Breach, and/or other unauthorized access, Use or Disclosure of PHI/PII to the CalOptima Health Privacy Officer, or Designee, in accordance with CalOptima Health Policy HH.3020: Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PII or other Unauthorized Use or Disclosure of PHI/PII.

C. CalOptima Health employees shall not save or store data files in an electronic format that contain PHI/PII on public or private computers, unencrypted personal removable storage devices, personal cloud storage, and/or personal email accounts, in accordance with CalOptima Health Policy HH.3016: Guidelines for Handling Protected Health Information (PHI) Off-site.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Health PACE Program Agreement
D. CalOptima Health Compliance Plan
E. CalOptima Health Policy GA.5005a: Acceptable Use of Technology Resources
F. CalOptima Health Policy GA.5005b: E-mail and Internet Use
G. CalOptima Health Policy HH.3002: Minimum Necessary Uses and Disclosure of Protected Health Information (PHI) and Document Controls
H. CalOptima Health Policy HH.3016: Guidelines for Handling Protected Health Information (PHI) Off-site
I. CalOptima Health Policy HH.3020: Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PII or other Unauthorized Use or Disclosure of PHI/PII
J. CalOptima Health Policy IT.1202: Technical Safeguards – Data Controls

VI. REGULATORY AGENCY APPROVAL(S)

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Date	Regulatory Agency	Response
09/17/2009	Department of Health Care Services (DHCS)	Approved as Submitted
07/16/2010	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/06/2018	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
11/07/2024	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	04/01/2003	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal
Revised	04/01/2007	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal
Revised	01/01/2008	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal
Revised	01/01/2009	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal
Revised	06/01/2010	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal
Revised	01/01/2011	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal
Revised	04/01/2013	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal OneCare
Revised	05/01/2014	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal
Revised	09/01/2015	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal
Revised	12/01/2016	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal OneCare OneCare Connect PACE
Revised	12/07/2017	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal OneCare OneCare Connect PACE

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Action	Date	Policy	Policy Title	Program(s)
Revised	12/05/2019	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal OneCare OneCare Connect PACE
Revised	12/03/2020	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal OneCare OneCare Connect PACE
Revised	12/20/2021	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal OneCare PACE
Revised	09/01/2023	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal OneCare PACE
Revised	11/07/2024	HH.3014	Use of Electronic Mail with Protected Health Information (PHI) and Personally Identifiable Information (PII)	Medi-Cal OneCare PACE
Revised	09/01/2025	HH.3014	Use of Electronic Mail with Protected Health Information (PHI) and Personally Identifiable Information (PII)	Medi-Cal OneCare PACE

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IX. GLOSSARY

Term	Definition
Breach	Has the meaning in 45, Code of Federal Regulations Section 164.402. The acquisition, access, Use, or Disclosure of protected health information in a manner not permitted under subpart E of this part which compromises the security or privacy of the protected health information. Breach excludes: 1. Any unintentional acquisition, access, or Use of protected health information by a workforce member or person acting under the authority of a covered entity or a Business Associate, if such acquisition, access, or Use was made in good faith and within the scope of authority and does not result in further Use or Disclosure in a manner not permitted under subpart E of this part. 2. Any inadvertent Disclosure by a person who is authorized to access protected health information at a covered entity or Business Associate to another person authorized to access protected health information at the same covered entity or Business Associate, or organized health care arrangement in which the covered entity participates, and the information received as a result of such Disclosure is not further Used or Disclosed in a manner not permitted under subpart E of this part. 3. A Disclosure of protected health information where a covered entity or Business Associate has a good faith belief that an unauthorized person to whom the Disclosure was made would not reasonably have been able to retain such information
Business Associate	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. A person or entity who: 1. On behalf of such covered entity or of an organized health care arrangement (as defined in this section) in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, creates, receives, maintains, or transmits protected health information for a function or activity regulated by this subchapter, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, patient safety activities listed at 42 CFR 3.20, billing, benefit management, practice management, and repricing; or 2. Provides, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation (as defined in §164.501 of this subchapter), management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the service involves the Disclosure of protected health information from such covered entity or arrangement, or from another Business Associate of such covered entity or arrangement, to the person. A covered entity may be a Business Associate of another covered entity.

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Term	Definition
	Business Associate includes: 1. A Health Information Organization, E-prescribing Gateway, or other person that provides data transmission services with respect to protected health information to a covered entity and that requires access on a routine basis to such protected health information. 2. A person that offers a personal health record to one or more individuals on behalf of a covered entity. 3. A subcontractor that creates, receives, maintains, or transmits protected health information on behalf of the Business Associate
Disclosure	Has the meaning in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.
Encryption	The Use of an algorithmic process to transform data into a form in which there is a low probability of assigning meaning without Use of a confidential process or key or a method of converting an original message of regular text into encoded or unreadable text that is eventually decrypted into plan comprehensible text.
First Tier, Downstream and Related Entities (FDR)	For purposes of this policy, FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, and Health Maintenance Organizations.
Health Network	For purposes of this policy, the contracted Health Networks of CalOptima Health, including Physician Hospital Consortia ("PHCs"), Shared Risk Medical Groups ("SRGs"), and Health Maintenance Organizations ("HMOs").
Member	A beneficiary enrolled in a CalOptima Health Program.
Minimum Necessary	The principle that a covered entity must make reasonable efforts to Use, Disclose, and request only the minimum amount of protected health information needed to accomplish the intended purpose of the Use, Disclosure, or request for Treatment, Payment or Health Care Operations.
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. Individually identifiable health information identifies the individual or there is reasonable basis to believe the information can be Used to identify the individual. The information was created or received by CalOptima Health or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.

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Term	Definition
Security Incident	Has the meaning in 45 Code of Federal Regulations Section 164.304. The attempted or successful unauthorized access, Use, Disclosure, modification, or destruction of information or interference with system operations in an information system.
Unsecured PHI/PII	Has the meaning in 45 Code of Federal Regulations Section 164.402. Protected Health Information that is not rendered unusable, unreadable, or indecipherable to unauthorized persons through the Use of a technology or methodology specified by the Secretary in the guidance issued under section 13402(h)(2) of Public Law 111-5.
Personally Identifiable Information (PII)	Any information about an individual maintained by an agency, including (1) any information that can be Used to distinguish or trace an individual's identity, such as name, social security number, date and place of birth, mother's maiden name, biometric records, race, ethnicity, language (REL), sexual orientation and gender identity (SOGI); and (2) any other information that is linked or linkable to an individual, such as medical, educational, financial, and employment information.
Use	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.

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Policy:	HH.3014
Title:	**Use of Electronic Mail with Protected Health Information (PHI) and Personally Identifiable Information (PII)**
Department:	Office of Compliance
Section:	Privacy
CEO Approval:	*/s/*
Effective Date:	04/01/2003
Revised Date:	09/01/2025
Applicable to:	☐ Administrative ☐ Covered California [Effective 2027] ☒ Medi-Cal ☒ OneCare ☒ PACE

For 2025 1106 BOD Review Only

I. PURPOSE

This policy describes CalOptima Health's procedures related to the Use of electronic mail (email) to send information containing Protected Health Information (PHI) and Personally Identifiable Information (PII).

II. POLICY

A. CalOptima Health, its Business Associates, and First Tier, Downstream, and Related Entities (FDRs) shall send email containing PHI/PII as follows:

1. Internal email

   a. Email sent within CalOptima Health's mail system may contain PHI/PII that is limited to the Use and Disclosure of the Minimum Necessary data to complete the required message, in accordance with CalOptima Health Policy HH.3002: Minimum Necessary Uses and Disclosure of Protected Health Information (PHI) and Document Controls.

   b. PHI/PII (e.g., Member name, Social Security Number, Client Index Number [CIN]) shall not be included in the subject line of the email.

2. External email sent on the Internet

   a. Email that CalOptima Health or a Business Associate sends to an external entity via the open Internet shall not contain PHI/PII unless the email, or attachment, has been encrypted to prevent anyone, other than the intended receiver, from reading the contents.

   b. Email that CalOptima Health or a Business Associate sends to an outside entity may contain PHI/PII that is limited to the Use and Disclosure of the Minimum Necessary data to complete the required message, in accordance with CalOptima Health Policy HH.3002: Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls.

   c. PHI/PII (e.g., Member name, Social Security Number, Client Index Number [CIN]) shall not be included in the subject line of the email.

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B. CalOptima Health staff shall appropriately use information and Information Technology (IT) resources and security of those resources when performing procedures related to the Use of email to send information containing PHI/PII, in accordance with CalOptima Health Policy GA.5005a: Acceptable Use of Technology Resources.

C. CalOptima Health staff shall follow instructions for Use of email, as set forth in CalOptima Health Policy GA.5005b: Email and Internet Use.

III. PROCEDURE

A. Communications via email sent through the open Internet requires Encryption to prevent unauthorized access to PHI/PII, in accordance with CalOptima Health Policy IT.1202: Technical Safeguards – Data Controls. CalOptima Health employees shall encrypt external emails by utilizing Microsoft Outlook Send Secure encryption, Transport Layer Security (TLS) encryption technology, or other encryption technologies established by IT.

B. CalOptima Health employees and Business Associates shall immediately report any suspected or known Security Incidents, Breach, and/or other unauthorized access, Use or Disclosure of PHI/PII to the CalOptima Health Privacy Officer, or Designee, in accordance with CalOptima Health Policy HH.3020: Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PII or other Unauthorized Use or Disclosure of PHI/PII.

C. CalOptima Health employees shall not save or store data files in an electronic format that contain PHI/PII on public or private computers, unencrypted personal removable storage devices, personal cloud storage, and/or personal email accounts, in accordance with CalOptima Health Policy HH.3016: Guidelines for Handling Protected Health Information (PHI) Off-site.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Health PACE Program Agreement
D. CalOptima Health Compliance Plan
E. CalOptima Health Policy GA.5005a: Acceptable Use of Technology Resources
F. CalOptima Health Policy GA.5005b: E-mail and Internet Use
G. CalOptima Health Policy HH.3002: Minimum Necessary Uses and Disclosure of Protected Health Information (PHI) and Document Controls
H. CalOptima Health Policy HH.3016: Guidelines for Handling Protected Health Information (PHI) Off-site
I. CalOptima Health Policy HH.3020: Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PII or other Unauthorized Use or Disclosure of PHI/PII
J. CalOptima Health Policy IT.1202: Technical Safeguards – Data Controls

VI. REGULATORY AGENCY APPROVAL(S)

For 20251106 BOD Review Only

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Date	Regulatory Agency	Response
09/17/2009	Department of Health Care Services (DHCS)	Approved as Submitted
07/16/2010	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/06/2018	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
11/07/2024	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	04/01/2003	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal
Revised	04/01/2007	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal
Revised	01/01/2008	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal
Revised	01/01/2009	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal
Revised	06/01/2010	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal
Revised	01/01/2011	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal
Revised	04/01/2013	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal OneCare
Revised	05/01/2014	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal
Revised	09/01/2015	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal
Revised	12/01/2016	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal OneCare OneCare Connect PACE
Revised	12/07/2017	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal OneCare OneCare Connect PACE

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Action	Date	Policy	Policy Title	Program(s)
Revised	12/05/2019	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal OneCare OneCare Connect PACE
Revised	12/03/2020	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal OneCare OneCare Connect PACE
Revised	12/20/2021	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal OneCare PACE
Revised	09/01/2023	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal OneCare PACE
Revised	11/07/2024	HH.3014	Use of Electronic Mail with Protected Health Information (PHI) and Personally Identifiable Information (PII)	Medi-Cal OneCare PACE
Revised	09/01/2025	HH.3014	Use of Electronic Mail with Protected Health Information (PHI) and Personally Identifiable Information (PII)	Medi-Cal OneCare PACE

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IX. GLOSSARY

Term	Definition
Breach	Has the meaning in 45, Code of Federal Regulations Section 164.402. The acquisition, access, Use, or Disclosure of protected health information in a manner not permitted under subpart E of this part which compromises the security or privacy of the protected health information. Breach excludes: 1. Any unintentional acquisition, access, or Use of protected health information by a workforce member or person acting under the authority of a covered entity or a Business Associate, if such acquisition, access, or Use was made in good faith and within the scope of authority and does not result in further Use or Disclosure in a manner not permitted under subpart E of this part. 2. Any inadvertent Disclosure by a person who is authorized to access protected health information at a covered entity or Business Associate to another person authorized to access protected health information at the same covered entity or Business Associate, or organized health care arrangement in which the covered entity participates, and the information received as a result of such Disclosure is not further Used or Disclosed in a manner not permitted under subpart E of this part. 3. A Disclosure of protected health information where a covered entity or Business Associate has a good faith belief that an unauthorized person to whom the Disclosure was made would not reasonably have been able to retain such information
Business Associate	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. A person or entity who: 1. On behalf of such covered entity or of an organized health care arrangement (as defined in this section) in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, creates, receives, maintains, or transmits protected health information for a function or activity regulated by this subchapter, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, patient safety activities listed at 42 CFR 3.20, billing, benefit management, practice management, and repricing; or 2. Provides, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation (as defined in §164.501 of this subchapter), management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the service involves the Disclosure of protected health information from such covered entity or arrangement, or from another Business Associate of such covered entity or arrangement, to the person. A covered entity may be a Business Associate of another covered entity.

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Term	Definition
	Business Associate includes: 1. A Health Information Organization, E-prescribing Gateway, or other person that provides data transmission services with respect to protected health information to a covered entity and that requires access on a routine basis to such protected health information. 2. A person that offers a personal health record to one or more individuals on behalf of a covered entity. 3. A subcontractor that creates, receives, maintains, or transmits protected health information on behalf of the Business Associate
Disclosure	Has the meaning in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.
Encryption	The Use of an algorithmic process to transform data into a form in which there is a low probability of assigning meaning without Use of a confidential process or key or a method of converting an original message of regular text into encoded or unreadable text that is eventually decrypted into plan comprehensible text.
First Tier, Downstream and Related Entities (FDR)	For purposes of this policy, FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, and Health Maintenance Organizations.
Health Network	For purposes of this policy, the contracted Health Networks of CalOptima Health, including Physician Hospital Consortia ("PHCs"), Shared Risk Medical Groups ("SRGs"), and Health Maintenance Organizations ("HMOs").
Member	A beneficiary enrolled in a CalOptima Health Program.
Minimum Necessary	The principle that a covered entity must make reasonable efforts to Use, Disclose, and request only the minimum amount of protected health information needed to accomplish the intended purpose of the Use, Disclosure, or request for Treatment, Payment or Health Care Operations.
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. Individually identifiable health information identifies the individual or there is reasonable basis to believe the information can be Used to identify the individual. The information was created or received by CalOptima Health or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.

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Term	Definition
Security Incident	Has the meaning in 45 Code of Federal Regulations Section 164.304. The attempted or successful unauthorized access, Use, Disclosure, modification, or destruction of information or interference with system operations in an information system.
Unsecured PHI/PII	Has the meaning in 45 Code of Federal Regulations Section 164.402. Protected Health Information that is not rendered unusable, unreadable, or indecipherable to unauthorized persons through the Use of a technology or methodology specified by the Secretary in the guidance issued under section 13402(h)(2) of Public Law 111-5.
Personally Identifiable Information (PII)	Any information about an individual maintained by an agency, including (1) any information that can be Used to distinguish or trace an individual's identity, such as name, social security number, date and place of birth, mother's maiden name, biometric records, race, ethnicity, language (REL), sexual orientation and gender identity (SOGI); and (2) any other information that is linked or linkable to an individual, such as medical, educational, financial, and employment information.
Use	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.

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Policy:	HH.3016
Title:	**Guidelines for Handling Protected Health Information Off-site**
Department:	Office of Compliance
Section:	Privacy
CEO Approval:	*/s/*
Effective Date:	04/01/2003
Revised Date:	09/01/2025
Applicable to:	☐ Administrative ☐ Covered California [Effective 2027] ☒ Medi-Cal ☒ OneCare ☒ PACE

For 2025 1106 BOD Review Only

I. PURPOSE

This policy describes the process for handling Protected Health Information (PHI) created, accessed, or taken off-site from CalOptima Health offices.

II. POLICY

A. CalOptima Health employees shall exercise precautions according to the regulations and standards set by the Health Insurance Portability and Accountability Act (HIPAA) and CalOptima Health policies when handling PHI, or EPHI, created, accessed, or taken off-site from the main office.

III. PROCEDURE

A. General guidelines

1. Staff shall adhere to Minimum Necessary requirements when viewing, documenting, and/or recording information during any work activities that require the Use of Medical Records in facilities.

2. Staff shall not access, use, or disclose any Member PHI via CalOptima Health system without a business need.

3. Staff shall collect all data relative to a Member, whether by interview, observation, or review of documents, in a setting that provides reasonable privacy and protects the information from unauthorized Disclosure.

4. Staff shall protect all physical documents that contain Member PHI from the view, or access, by an unauthorized person during transport from and to the office through Use of:

   a. Binders; and/or

   b. Folders, or other protective cover; and/or

   c. Appropriate vehicle safeguards (e.g., locked in trunk of the vehicle); or

   d. Personal possession of Member PHI such that it is in sight at all times.

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5. Staff shall not leave any paper documents containing PHI, or other data collection forms including, without limitation, audit or other data collection forms unattended in areas accessible by an unauthorized person.

6. "Staff shall not print documents containing PHI or data collection forms off-site, except at approved Remote Work Locations. Work-from-home locations are not considered approved for printing.

7. Staff shall not forward any confidential, PHI, or sensitive information to personal or other unauthorized email accounts at any time.

8. Staff shall not store confidential, personal, or sensitive information unattended in vehicles at any time.

9. Staff shall not store confidential, personal, or sensitive information unattended in baggage, at any time, during travel.

10. Staff shall not save or store data files in an electronic format that contain PHI on public, or private, computers, unencrypted personal removable storage devices, personal cloud storage, and/or personal email accounts.

11. Staff shall not Use mobile devices of any kind to take and save photos of information and/or images containing PHI.

12. Staff shall maintain physical control of CalOptima Health laptops, cell phones, tablets, USB drives, and all other mobile devices at all times.

13. Staff shall only Use CalOptima Health-issued encrypted storage devices to store files containing PHI, in accordance with CalOptima Health Policy GA.5005a: Use of Technology Resources.

14. Staff shall shred PHI documents, or files, prior to disposal. If necessary, staff shall return documents, or files, to the main office for disposal.

15. Staff shall adhere to CalOptima Health telework workplace arrangements, in accordance with CalOptima Health Policy GA.8044: Telework Program and Telework Program Guidelines.

B. Use of Personal Computer (PC) from remote locations

1. If applicable, employees granted access to CalOptima Health's networks are required to adhere to the following procedures:

   a. Maintain the Confidentiality of his or her user sign-on identification code and password;

   b. Keep the PC secure at all times and do not leave it unattended during travel to, or working off-site at, public places (e.g., hospitals, Long Term Care (LTC) facilities, conferences, etc.);

   c. Log off the CalOptima Health network, or lock computer, when the PC will be left inactive, or unattended; and

   d. Ensure that passwords, or operating instructions for accessing the CalOptima Health systems, are not stored with the computer.

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C. CalOptima Health employees, Business Associates, and First Tier, Downstream, and Related Entities (FDRs) shall report any Security Incidents, Breaches of Unsecured PHI/PI and/or other unauthorized access, Use, or Disclosure, of PHI/PI immediately after discovery during a workweek to the CalOptima Health Privacy Officer, in accordance with CalOptima Health Policy HH.3020: Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other unauthorized Use or Disclosure of PHI/PI.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Health PACE Program Agreement
D. CalOptima Health Compliance Plan
E. CalOptima Health Policy GA.5005a: Use of Technology Resources
F. CalOptima Health Policy GA.8044: Telework Program and Telework Program Guidelines
G. CalOptima Health Policy HH.3020: Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI
H. CalOptima Health Policy IT.1102: Electronic Media, Electronic Storage Device and Hardware Controls
I. CalOptima Health Policy IT.1201: EPHI Technical Safeguards - Access Controls
J. Health Administrative Manual
K. Title 45, Code of Federal Regulations (C.F.R.), §164.103
L. Title 45, Code of Federal Regulations (C.F.R.), §164.502(b)
M. Title 45, Code of Federal Regulations (C.F.R.), §164.530(c)(1)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
09/21/2009	Department of Health Care Services (DHCS)	Approved as Submitted
07/16/2010	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/06/2018	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
11/07/2024	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program
Effective	04/01/2003	HH.3016	Guidelines for Handling Protected Health Information Offsite	Medi-Cal

FC 2025.106 BOD Review Only

Action	Date	Policy	Policy Title	Program
Revised	04/01/2007	HH.3016	Guidelines for Handling Protected Health Information Offsite	Medi-Cal
Revised	01/01/2009	HH.3016	Guidelines for Handling Protected Health Information Offsite	Medi-Cal
Revised	06/01/2010	HH.3016	Guidelines for Handling Protected Health Information Offsite	Medi-Cal
Revised	04/01/2013	HH.3016	Guidelines for Handling Protected Health Information Offsite	Medi-Cal
Revised	09/01/2015	HH.3016	Guidelines for Handling Protected Health Information Offsite	Medi-Cal
Revised	12/01/2016	HH.3016	Guidelines for Handling Protected Health Information Offsite	Medi-Cal OneCare OneCare Connect PACE
Revised	12/07/2017	HH.3016	Guidelines for Handling Protected Health Information Offsite	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.3016	Guidelines for Handling Protected Health Information Offsite	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.3016	Guidelines for Handling Protected Health Information Offsite	Medi-Cal OneCare OneCare Connect PACE
Revised	12/03/2020	HH.3016	Guidelines for Handling Protected Health Information Offsite	Medi-Cal OneCare OneCare Connect PACE
Revised	12/20/2021	HH.3016	Guidelines for Handling Protected Health Information Offsite	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	HH.3016	Guidelines for Handling Protected Health Information Offsite	Medi-Cal OneCare PACE
Revised	09/01/2023	HH.3016	Guidelines for Handling Protected Health Information Offsite	Medi-Cal OneCare PACE
Revised	11/07/2024	HH.3016	Guidelines for Handling Protected Health Information Offsite	Medi-Cal OneCare PACE
Revised	09/01/2025	HH.3016	Guidelines for Handling Protected Health Information Offsite	Medi-Cal OneCare PACE

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IX. GLOSSARY

Term	Definition
Access Controls	Controls that identify and authenticate a User to allow access to confidential information and Protected Health Information (PHI) based on a business need to know. Access Controls protect the computer systems from unauthorized access as well as determine the type of access a User is entitled to have.
Breach	Has the meaning in 45, Code of Federal Regulations Section 164.402. The acquisition, access, Use, or Disclosure of protected health information in a manner not permitted under subpart E of this part which compromises the security or privacy of the protected health information. Breach excludes: 1. Any unintentional acquisition, access, or Use of protected health information by a workforce Member or person acting under the authority of a covered entity or a Business Associate, if such acquisition, access, or Use was made in good faith and within the scope of authority and does not result in further Use or Disclosure in a manner not permitted under subpart E of this part. 2. Any inadvertent Disclosure by a person who is authorized to access protected health information at a covered entity or Business Associate to another person authorized to access protected health information at the same covered entity or Business Associate, or organized health care arrangement in which the covered entity participates, and the information received as a result of such Disclosure is not further Used or disclosed in a manner not permitted under subpart E of this part. 3. A Disclosure of protected health information where a covered entity or Business Associate has a good faith belief that an unauthorized person to whom the Disclosure was made would not reasonably have been able to retain such information
Business Associate	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. A person or entity who: 1. On behalf of such covered entity or of an organized health care arrangement (as defined in this section) in which the covered entity participates, but other than in the capacity of a Member of the workforce of such covered entity or arrangement, creates, receives, maintains, or transmits protected health information for a function or activity regulated by this subchapter, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, patient safety activities listed at 42 CFR 3.20, billing, benefit management, practice management, and repricing; or 2. Provides, other than in the capacity of a Member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation (as defined in §164.501 of this subchapter), management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the service involves the Disclosure of protected health information from such covered entity or arrangement, or from another Business Associate of such covered entity or arrangement, to the person. A covered entity may be a Business Associate of another covered entity.

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Term	Definition
	Business Associate includes: 1. A Health Information Organization, E-prescribing Gateway, or other person that provides data transmission services with respect to protected health information to a covered entity and that requires access on a routine basis to such protected health information. 2. A person that offers a personal health record to one or more individuals on behalf of a covered entity. 3. A subcontractor that creates, receives, maintains, or transmits protected health information on behalf of the Business Associate.
Designee	A person selected or designated to carry out a duty or role. The assigned Designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Disclosure	Has the meaning in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.
Downstream Entity	Any party that enters into an acceptable written arrangement below the level of the arrangement between a Medicare Advantage (MA) organization (and contract applicant) and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.
Electronic Protected Health Information (EPHI)	Has the meaning in 45, Code of Federal Regulations Section 160.103. Individually identifiable health information transmitted by electronic media or maintained in electronic media.
Facility	Off-site, CalOptima Health-affiliated locations; any site outside of the 505 City Parkway West building.
First Tier, Downstream, and Related Entities (FDR)	Means First Tier, Downstream or Related Entity, as separately defined herein.
First Tier Entity	Any party that enters into a written arrangement, acceptable to CMS, with an MAO or Part D plan sponsor or applicant to provide administrative services or health care services to a Medicare eligible individual under the MA program or Part D program.
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information, and as subsequently amended.
Intrusion	The act of wrongfully (without authorization) entering upon, seizing, or taking possession of computerized data that compromises the security, confidentiality, or integrity of personal information maintained by CalOptima Health or its Business Associates.
Long Term Care (LTC)	Medi-Cal: Care provided in a skilled nursing facility and sub-acute care services that lasts longer than 60 days. OneCare: A variety of services that help Members with health or personal needs and activities of daily living over a period of time. Long Term Care (LTC) may be provided at home, in the community or in various types of facilities, including nursing homes and assisted living facilities.

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Term	Definition
Medical Record	Medi-Cal: Any single, complete record kept or required to be kept by any Provider 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 Health policy. OneCare: A Medical Record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is Used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical Records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal.
Member	A beneficiary enrolled in a CalOptima Health program.
Minimum Necessary	The principle that covered entity must make reasonable efforts to Use, disclose, and request only the minimum amount of protected health information needed to accomplish the intended purpose of the Use, Disclosure, or request for Treatment, Payment or Health Care Operations.
Prior Authorization	Medi-Cal: A formal process requiring a health care Provider to obtain advance approval of Medically Necessary Covered Services, including the amount, duration and scope of services, except in the case of an emergency. OneCare: A process through which a physician or other health care provider is required to obtain advance approval, from CalOptima Health and/or a delegated entity, that payment will be made for a service or item furnished to a Member. PACE: A formal process requiring a health care provider to obtain advance approval to provide specific services or procedures, or the process by which an IDT approves a member to receive a specific service or procedure.
Personally Identifiable Information (PII)	PII is —any information about an individual maintained by an agency, including (1) any information that can be Used to distinguish or trace an individual's identity, such as name, social security number, date and place of birth, mother's maiden name, or biometric records; and (2) any other information that is linked or linkable to an individual, such as medical, educational, financial, and employment information.
Protected Health Information (PHI)	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. Individually identifiable health information identifies the individual or there is reasonable basis to believe the information can be Used to identify the individual. The information was created or received by CalOptima Health or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.

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Term	Definition
Related Entity	Any entity that is related to CalOptima Health by common ownership or control and that: performs some of CalOptima Health'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 Health at a cost of more than two thousand five hundred dollars ($2,500) during a contract period.
Remote Work Location	The Employee's home office or other designated pre-approved work location that is not the Central Worksite.
Security Incident	Has the meaning in 45 Code of Federal Regulations Section 164.304. The attempted or successful unauthorized access, Use, Disclosure, modification, or destruction of information or interference with system operations in an information system.
Unsecured PHI/PI	Has the meaning in 45 Code of Federal Regulations Section 164.402. Protected Health Information that is not rendered unusable, unreadable, or indecipherable to unauthorized persons through the use of a technology or methodology specified by the Secretary in the guidance issued under Section 13402(h)(2) of Public Law 111-5.
Use	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.

For 20251106 BOD Review Only

Policy:	HH.3016
Title:	**Guidelines for Handling Protected Health Information Off-site**
Department:	Office of Compliance
Section:	Privacy
CEO Approval:	*/s/*
Effective Date:	04/01/2003
Revised Date:	09/01/2025
Applicable to:	☐ Administrative ☐ Covered California [Effective 2027] ☒ Medi-Cal ☒ OneCare ☒ PACE

For 2025 1106 BOD Review Only

I. PURPOSE

This policy describes the process for handling Protected Health Information (PHI) created, accessed, or taken off-site from CalOptima Health offices.

II. POLICY

A. CalOptima Health employees shall exercise precautions according to the regulations and standards set by the Health Insurance Portability and Accountability Act (HIPAA) and CalOptima Health policies when handling PHI, or EPHI, created, accessed, or taken off-site from the main office.

III. PROCEDURE

A. General guidelines

1. Staff shall adhere to Minimum Necessary requirements when viewing, documenting, and/or recording information during any work activities that require the Use of Medical Records in facilities.

2. Staff shall not access, use, or disclose any Member PHI via CalOptima Health system without a business need.

3. Staff shall collect all data relative to a Member, whether by interview, observation, or review of documents, in a setting that provides reasonable privacy and protects the information from unauthorized Disclosure.

4. Staff shall protect all physical documents that contain Member PHI from the view, or access, by an unauthorized person during transport from and to the office through Use of:

   a. Binders; and/or

   b. Folders, or other protective cover; and/or

   c. Appropriate vehicle safeguards (e.g., locked in trunk of the vehicle); or

   d. Personal possession of Member PHI such that it is in sight at all times.

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5. Staff shall not leave any paper documents containing PHI, or other data collection forms including, without limitation, audit or other data collection forms unattended in areas accessible by an unauthorized person.

6. "Staff shall not print documents containing PHI or data collection forms off-site, except at approved Remote Work Locations. Work-from-home locations are not considered approved for printing.

7. Staff shall not forward any confidential, PHI, or sensitive information to personal or other unauthorized email accounts at any time.
8. Staff shall not store confidential, personal, or sensitive information unattended in vehicles at any time.

9. Staff shall not store confidential, personal, or sensitive information unattended in baggage, at any time, during travel.

10. Staff shall not save or store data files in an electronic format that contain PHI on public, or private, computers, unencrypted personal removable storage devices, personal cloud storage, and/or personal email accounts.

11. Staff shall not Use mobile devices of any kind to take and save photos of information and/or images containing PHI.

12. Staff shall maintain physical control of CalOptima Health laptops, cell phones, tablets, USB drives, and all other mobile devices at all times.

13. Staff shall only Use CalOptima Health-issued encrypted storage devices to store files containing PHI, in accordance with CalOptima Health Policy GA.5005a: Use of Technology Resources.

14. Staff shall shred PHI documents, or files, prior to disposal. If necessary, staff shall return documents, or files, to the main office for disposal.

15. Staff shall adhere to CalOptima Health telework workplace arrangements, in accordance with CalOptima Health Policy GA.8044: Telework Program and Telework Program Guidelines.

B. Use of Personal Computer (PC) from remote locations

1. If applicable, employees granted access to CalOptima Health's networks are required to adhere to the following procedures:

a. Maintain the Confidentiality of his or her user sign-on identification code and password;

b. Keep the PC secure at all times and do not leave it unattended during travel to, or working off-site at, public places (e.g., hospitals, Long Term Care (LTC) facilities, conferences, etc.);

c. Log off the CalOptima Health network, or lock computer, when the PC will be left inactive, or unattended; and

d. Ensure that passwords, or operating instructions for accessing the CalOptima Health systems, are not stored with the computer.

C. CalOptima Health employees, Business Associates, and First Tier, Downstream, and Related Entities (FDRs) shall report any Security Incidents, Breaches of Unsecured PHI/PI and/or other unauthorized

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access, Use, or Disclosure, of PHI/PI immediately after discovery during a workweek to the CalOptima Health Privacy Officer, in accordance with CalOptima Health Policy HH.3020: Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other unauthorized Use or Disclosure of PHI/PI.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Health PACE Program Agreement
D. CalOptima Health Compliance Plan
E. CalOptima Health Policy GA.5005a: Use of Technology Resources
F. CalOptima Health Policy GA.8044: Telework Program and Telework Program Guidelines
G. CalOptima Health Policy HH.3020: Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI
H. CalOptima Health Policy IT.1102: Electronic Media, Electronic Storage Device and Hardware Controls
I. CalOptima Health Policy IT.1201: EPHI Technical Safeguards - Access Controls
J. Health Administrative Manual
K. Title 45, Code of Federal Regulations (C.F.R.), §164.103
L. Title 45, Code of Federal Regulations (C.F.R.), §164.502(b)
M. Title 45, Code of Federal Regulations (C.F.R.), §164.530(c)(1)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
09/21/2009	Department of Health Care Services (DHCS)	Approved as Submitted
07/16/2010	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/06/2018	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
11/07/2024	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program
Effective	04/01/2003	HH.3016	Guidelines for Handling Protected Health Information Offsite	Medi-Cal
Revised	04/01/2007	HH.3016	Guidelines for Handling Protected Health Information Offsite	Medi-Cal

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Action	Date	Policy	Policy Title	Program
Revised	01/01/2009	HH.3016	Guidelines for Handling Protected Health Information Offsite	Medi-Cal
Revised	06/01/2010	HH.3016	Guidelines for Handling Protected Health Information Offsite	Medi-Cal
Revised	04/01/2013	HH.3016	Guidelines for Handling Protected Health Information Offsite	Medi-Cal
Revised	09/01/2015	HH.3016	Guidelines for Handling Protected Health Information Offsite	Medi-Cal
Revised	12/01/2016	HH.3016	Guidelines for Handling Protected Health Information Offsite	Medi-Cal OneCare OneCare Connect PACE
Revised	12/07/2017	HH.3016	Guidelines for Handling Protected Health Information Offsite	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.3016	Guidelines for Handling Protected Health Information Offsite	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.3016	Guidelines for Handling Protected Health Information Offsite	Medi-Cal OneCare OneCare Connect PACE
Revised	12/03/2020	HH.3016	Guidelines for Handling Protected Health Information Offsite	Medi-Cal OneCare OneCare Connect PACE
Revised	12/20/2021	HH.3016	Guidelines for Handling Protected Health Information Offsite	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	HH.3016	Guidelines for Handling Protected Health Information Offsite	Medi-Cal OneCare PACE
Revised	09/01/2023	HH.3016	Guidelines for Handling Protected Health Information Offsite	Medi-Cal OneCare PACE
Revised	11/07/2024	HH.3016	Guidelines for Handling Protected Health Information Offsite	Medi-Cal OneCare PACE
Revised	09/01/2025	HH.3016	Guidelines for Handling Protected Health Information Offsite	Medi-Cal OneCare PACE

IX. GLOSSARY

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Term	Definition
Access Controls	Controls that identify and authenticate a User to allow access to confidential information and Protected Health Information (PHI) based on a business need to know. Access Controls protect the computer systems from unauthorized access as well as determine the type of access a User is entitled to have.
Breach	Has the meaning in 45, Code of Federal Regulations Section 164.402. The acquisition, access, Use, or Disclosure of protected health information in a manner not permitted under subpart E of this part which compromises the security or privacy of the protected health information. Breach excludes: 1. Any unintentional acquisition, access, or Use of protected health information by a workforce Member or person acting under the authority of a covered entity or a Business Associate, if such acquisition, access, or Use was made in good faith and within the scope of authority and does not result in further Use or Disclosure in a manner not permitted under subpart E of this part. 2. Any inadvertent Disclosure by a person who is authorized to access protected health information at a covered entity or Business Associate to another person authorized to access protected health information at the same covered entity or Business Associate, or organized health care arrangement in which the covered entity participates, and the information received as a result of such Disclosure is not further Used or disclosed in a manner not permitted under subpart E of this part. 3. A Disclosure of protected health information where a covered entity or Business Associate has a good faith belief that an unauthorized person to whom the Disclosure was made would not reasonably have been able to retain such information
Business Associate	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. A person or entity who: 1. On behalf of such covered entity or of an organized health care arrangement (as defined in this section) in which the covered entity participates, but other than in the capacity of a Member of the workforce of such covered entity or arrangement, creates, receives, maintains, or transmits protected health information for a function or activity regulated by this subchapter, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, patient safety activities listed at 42 CFR 3.20, billing, benefit management, practice management, and repricing; or 2. Provides, other than in the capacity of a Member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation (as defined in §164.501 of this subchapter), management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the service involves the Disclosure of protected health information from such covered entity or arrangement, or from another Business Associate of such covered entity or arrangement, to the person. A covered entity may be a Business Associate of another covered entity.

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Term	Definition
	Business Associate includes: 1. A Health Information Organization, E-prescribing Gateway, or other person that provides data transmission services with respect to protected health information to a covered entity and that requires access on a routine basis to such protected health information. 2. A person that offers a personal health record to one or more individuals on behalf of a covered entity. 3. A subcontractor that creates, receives, maintains, or transmits protected health information on behalf of the Business Associate.
Designee	A person selected or designated to carry out a duty or role. The assigned Designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Disclosure	Has the meaning in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.
Downstream Entity	Any party that enters into an acceptable written arrangement below the level of the arrangement between a Medicare Advantage (MA) organization (and contract applicant) and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.
Electronic Protected Health Information (EPHI)	Has the meaning in 45, Code of Federal Regulations Section 160.103. Individually identifiable health information transmitted by electronic media or maintained in electronic media.
Facility	Off-site, CalOptima Health-affiliated locations; any site outside of the 505 City Parkway West building.
First Tier, Downstream, and Related Entities (FDR)	Means First Tier, Downstream or Related Entity, as separately defined herein.
First Tier Entity	Any party that enters into a written arrangement, acceptable to CMS, with an MAO or Part D plan sponsor or applicant to provide administrative services or health care services to a Medicare eligible individual under the MA program or Part D program.
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information, and as subsequently amended.
Intrusion	The act of wrongfully (without authorization) entering upon, seizing, or taking possession of computerized data that compromises the security, confidentiality, or integrity of personal information maintained by CalOptima Health or its Business Associates.
Long Term Care (LTC)	Medi-Cal: Care provided in a skilled nursing facility and sub-acute care services that lasts longer than 60 days. OneCare: A variety of services that help Members with health or personal needs and activities of daily living over a period of time. Long Term Care (LTC) may be provided at home, in the community or in various types of facilities, including nursing homes and assisted living facilities.

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Term	Definition
Medical Record	Medi-Cal: Any single, complete record kept or required to be kept by any Provider 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 Health policy. OneCare: A Medical Record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is Used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical Records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal.
Member	A beneficiary enrolled in a CalOptima Health program.
Minimum Necessary	The principle that covered entity must make reasonable efforts to Use, disclose, and request only the minimum amount of protected health information needed to accomplish the intended purpose of the Use, Disclosure, or request for Treatment, Payment or Health Care Operations.
Prior Authorization	Medi-Cal: A formal process requiring a health care Provider to obtain advance approval of Medically Necessary Covered Services, including the amount, duration and scope of services, except in the case of an emergency. OneCare: A process through which a physician or other health care provider is required to obtain advance approval, from CalOptima Health and/or a delegated entity, that payment will be made for a service or item furnished to a Member. PACE: A formal process requiring a health care provider to obtain advance approval to provide specific services or procedures, or the process by which an IDT approves a member to receive a specific service or procedure.
Personally Identifiable Information (PII)	PII is —any information about an individual maintained by an agency, including (1) any information that can be Used to distinguish or trace an individual's identity, such as name, social security number, date and place of birth, mother's maiden name, or biometric records; and (2) any other information that is linked or linkable to an individual, such as medical, educational, financial, and employment information.
Protected Health Information (PHI)	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. Individually identifiable health information identifies the individual or there is reasonable basis to believe the information can be Used to identify the individual. The information was created or received by CalOptima Health or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.

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Term	Definition
Related Entity	Any entity that is related to CalOptima Health by common ownership or control and that: performs some of CalOptima Health'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 Health at a cost of more than two thousand five hundred dollars ($2,500) during a contract period.
Remote Work Location	The Employee's home office or other designated pre-approved work location that is not the Central Worksite.
Security Incident	Has the meaning in 45 Code of Federal Regulations Section 164.304. The attempted or successful unauthorized access, Use, Disclosure, modification, or destruction of information or interference with system operations in an information system.
Unsecured PHI/PI	Has the meaning in 45 Code of Federal Regulations Section 164.402. Protected Health Information that is not rendered unusable, unreadable, or indecipherable to unauthorized persons through the use of a technology or methodology specified by the Secretary in the guidance issued under Section 13402(h)(2) of Public Law 111-5.
Use	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.

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Policy:	HH.3024
Title:	**Confidentiality of Medical Information Act Compliance**
Department:	Office of Compliance
Section:	Privacy
CEO Approval:	*/s/*
Effective Date:	11/07/2024
Revised Date:	10/01/2025
Applicable to:	☐ Administrative ☒ Covered California [Effective 2027] ☒ Medi-Cal ☒ OneCare ☒ PACE

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I. PURPOSE

This policy is intended to ensure compliance with the California Confidentiality of Medical Information Act (CMIA).

II. POLICY

A. In addition to the requirements under the federal Health Insurance Portability Accountability Act (HIPAA) and its implementing regulations, CalOptima Health must protect the confidentiality of patient Medical Information in accordance with CMIA. CalOptima Health may not share, sell, use for marketing, or otherwise use any Medical Information for any purpose not necessary to providing health care services to a Member or paying for those services unless an exception applies.

B. The CMIA allows CalOptima Health to disclose Medical Information only as authorized by state or federal law, or as otherwise expressly authorized by a Member.

C. The CMIA requires CalOptima Health to comply with Confidential Communications Requests from Members and prohibits CalOptima Health from requiring a Member covered under another Member's benefit plan or a minor who can consent to treatment (the non-primary Member) to obtain Authorization from the primary subscriber or another enrollee to obtain Sensitive Services if the individual has the right to consent to care. CalOptima Health may not condition enrollment or coverage on a Member waiving their rights under the CMIA.

D. The CMIA also requires that CalOptima Health ensure any entities that offer a Reproductive or Sexual Digital Service to CalOptima Health Members comply with the CMIA and that contractors that maintain electronic Medical Information segregate the information from the rest of the Member's record.

E. CalOptima Health agrees to comply with all applicable California state health information privacy and security laws applicable to Personally Identifiable Information (PII), including the CMIA, referred to as "California Requirements."

III. PROCEDURE

A. General Disclosures and Authorization: CalOptima Health will not disclose Medical Information unless the Member has provided a valid authorization for disclosure or as permitted or required by law, including:

1. CalOptima Health will disclose Medical Information without authorization as required by a court order, subpoena, or otherwise required by law.
2. CalOptima Health may disclose Medical Information without authorization when necessary for treatment, payment, or health care operations purposes.

B. Communications Regarding Sensitive Services Provided to non-primary Members:

1. CalOptima Health may not disclose to the primary subscriber, or another enrollee, any Medical Information related to Sensitive Services received by a non-primary Member without express authorization from the non-primary Member.

2. CalOptima Health must direct all communications regarding Sensitive Services to the non-primary Member's designated alternate mailing address, email address, or telephonic number or, in the absence of such information, to the address or telephone on file in the name of the non-primary Member.

3. CalOptima Health may not require a non-primary Member to obtain authorization from the primary subscriber or another enrollee for the non-primary Member to obtain Sensitive Services if the non-primary Member has the right to consent to care.

4. For example, CalOptima Health must not require that a minor 12 years old or older obtain parental consent to obtain outpatient mental health treatment if in the opinion of the treating professional the minor is mature enough to participate intelligently in their care. In addition, the minor may request that CalOptima Health send Communications regarding those mental health or counseling services to a mailing address, email address, or telephone number specified by the minor Member.

C. Confidential Communications Requests: Members may submit Confidential Communications Requests to CalOptima Health as outlined in CalOptima Health's Evidence of Coverage and on CalOptima Health's website, and CalOptima Health shall process those requests as follows:

1. Privacy Department shall implement requests received electronically or telephonically within seven (7) calendar days of receipt or mail requests within fourteen (14) calendar days of receipt.

2. The Privacy Department will acknowledge receipt within two (2) business days. CalOptima Health shall also inform the Member within two (2) business days of the status of implementing the request if the Member asks CalOptima Health.

3. The Privacy Department will copy the Office of Compliance on any and all written communications with Members regarding Confidential Communication Requests.

4. To the extent readily producible, CalOptima Health will produce Confidential Communications in the form and format requested by the Member.

5. The Member's Confidential Communications Request shall remain in effect until revoked or replaced by the Member.

6. CalOptima Health will apply Confidential Communications Requests to all Communications that disclose Medical Information or Provider name and address information related to the Member's receipt of Sensitive Services.

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D. Confidential Information Policy Requests: Members may request a written statement from CalOptima Health that describes how CalOptima Health maintains the confidentiality of Medical Information obtained by and in the possession of CalOptima Health. CalOptima Health shall respond to such requests with a statement that complies with the following:

1. Is in at least 12 point font type.

2. Describes how CalOptima Health protects the confidentiality of Member Medical Information and informs the Member that any disclosure of Medical Information beyond the provisions of the law is prohibited.

3. Describes the types of Medical Information that may be collected and the sources that may be used to collect the information, as well as the purposes for which CalOptima Health obtains Medical Information from other health care Providers.

4. Describes the circumstances under which Medical Information may be disclosed without prior authorization, in accordance with CalOptima Policies HH.3010: Protected Health Information Disclosures Permitted and Required by Law and HH.3015: Member Authorization for the Use and Disclosure of Protected Health Information.

5. Describes how Members may obtain access to Medical Information created by and in the possession of CalOptima Health, including copies of Medical Information. Members may request Confidential Communications in accordance with CalOptima Health Policy HH.3008: Member Right to Request Confidential Communications.

E. Reproductive or Sexual Health Digital Service: If CalOptima Health contracts with any entity that provides a Reproductive or Sexual Health Digital Service to CalOptima Health Members for the purpose of allowing Members to manage their information, or for the diagnosis, treatment, or management of medical conditions of Members, that entity is deemed a Provider subject to the CMIA. CalOptima Health shall ensure its contract with that entity requires the entity to comply with the CMIA.

1. For example, a software Provider that provides Members with an application for the Members to track their menstrual cycle is considered a Provider by the CMIA. CalOptima Health must ensure such a software Provider complies with the CMIA.

F. Abortion Services Information:

1. CalOptima Health shall not knowingly disclose, transmit, transfer, or grant access to Medical Information to an individual in another state that identifies or is related to an individual seeking, obtaining, providing, supporting, or aiding in the performance of an abortion that is lawful in California (Abortion Services), unless such access is:

   a. Properly authorized under Section III.A of this Policy and clearly states that Medical Information for Abortion Services may be disclosed;

   b. For payment, claims, and billing purposes;

   c. To persons reviewing competence or qualifications of health care professionals;

   d. To persons reviewing health care services with respect to necessity or services, quality of care, or justification of charges;

   e. To accrediting organizations; or

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f. For bona fide research purposes, as permitted under California Civil Code, Sections 56.10(c)(2)-(5), (7) and 56.110(a).

2. Notwithstanding Section III.F.1, CalOptima Health shall disclose electronic Medical Information related to Abortion Services:

a. At the request of a Member or their authorized representative under the Patient Access to Health Records Act;

b. In response to a California or federal court order to the extent clearly stated in the order and consistent with Penal Code § 1543, if applicable, if all information about the Member's identity and records are protected from public scrutiny, through mechanisms, including but not limited to, a sealed proceeding or court record; or

c. Where required by federal law that preempts California law, but only to the extent expressly required.

3. Neither CalOptima Health nor its providers or contractors shall release Medical Information related to an individual seeking or obtaining an abortion in response to a subpoena or request if that subpoena or request is based on either another state's laws that interfere with a person's rights under the Reproductive Privacy Act or a foreign penal civil action, as provided in Civil Code § 56.108(a).

G. Information Segregation and Investigations:

1. CalOptima Health shall ensure any contractor that maintains the electronic Medical Information of CalOptima Health Members complies with the following requirements regarding Sensitive Services:

a. Limits access privileges to information systems containing Medical Information related to Gender Affirming Care, abortion, abortion-related services, and contraception (Restricted Information) only to persons authorized to access that specified information;

b. Prevents disclosure, access, transfer, transmission, or processing (and provides the ability to automatically disable access) of Restricted Information by persons and entities outside of California; and

c. Segregates Restricted Information from the rest of the Member's records.

2. CalOptima Health and any of its contractors that maintain Restricted Information of CalOptima Health Members shall not cooperate with any inquiry or investigation by or provide Medical Information to any individual, agency, or department from another state regarding Abortion Services, unless the request for Restricted Information is authorized, as specified in Section III.F. above. This prohibition also applies to a federal law enforcement agency, to the extent allowed under federal law.

3. For example, if CalOptima Health's care management systems vendor hosts Member Restricted Information data, the care management system vendor must ensure that Restricted Information is segregated from the rest of the Member's record, the system provides access only to those individuals designated to have access to the Restricted Information, and Restricted Information is not accessible to persons or entities outside of California without proper Member authorization.

IV. ATTACHMENT(S)

Not Applicable

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V. REFERENCE(S)

A. CalOptima Health Policy HH.3000: Notice of Privacy Practices
B. CalOptima Health Policy HH.3008: Member Right to Request Confidential Communications
C. CalOptima Health Policy HH.3010: Protected Health Information Disclosures Permitted and Required by Law
D. CalOptima Health Policy HH.3011: Use and Disclosure of Protected Health Information (PHI) for Treatment, Payment, and Health Care Operations
E. CalOptima Health Policy HH.3015: Member Authorization for the Use and Disclosure of Protected Health Information
F. CalOptima Health Policy HH.3022: Business Associate Agreements
G. California Civil Code §§ 56.06(e), 56.10, 56.107, 56.110, and 56.11
H. California Penal Code § 1543
I. 45 CFR §§ 164.502(a)(5)(iii)(A), (C); 164.509; and 164.512(d), (e), (f), (g)(1)

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
11/07/2024	Regular Meeting of the CalOptima Health Board of Directors
11/06/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	11/07/2024	HH.3024	Confidentiality of Medical Information Act Compliance	Medi-Cal OneCare PACE
Revised	05/01/2025	HH.3024	Confidentiality of Medical Information Act Compliance	Covered California Medi-Cal OneCare PACE
Revised	10/01/2025	HH.3024	Confidentiality of Medical Information Act Compliance	Covered California Medi-Cal OneCare PACE

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IX. GLOSSARY

Term	Definition
Authorization	Permission granted in accordance with Civil Code §§ 56.11 or 56.21 for the disclosure of Medical Information.
Authorized Representative (AR)	Any individual appointed in writing by a competent Member or Potential Member, to act in place or on behalf of the Member or Potential Member for purposes of assisting or representing the Member or Potential Member with Grievances and Appeals, State Fair Hearings, Independent Medical Reviews and in any other capacity, as specified by the Member or Potential Member.
Communications	For purposes of this policy and unless otherwise specified, communications subject to this policy include written, verbal, or electronic communications related to the receipt of Sensitive Services, including bills and attempts to collect payment; notices of adverse benefits determinations; explanation of benefits notices; CalOptima Health's request for additional information regarding a claim; a notice of a contested claim; the name and address of a provider, description of services provided, and any other information related to a visit; and any communication from CalOptima Health that contains Medical Information.
Confidential Communications Request	For purposes of this policy, this is a request by a Member that communications from CalOptima Health containing Medical Information ("Confidential Communications") be communicated to the Member at a specific mail address, email address, or telephone number, as designated by the Member. Civ. Code § 56.05(c). These requests also apply to communications that disclose a provider's name and address related to receipt of services by the Member the requesting confidential communication. Civ. Code § 56.107(b)(4).
Confidentiality of Medical Information Act (CMIA)	The Confidentiality of Medical Information Act (California Civil Code § 56 *et seq*.), to the extent applicable to operation of CalOptima Health.
Covered California	The California Health Benefit Exchange, doing business as Covered California and an independent entity within the government of the State of California.
Evidence of Coverage	The state-regulator approved document which describes the benefits, exclusions, limitations, conditions, and the benefit levels of the applicable Plans issued to a Subscriber or Member.
Health Insurance Portability and Accountability Act of 1996 (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information, as amended.
Gender Affirming Care	Medically necessary health care or Gender Affirming Mental Health Care that respects the gender identity of the patient, as experienced and defined by the patient, and may include, but is not limited to: 1. Interventions to suppress the development of endogenous secondary sex characteristics; 2. Interventions to align the patient's appearance or physical body with the patient's gender identity; and 3. Interventions to alleviate symptoms of clinically significant distress resulting from gender dysphoria, as defined in the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition. Welfare and Institutions Code § 16010.2(b).
Gender Affirming Mental Health Care	Mental health care or behavioral health care that respects the gender identity of the patient, as experienced and defined by the patient, and may include,

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Term	Definition
	but is not limited to, developmentally appropriate exploration and integration of identity, reduction of distress, adaptive coping, and strategies to increase family acceptance.
Medical Information	Any individually identifiable information, in electronic or physical form, in possession of or derived from a provider of health care, health care service plan, pharmaceutical company, or contractor regarding a patient's medical history, mental health application information, Reproductive or Sexual Health Application Information, mental or physical condition, or treatment. "Individually Identifiable" means that the Medical Information includes or contains any element of personal identifying information sufficient to allow identification of the individual, such as the patient's name, address, electronic mail address, telephone number, or social security number, or other information that, alone or in combination with other publicly available information, reveals the identity of the individual. Civ. Code § 56.05(j).
Member	An individual enrolled in a CalOptima Health program.
Personally Identifiable Information (PII)	Covered California: Any information that identifies or describes an individual, including his or her name, social security number, physical description, home address, home telephone number, education, financial matters, medical or employment history, and statements made by, or attributed to, the individual. Med-Cal & OneCare: Any information about an individual maintained by an agency, including: 1. Any information that can be used to distinguish or trace an individual's identity, such as name, social security number, date and place of birth, mother's maiden name, or biometric records; and 2. Any other information that is linked or linkable to an individual, such as medical, educational, financial, and employment information.
Provider	Covered California: A licensed health care facility or as stipulated by local or international jurisdictions, a program, agency or health professional that delivers Covered Services. Med-Cal: Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so. OneCare: Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier) 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.
Reproductive or Sexual Health Application Information	Information about an individual's reproductive health, menstrual cycle, fertility, pregnancy, pregnancy outcome, plans to conceive, or type of sexual activity collected by a reproductive or sexual health digital service, including, but not limited to, information from which one can infer someone's pregnancy status, menstrual cycle, fertility, hormone levels, birth control use, sexual activity, or gender identity. Civ. Code § 56.05(q).

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Term	Definition
Reproductive or Sexual Health Digital Service	A mobile-based application or internet website that collects Reproductive or Sexual Health Application Information from a consumer, markets itself as facilitating Reproductive or Sexual Health Services to a consumer and uses the information to facilitate Reproductive or Sexual Health Services to a consumer.
Sensitive Services	All health care services related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender affirming care, and intimate partner violence, and includes services described in Family Code, Sections 6924, 6925, 6926, 6927, 6928, 6929, and 6930, and Health and Safety Code, Sections 121020 and 124260, obtained by a patient at or above the minimum age specified for consenting to the service, in accordance with California Civil Code, Section 56.05(s).

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Policy:	HH.3024
Title:	**Confidentiality of Medical Information Act Compliance**
Department:	Office of Compliance
Section:	Privacy
CEO Approval:	*/s/*
Effective Date:	11/07/2024
Revised Date:	10/01/2025
Applicable to:	☐ Administrative ☒ Covered California [Effective 2027] ☒ Medi-Cal ☒ OneCare ☒ PACE

For 2025 1106 BOD Review Only

I. PURPOSE

This policy is intended to ensure compliance with the California Confidentiality of Medical Information Act (CMIA).

II. POLICY

A. In addition to the requirements under the federal Health Insurance Portability Accountability Act (HIPAA) and its implementing regulations, CalOptima Health must protect the confidentiality of patient Medical Information in accordance with CMIA. CalOptima Health may not share, sell, use for marketing, or otherwise use any Medical Information for any purpose not necessary to providing health care services to a Member or paying for those services unless an exception applies.

B. The CMIA allows CalOptima Health to disclose Medical Information only as authorized by state or federal law, or as otherwise expressly authorized by a Member.

C. The CMIA requires CalOptima Health to comply with Confidential Communications Requests from Members and prohibits CalOptima Health from requiring a Member covered under another Member's benefit plan or a minor who can consent to treatment (the non-primary Member) to obtain Authorization from the primary subscriber or another enrollee to obtain Sensitive Services if the individual has the right to consent to care. CalOptima Health may not condition enrollment or coverage on a Member waiving their rights under the CMIA.

D. The CMIA also requires that CalOptima Health ensure any entities that offer a Reproductive or Sexual Digital Service to CalOptima Health Members comply with the CMIA and that contractors that maintain electronic Medical Information segregate the information from the rest of the Member's record.

E. CalOptima Health agrees to comply with all applicable California state health information privacy and security laws applicable to Personally Identifiable Information (PII), including the CMIA, referred to as "California Requirements."

III. PROCEDURE

A. General Disclosures and Authorization: CalOptima Health will not disclose Medical Information unless the Member has provided a valid authorization for disclosure or as permitted or required by law, including:

1. CalOptima Health will disclose Medical Information without authorization as required by a court order, subpoena, or otherwise required by law.
2. CalOptima Health may disclose Medical Information without authorization when necessary for treatment, payment, or health care operations purposes.

B. Communications Regarding Sensitive Services Provided to non-primary Members:

1. CalOptima Health may not disclose to the primary subscriber, or another enrollee, any Medical Information related to Sensitive Services received by a non-primary Member without express authorization from the non-primary Member.

2. CalOptima Health must direct all communications regarding Sensitive Services to the non-primary Member's designated alternate mailing address, email address, or telephonic number or, in the absence of such information, to the address or telephone on file in the name of the non-primary Member.

3. CalOptima Health may not require a non-primary Member to obtain authorization from the primary subscriber or another enrollee for the non-primary Member to obtain Sensitive Services if the non-primary Member has the right to consent to care.

4. For example, CalOptima Health must not require that a minor 12 years old or older obtain parental consent to obtain outpatient mental health treatment if in the opinion of the treating professional the minor is mature enough to participate intelligently in their care. In addition, the minor may request that CalOptima Health send Communications regarding those mental health or counseling services to a mailing address, email address, or telephone number specified by the minor Member.

C. Confidential Communications Requests: Members may submit Confidential Communications Requests to CalOptima Health as outlined in CalOptima Health's Evidence of Coverage and on CalOptima Health's website, and CalOptima Health shall process those requests as follows:

1. Privacy Department shall implement requests received electronically or telephonically within seven (7) calendar days of receipt or mail requests within fourteen (14) calendar days of receipt.

2. The Privacy Department will acknowledge receipt within two (2) business days. CalOptima Health shall also inform the Member within two (2) business days of the status of implementing the request if the Member asks CalOptima Health.

3. The Privacy Department will copy the Office of Compliance on any and all written communications with Members regarding Confidential Communication Requests.

4. To the extent readily producible, CalOptima Health will produce Confidential Communications in the form and format requested by the Member.

5. The Member's Confidential Communications Request shall remain in effect until revoked or replaced by the Member.

6. CalOptima Health will apply Confidential Communications Requests to all Communications that disclose Medical Information or Provider name and address information related to the Member's receipt of Sensitive Services.

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D. Confidential Information Policy Requests: Members may request a written statement from CalOptima Health that describes how CalOptima Health maintains the confidentiality of Medical Information obtained by and in the possession of CalOptima Health. CalOptima Health shall respond to such requests with a statement that complies with the following:

1. Is in at least 12 point font type.

2. Describes how CalOptima Health protects the confidentiality of Member Medical Information and informs the Member that any disclosure of Medical Information beyond the provisions of the law is prohibited.

3. Describes the types of Medical Information that may be collected and the sources that may be used to collect the information, as well as the purposes for which CalOptima Health obtains Medical Information from other health care Providers.

4. Describes the circumstances under which Medical Information may be disclosed without prior authorization, in accordance with CalOptima Policies HH.3010: Protected Health Information Disclosures Permitted and Required by Law and HH.3015: Member Authorization for the Use and Disclosure of Protected Health Information.

5. Describes how Members may obtain access to Medical Information created by and in the possession of CalOptima Health, including copies of Medical Information. Members may request Confidential Communications in accordance with CalOptima Health Policy HH.3008: Member Right to Request Confidential Communications.

E. Reproductive or Sexual Health Digital Service: If CalOptima Health contracts with any entity that provides a Reproductive or Sexual Health Digital Service to CalOptima Health Members for the purpose of allowing Members to manage their information, or for the diagnosis, treatment, or management of medical conditions of Members, that entity is deemed a Provider subject to the CMIA. CalOptima Health shall ensure its contract with that entity requires the entity to comply with the CMIA.

1. For example, a software Provider that provides Members with an application for the Members to track their menstrual cycle is considered a Provider by the CMIA. CalOptima Health must ensure such a software Provider complies with the CMIA.

F. Abortion Services Information:

1. CalOptima Health shall not knowingly disclose, transmit, transfer, or grant access to Medical Information to an individual in another state that identifies or is related to an individual seeking, obtaining, providing, supporting, or aiding in the performance of an abortion that is lawful in California (Abortion Services), unless such access is:

   a. Properly authorized under Section III.A of this Policy and clearly states that Medical Information for Abortion Services may be disclosed;

   b. For payment, claims, and billing purposes;

   c. To persons reviewing competence or qualifications of health care professionals;

   d. To persons reviewing health care services with respect to necessity or services, quality of care, or justification of charges;

   e. To accrediting organizations; or

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f. For bona fide research purposes, as permitted under California Civil Code, Sections 56.10(c)(2)-(5), (7) and 56.110(a).

2. Notwithstanding Section III.F.1, CalOptima Health shall disclose electronic Medical Information related to Abortion Services:

a. At the request of a Member or their authorized representative under the Patient Access to Health Records Act;

b. In response to a California or federal court order to the extent clearly stated in the order and consistent with Penal Code § 1543, if applicable, if all information about the Member's identity and records are protected from public scrutiny, through mechanisms, including but not limited to, a sealed proceeding or court record; or

c. Where required by federal law that preempts California law, but only to the extent expressly required.

3. Neither CalOptima Health nor its providers or contractors shall release Medical Information related to an individual seeking or obtaining an abortion in response to a subpoena or request if that subpoena or request is based on either another state's laws that interfere with a person's rights under the Reproductive Privacy Act or a foreign penal civil action, as provided in Civil Code § 56.108(a).

G. Information Segregation and Investigations:

1. CalOptima Health shall ensure any contractor that maintains the electronic Medical Information of CalOptima Health Members complies with the following requirements regarding Sensitive Services:

a. Limits access privileges to information systems containing Medical Information related to Gender Affirming Care, abortion, abortion-related services, and contraception (Restricted Information) only to persons authorized to access that specified information;

b. Prevents disclosure, access, transfer, transmission, or processing (and provides the ability to automatically disable access) of Restricted Information by persons and entities outside of California; and

c. Segregates Restricted Information from the rest of the Member's records.

2. CalOptima Health and any of its contractors that maintain Restricted Information of CalOptima Health Members shall not cooperate with any inquiry or investigation by or provide Medical Information to any individual, agency, or department from another state regarding Abortion Services, unless the request for Restricted Information is authorized, as specified in Section III.F. above. This prohibition also applies to a federal law enforcement agency, to the extent allowed under federal law.

3. For example, if CalOptima Health's care management systems vendor hosts Member Restricted Information data, the care management system vendor must ensure that Restricted Information is segregated from the rest of the Member's record, the system provides access only to those individuals designated to have access to the Restricted Information, and Restricted Information is not accessible to persons or entities outside of California without proper Member authorization.

IV. ATTACHMENT(S)

Not Applicable

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V. REFERENCE(S)

A. CalOptima Health Policy HH.3000: Notice of Privacy Practices
B. CalOptima Health Policy HH.3008: Member Right to Request Confidential Communications
C. CalOptima Health Policy HH.3010: Protected Health Information Disclosures Permitted and Required by Law
D. CalOptima Health Policy HH.3011: Use and Disclosure of Protected Health Information (PHI) for Treatment, Payment, and Health Care Operations
E. CalOptima Health Policy HH.3015: Member Authorization for the Use and Disclosure of Protected Health Information
F. CalOptima Health Policy HH.3022: Business Associate Agreements
G. California Civil Code §§ 56.06(e), 56.10, 56.107, 56.110, and 56.11
H. California Penal Code § 1543
I. 45 CFR §§ 164.502(a)(5)(iii)(A), (C); 164.509; and 164.512(d), (e), (f), (g)(1)

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
11/07/2024	Regular Meeting of the CalOptima Health Board of Directors
11/06/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	11/07/2024	HH.3024	Confidentiality of Medical Information Act Compliance	Medi-Cal OneCare PACE
Revised	05/01/2025	HH.3024	Confidentiality of Medical Information Act Compliance	Covered California Medi-Cal OneCare PACE
Revised	10/01/2025	HH.3024	Confidentiality of Medical Information Act Compliance	Covered California Medi-Cal OneCare PACE

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IX. GLOSSARY

Term	Definition
Authorization	Permission granted in accordance with Civil Code §§ 56.11 or 56.21 for the disclosure of Medical Information.
Authorized Representative (AR)	Any individual appointed in writing by a competent Member or Potential Member, to act in place or on behalf of the Member or Potential Member for purposes of assisting or representing the Member or Potential Member with Grievances and Appeals, State Fair Hearings, Independent Medical Reviews and in any other capacity, as specified by the Member or Potential Member.
Communications	For purposes of this policy and unless otherwise specified, communications subject to this policy include written, verbal, or electronic communications related to the receipt of Sensitive Services, including bills and attempts to collect payment; notices of adverse benefits determinations; explanation of benefits notices; CalOptima Health's request for additional information regarding a claim; a notice of a contested claim; the name and address of a provider, description of services provided, and any other information related to a visit; and any communication from CalOptima Health that contains Medical Information.
Confidential Communications Request	For purposes of this policy, this is a request by a Member that communications from CalOptima Health containing Medical Information ("Confidential Communications") be communicated to the Member at a specific mail address, email address, or telephone number, as designated by the Member. Civ. Code § 56.05(c). These requests also apply to communications that disclose a provider's name and address related to receipt of services by the Member the requesting confidential communication. Civ. Code § 56.107(b)(4).
Confidentiality of Medical Information Act (CMIA)	The Confidentiality of Medical Information Act (California Civil Code § 56 *et seq*.), to the extent applicable to operation of CalOptima Health.
Covered California	The California Health Benefit Exchange, doing business as Covered California and an independent entity within the government of the State of California.
Evidence of Coverage	The state-regulator approved document which describes the benefits, exclusions, limitations, conditions, and the benefit levels of the applicable Plans issued to a Subscriber or Member.
Health Insurance Portability and Accountability Act of 1996 (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information, as amended.
Gender Affirming Care	Medically necessary health care or Gender Affirming Mental Health Care that respects the gender identity of the patient, as experienced and defined by the patient, and may include, but is not limited to: 1. Interventions to suppress the development of endogenous secondary sex characteristics; 2. Interventions to align the patient's appearance or physical body with the patient's gender identity; and 3. Interventions to alleviate symptoms of clinically significant distress resulting from gender dysphoria, as defined in the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition. Welfare and Institutions Code § 16010.2(b).
Gender Affirming Mental Health Care	Mental health care or behavioral health care that respects the gender identity of the patient, as experienced and defined by the patient, and may include,

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Term	Definition
	but is not limited to, developmentally appropriate exploration and integration of identity, reduction of distress, adaptive coping, and strategies to increase family acceptance.
Medical Information	Any individually identifiable information, in electronic or physical form, in possession of or derived from a provider of health care, health care service plan, pharmaceutical company, or contractor regarding a patient's medical history, mental health application information, Reproductive or Sexual Health Application Information, mental or physical condition, or treatment. "Individually Identifiable" means that the Medical Information includes or contains any element of personal identifying information sufficient to allow identification of the individual, such as the patient's name, address, electronic mail address, telephone number, or social security number, or other information that, alone or in combination with other publicly available information, reveals the identity of the individual. Civ. Code § 56.05(j).
Member	An individual enrolled in a CalOptima Health program.
Personally Identifiable Information (PII)	Covered California: Any information that identifies or describes an individual, including his or her name, social security number, physical description, home address, home telephone number, education, financial matters, medical or employment history, and statements made by, or attributed to, the individual. Med-Cal & OneCare: Any information about an individual maintained by an agency, including: 1. Any information that can be used to distinguish or trace an individual's identity, such as name, social security number, date and place of birth, mother's maiden name, or biometric records; and 2. Any other information that is linked or linkable to an individual, such as medical, educational, financial, and employment information.
Provider	Covered California: A licensed health care facility or as stipulated by local or international jurisdictions, a program, agency or health professional that delivers Covered Services. Med-Cal: Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so. OneCare: Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier) 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.
Reproductive or Sexual Health Application Information	Information about an individual's reproductive health, menstrual cycle, fertility, pregnancy, pregnancy outcome, plans to conceive, or type of sexual activity collected by a reproductive or sexual health digital service, including, but not limited to, information from which one can infer someone's pregnancy status, menstrual cycle, fertility, hormone levels, birth control use, sexual activity, or gender identity. Civ. Code § 56.05(q).

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Term	Definition
Reproductive or Sexual Health Digital Service	A mobile-based application or internet website that collects Reproductive or Sexual Health Application Information from a consumer, markets itself as facilitating Reproductive or Sexual Health Services to a consumer and uses the information to facilitate Reproductive or Sexual Health Services to a consumer.
Sensitive Services	All health care services related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender affirming care, and intimate partner violence, and includes services described in Family Code, Sections 6924, 6925, 6926, 6927, 6928, 6929, and 6930, and Health and Safety Code, Sections 121020 and 124260, obtained by a patient at or above the minimum age specified for consenting to the service, in accordance with California Civil Code, Section 56.05(s).

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Policy:	HH.4002
Title:	**CalOptima Health Internal Oversight**
Department:	Office of Compliance
Section:	Internal Audit
CEO Approval:	*/s/*
Effective Date:	12/01/2016
Revised Date:	09/01/2025
Applicable to:	☒ Administrative ☐ Covered California [Effective 2027] ☐ Medi-Cal ☐ OneCare ☐ PACE

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I. PURPOSE

This policy defines the process for Internal Monitoring and Oversight of CalOptima Health to ensure compliance with statutory, regulatory, contractual, and CalOptima Health policy requirements.

II. POLICY

A. The Internal Audit Department (IAD) shall establish protocols to ensure compliance risks are identified and conduct effective Auditing and Monitoring of internal department processes, and outcomes within CalOptima Health to ensure continuous improvement of Member care, administrative processes, and management.

B. The Internal Audit Department shall perform a (Monthly/Quarterly), and at least an Annual Risk Assessment, as outlined in CalOptima Health Policy HH.4003: Annual Risk Assessment (Internal) and develop an Annual Internal Audit and Monitoring Work Plan (hereinafter, the Work Plan).

1. The Annual Risk Assessment and Work Plan shall incorporate, at minimum, current Centers for Medicare & Medicaid Services (CMS) and Department of Health Care Services (DHCS) contractual and regulatory requirements, Department of Managed Health Care (DMHC) Technical Assistance Guides, CMS program audit process and protocols, National Committee for Quality Assurance (NCQA) standards, and any identified high-risk areas related to the CalOptima Health Medi-Cal, OneCare, and PACE programs.

C. Internal Audit Department shall assess each of the CalOptima Health departments identified on the Work Plan. Each may be subject to Audit and/or routine Monitoring, and Focused Reviews.

D. The Work Plan shall identify the functional area(s) subject to Audit and describe the schedule of Audits to be conducted by the Internal Audit Department in the coming year. The Work Plan shall also identify specific functional areas that require continuous Monitoring. The Work Plan may be subject to revision during the year in response to changing circumstances; these changes will require approval of the Compliance Committee.

E. The Internal Audit Department shall identify functional areas requiring improvement through internal Audits and Monitoring activities, risk assessments, or regulatory Audits, and shall Monitor

performance to ensure applicable regulatory and industry standards are met. If monitoring results reveal deficiencies, the internal department(s) will be subject to a Focused Review.

F. CalOptima Health shall continually assess a functional area's ability to perform functions through initial reviews, on-going Monitoring, performance reviews, and analysis of data and reports against industry, regulatory, and/or quality benchmarks, when available.

G. Audits of CalOptima Health's internal functional areas will be conducted, at minimum, annually by desktop and on-site and/or webinar review. CalOptima Health shall ensure Audits are conducted at reasonable times.

H. CalOptima Health's Internal Audit Department shall maintain documentation of Internal Oversight activities as described herein.

I. The Auditing and Monitoring results shall be reported to the Compliance Committee for review and recommendations. When appropriate, CalOptima Health's Regulatory Affairs & Compliance Department shall inform the CMS, DHCS, DMHC, National Benefit Integrity Medicare Drug Contractor (NBI MEDIC), or law enforcement of aberrant findings that may cause harm or impact the delivery of care to CalOptima Health Members.

J. Failure by an internal department to respond accurately, timely, and in compliance with statutory, regulatory, contractual, CalOptima Health policies, or other requirements to CalOptima Health's Office of Compliance's Immediate Corrective Action Plan (ICAP) or Corrective Action Plan (CAP) request shall lead to further action, in accordance with CalOptima Health Policy HH.2005: Corrective Action Plan.

III. PROCEDURE

A. CalOptima Health shall conduct activities in accordance with the terms and conditions of all applicable regulatory requirements, CalOptima Health policies and procedures, CalOptima Health contracts with the CMS and/or the DHCS, DMHC Full Service Technical Assistance Guides, and NCQA Accreditation.

B. CalOptima Health shall provide Internal Oversight using, without limit, the following components:

1. Desktop reviews;
2. Focused and ad hoc reviews, and Audits and Monitoring;
3. Periodic reviews and Audits; and
4. On-going monitoring.

C. Functional areas shall include, without limit:

1. Credentialing, recredentialing, and facility site review;
2. Utilization Management;
3. Claims processing/adjudication and payment timeliness;
4. Provider disputes and claim appeals;

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5. Member rights;

6. Customer service;

7. Exclusion and preclusion monitoring oversight;

8. Care coordination;

9. Grievance and appeals;

10. Provider network adequacy;

11. Pharmacy;

12. Case Management;

13. Program for All-Inclusive Care for the Elderly (PACE);

14. Grant Management;

15. Communication services, including but not limited to, cultural & linguistic services, and alternative formats;

16. Access and availability, including compliance with the Americans with Disabilities Act (ADA);

17. Systems utilized to carry out business functions;

18. Reporting and Monitoring; and

19. Other functional areas identified by the Annual Risk Assessment as having potential for high or medium risk.

D. The Internal Audit Department shall develop comprehensive audit tools for Internal Oversight of the focus areas as described in Section III.C. of this Policy, in consultation with subject matter experts including CalOptima Health operational departments, the Regulatory Affairs & Compliance Department, and legal counsel, as necessary. The Internal Audit Department shall review and update audit tools in collaboration with the respective subject matter experts annually, or as necessary, based upon regulatory, contractual, and accreditation changes.

E. Annual Audit Oversight Process

1. At least annually, the Internal Audit Department shall identify and schedule Audits as a result of the Annual Risk Assessment, focused Audit findings, deficient Monitoring results, Fraud, Waste, and Abuse (FWA), or program Audit findings.

2. The Audit will evaluate, at a minimum, performance with applicable statutes, regulations, and compliance with CalOptima Health policies and procedures.

3. Sixty (60) days prior to the scheduled Audit, the Internal Audit Department will send, via email, the CalOptima Health department management staff a notice confirming the date and scope of the Audit. The notice will include a description of any universes required, the Audit period, the

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due date, method of delivery, and Audit format. The Internal Audit Department shall utilize industry standard Audit protocols and appropriate methods for Auditing with respect to tools, sample size, data mining, etc.

4. Upon receipt of the requested universe(s), the assigned auditor shall select a sample size appropriate for the type of Audit being conducted, such as:

    a. Processes considered to be high-risk and/or have potential Member harm;

    b. Compliance with CMS, DHCS, DMHC, and NCQA-mandated elements, or contractual obligations; and

    c. Areas identified as deficient in previous Audits.

5. If the minimum number of cases is not available in the universe the auditor may request additional information or documentation.

6. The Internal Audit auditor will notify the CalOptima Health department of samples selected, and documentation required seven (7) calendar days prior to the Audit when provided in electronic format, or when sample files are supplied in alternate formats.

    a. The Internal Audit auditor shall review sample cases and functional areas shall submit samples and documentation electronically whenever possible.

    b. The Internal Audit auditor may, at his or her discretion, request additional materials during the review.

7. The Audit will include validation of documentation, including but not limited to CalOptima Health policies and procedures, training, reports, systems, and file review(s) and universe(s).

8. The Internal Audit auditor shall discuss findings from the annual Audit with the respective CalOptima Health department and document findings in a preliminary audit report.

9. Preliminary Report and Rebuttal Process:

    a. A preliminary report outlining any non-compliant regulatory findings shall be issued to the internal business department(s) within five (5) business days of receipt of final evidence from the Document Request Form (DRF).

    b. If the internal business department disagrees with any of the preliminary results, the department may exercise their right to a rebuttal process.

    c. Rebuttals from the internal business department(s) are due to the Internal Audit Department within five (5) business days of the issuance of the preliminary report.

        i. The request for rebuttal must be submitted in writing and must include a detailed description, reason for the rebuttal, and supporting evidence to support the disagreement.

        ii. The Internal Audit Department will review the rebuttal and will provide a decision to overturn or uphold its initial decision in a formal memorandum within five (5) business days of receipt of the request.

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10. The final results summary with a CAP, if necessary, shall be issued:

    a. If the department receives a score of less than the established passing score for an individual audit element, a CAP or CAP(s) shall be developed in accordance with CalOptima Health Policy HH.2005: Corrective Action Plan.

    b. Within two (2) business days of the rebuttal period conclusion, if no CAP is filed; or

    c. On the sixth (6th) business day after the rebuttal period concludes if a CAP is filed.

11. The CAP(s) response will be due within ten (10) business days from the internal business department.

    a. The Internal Audit auditor is responsible for confirming remediation or interacting with the leadership of the audited department to ensure the department has documented and completed the remediation in accordance with CalOptima Health Policy HH.2005: Corrective Action Plan .

12. Audit findings and any CAPs, including the timeline for CAP remediation, will be presented to the Compliance Committee by the Internal Audit Department for the respective functional area reviewed. The Internal Audit Department shall determine any follow up activities, process improvement, and/or additional review based on the recommendations of the Internal Audit auditor.

    a. In the event the elements of the CAP are not successfully completed within the established timeframe, the Director of Internal Audit shall report status to the Compliance Committee following the CAP period. The Compliance Committee will review the outstanding CAP items to determine, at its discretion, whether the CAP deadline should be extended.

    b. The Internal Audit Department must demonstrate to the Compliance Committee the appropriateness for an extension and provide a detailed action plan to ensure that the items for correction are being addressed in a timely manner.

13. The Internal Audit Department shall determine whether ad hoc audits, reviews, and or other remediation or actions are necessary to confirm remediation of identified issues. Issues escalated will be reviewed by the Internal Audit Department, and the Compliance Committee, as applicable.

F. Ongoing Internal Oversight Process

1. The Internal Audit Department will conduct on-going Internal Oversight of the business areas outlined in Section III.C. of this policy based on the risk level determined during the Annual Risk Assessment, and as outlined on the Work Plan.

2. On a monthly basis, Internal Key Performance Indicators (KPI)/Dashboard Reporting data shall be used to Monitor processing timeliness, accuracy, business activities, goals, and measures.

    a. The Internal Audit Department shall Monitor KPI/Dashboard Reporting results and may make recommendations for corrective action if performance falls below the standard defined by Regulatory Affairs and the Compliance Committee.

    b. If there is a consistent pattern of non-compliance of a particular KPI measure, as defined in the Internal Audit Department's Monitoring Key Performance Indicators (KPI),

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Department File Review, and Compliance Oversight Activities (COA) Desktop Procedure (DTP) Section 5-6, the Internal Audit Department may conduct a Focused Review and issue a request for Corrective Action Plan, if necessary.

i. If the results of the Focused Review are unfavorable, the auditor will escalate for further action. This includes, but is not limited to, reporting the issue to the Compliance Committee for disciplinary action and/or development of a remediation plan with the internal business area.

G. Corrective Action Plan (CAP)

1. If any area of deficiency or non-compliance is identified through, including but not limited to, Member or Provider Complaints, readiness assessment reviews, regular reports, oversight reviews, and ongoing Monitoring, the Internal Audit Department will be required to issue a Corrective Action Plan (CAP) request, in accordance with CalOptima Health Policy HH.2005: Corrective Action Plan.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Compliance Plan
B. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima Health PACE Program Agreement
E. CalOptima Health Policy HH.2005: Corrective Action Plan
F. CalOptima Health Policy HH.4003: Annual Risk Assessment (Internal)
G. Title 42, Code of Federal Regulations (C.F.R.), §455.2
H. Welfare and Institutions Code, §14043.1(a)

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/06/2018	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
12/01/2022	Regular Meeting of the CalOptima Health Board of Directors
10/05/2023	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

FC 20251106 BOD Review Only

Action	Date	Policy	Policy Title	Program(s)
Effective	12/01/2016	HH.4002	CalOptima Internal Oversight	Administrative
Revised	12/07/2017	HH.4002	CalOptima Internal Oversight	Administrative
Revised	12/06/2018	HH.4002	CalOptima Internal Oversight	Administrative
Revised	12/05/2019	HH.4002	CalOptima Internal Oversight	Administrative
Revised	12/03/2020	HH.4002	CalOptima Internal Oversight	Administrative
Revised	12/20/2021	HH.4002	CalOptima Internal Oversight	Administrative
Revised	12/31/2022	HH.4002	CalOptima Health Internal Oversight	Administrative
Revised	10/05/2023	HH.4002	CalOptima Health Internal Oversight	Administrative
Revised	05/01/2024	HH.4002	CalOptima Health Internal Oversight	Administrative
Revised	09/01/2025	HH.4002	CalOptima Health Internal Oversight	Administrative

For 20251106 BOD Review Only

IX. GLOSSARY

Term	Definition
Abuse	Medi-Cal: Practices that are inconsistent with sound fiscal and business practices or medical standards, and result in an unnecessary cost to the Medi-Cal program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to the Medi-Cal program. OneCare: A Provider practice that is inconsistent with sound fiscal, business, or medical practice, and results in an unnecessary cost to CalOptima Health and the OneCare program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to CalOptima Health and the OneCare program.
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.
Business Owner	CalOptima Health management and staff vested in the compliance of their respective CalOptima Health functional area in accordance with statutory, regulatory, contractual, and CalOptima Health policy requirements.
Compliance Committee	This CalOptima Health committee consists of executive officers, managers of key operating divisions, and legal counsel and oversees the implementation of CalOptima Health's Compliance Program.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima Health, the Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima Health departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima Health and its regulators.
Department of Health Care Services (DHCS)	The single State department responsible for the administration of the Medi-Cal Program, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), and other health related programs as provided by statute and/or regulation.
Department of Managed Health Care (DMHC)	The California Department of Managed Health Care that oversees California's managed care system. DMHC regulates health maintenance organizations licensed under the Knox-Keene Act, Health & Safety Code, Sections 1340 *et seq*.
Focused Review	An audit that specifically targets areas of potential deficiency.

For 20251106 BOD Review Only

Term	Definition
Fraud	An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law, in accordance with Title 42 Code of Federal Regulations section 455.2, Welfare and Institutions Code section 14043.1(i).
Internal Audit and Monitoring Work Plan	An outline of goals and objectives to define the audit scope for internal functional areas to ensure health plan compliance, as well as conduct on-going performance measurements to determine opportunities for improvement and/or the effectiveness of interventions.
Internal Oversight	The process by which CalOptima Health's Internal Audit Department conducts audits to monitor internal functional areas in accordance with regulatory, statutory, contractual, and CalOptima Health policy requirements to ensure health plan compliance.
Key Performance Indicators (KPI) Dashboard Reporting	For purposes of this policy, the critical (key) quantifiable indicators of progress toward an intended goal measure result. KPIs provide a focus for strategic and operational improvement, create an analytical basis for timeliness, accuracy, decision making and tracking progress against those targets. Reports are created by pulling together data from existing reports available, giving the CalOptima Health Internal Audit (IA) Department a graphical snapshot of the Internal Business Departments performance.
Member	A beneficiary enrolled in a CalOptima Health 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.
National Committee for Quality Assurance (NCQA)	An organization responsible for the accreditation of managed care plans and other health care entities and for developing and managing health care measures that assess the Quality of Care and services that Members receive.
Risk Assessment Tool	A tool utilized to stratify level of risk (high, medium, low) based upon Audit results and corrective actions issued to identify specific CalOptima Health functional areas vulnerable to potential Compliance risk.
Waste	The overutilization or inappropriate utilization of services and misuse of resources.

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Policy:	HH.4002
Title:	**CalOptima Health Internal Oversight**
Department:	Office of Compliance
Section:	Internal Audit
CEO Approval:	*/s/*
Effective Date:	12/01/2016
Revised Date:	09/01/2025
Applicable to:	☒ Administrative ☐ Covered California [Effective 2027] ☐ Medi-Cal ☐ OneCare ☐ PACE

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I. PURPOSE

This policy defines the process for Internal Monitoring and Oversight of CalOptima Health to ensure compliance with statutory, regulatory, contractual, and CalOptima Health policy requirements.

II. POLICY

A. The Internal Audit Department (IAD) shall establish protocols to ensure compliance risks are identified and conduct effective Auditing and Monitoring of internal department processes, and outcomes within CalOptima Health to ensure continuous improvement of Member care, administrative processes, and management.

B. The Internal Audit Department shall perform a (Monthly/Quarterly), and at least an Annual Risk Assessment, as outlined in CalOptima Health Policy HH.4003: Annual Risk Assessment (Internal) and develop an Annual Internal Audit and Monitoring Work Plan (hereinafter, the Work Plan).

1. The Annual Risk Assessment and Work Plan shall incorporate, at minimum, current Centers for Medicare & Medicaid Services (CMS) and Department of Health Care Services (DHCS) contractual and regulatory requirements, Department of Managed Health Care (DMHC) Technical Assistance Guides, CMS program audit process and protocols, National Committee for Quality Assurance (NCQA) standards, and any identified high-risk areas related to the CalOptima Health Medi-Cal, OneCare, and PACE programs.

C. Internal Audit Department shall assess each of the CalOptima Health departments identified on the Work Plan. Each may be subject to Audit and/or routine Monitoring, and Focused Reviews.

D. The Work Plan shall identify the functional area(s) subject to Audit and describe the schedule of Audits to be conducted by the Internal Audit Department in the coming year. The Work Plan shall also identify specific functional areas that require continuous Monitoring. The Work Plan may be subject to revision during the year in response to changing circumstances; these changes will require approval of the Compliance Committee.

E. The Internal Audit Department shall identify functional areas requiring improvement through internal Audits and Monitoring activities, risk assessments, or regulatory Audits, and shall Monitor

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performance to ensure applicable regulatory and industry standards are met. If monitoring results reveal deficiencies, the internal department(s) will be subject to a Focused Review.

F. CalOptima Health shall continually assess a functional area's ability to perform functions through initial reviews, on-going Monitoring, performance reviews, and analysis of data and reports against industry, regulatory, and/or quality benchmarks, when available.

G. Audits of CalOptima Health's internal functional areas will be conducted, at minimum, annually by desktop and on-site and/or webinar review. CalOptima Health shall ensure Audits are conducted at reasonable times.

H. CalOptima Health's Internal Audit Department shall maintain documentation of Internal Oversight activities as described herein.

I. The Auditing and Monitoring results shall be reported to the Compliance Committee for review and recommendations. When appropriate, CalOptima Health's Regulatory Affairs & Compliance Department shall inform the CMS, DHCS, DMHC, National Benefit Integrity Medicare Drug Contractor (NBI MEDIC), or law enforcement of aberrant findings that may cause harm or impact the delivery of care to CalOptima Health Members.

J. Failure by an internal department to respond accurately, timely, and in compliance with statutory, regulatory, contractual, CalOptima Health policies, or other requirements to CalOptima Health's Office of Compliance's Immediate Corrective Action Plan (ICAP) or Corrective Action Plan (CAP) request shall lead to further action, in accordance with CalOptima Health Policy HH.2005: Corrective Action Plan.

III. PROCEDURE

A. CalOptima Health shall conduct activities in accordance with the terms and conditions of all applicable regulatory requirements, CalOptima Health policies and procedures, CalOptima Health contracts with the CMS and/or the DHCS, DMHC Full Service Technical Assistance Guides, and NCQA Accreditation.

B. CalOptima Health shall provide Internal Oversight using, without limit, the following components:

1. Desktop reviews;
2. Focused and ad hoc reviews, and Audits and Monitoring;
3. Periodic reviews and Audits; and
4. On-going monitoring.

C. Functional areas shall include, without limit:

1. Credentialing, recredentialing, and facility site review;
2. Utilization Management;
3. Claims processing/adjudication and payment timeliness;
4. Provider disputes and claim appeals;

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5. Member rights;

6. Customer service;

7. Exclusion and preclusion monitoring oversight;

8. Care coordination;

9. Grievance and appeals;

10. Provider network adequacy;

11. Pharmacy;

12. Case Management;

13. Program for All-Inclusive Care for the Elderly (PACE);

14. Grant Management;

15. Communication services, including but not limited to, cultural & linguistic services, and alternative formats;

16. Access and availability, including compliance with the Americans with Disabilities Act (ADA);

17. Systems utilized to carry out business functions;

18. Reporting and Monitoring; and

19. Other functional areas identified by the Annual Risk Assessment as having potential for high or medium risk.

D. The Internal Audit Department shall develop comprehensive audit tools for Internal Oversight of the focus areas as described in Section III.C. of this Policy, in consultation with subject matter experts including CalOptima Health operational departments, the Regulatory Affairs & Compliance Department, and legal counsel, as necessary. The Internal Audit Department shall review and update audit tools in collaboration with the respective subject matter experts annually, or as necessary, based upon regulatory, contractual, and accreditation changes.

E. Annual Audit Oversight Process

1. At least annually, the Internal Audit Department shall identify and schedule Audits as a result of the Annual Risk Assessment, focused Audit findings, deficient Monitoring results, Fraud, Waste, and Abuse (FWA), or program Audit findings.

2. The Audit will evaluate, at a minimum, performance with applicable statutes, regulations, and compliance with CalOptima Health policies and procedures.

3. Sixty (60) days prior to the scheduled Audit, the Internal Audit Department will send, via email, the CalOptima Health department management staff a notice confirming the date and scope of the Audit. The notice will include a description of any universes required, the Audit period, the

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due date, method of delivery, and Audit format. The Internal Audit Department shall utilize industry standard Audit protocols and appropriate methods for Auditing with respect to tools, sample size, data mining, etc.

4. Upon receipt of the requested universe(s), the assigned auditor shall select a sample size appropriate for the type of Audit being conducted, such as:

    a. Processes considered to be high-risk and/or have potential Member harm;

    b. Compliance with CMS, DHCS, DMHC, and NCQA-mandated elements, or contractual obligations; and

    c. Areas identified as deficient in previous Audits.

5. If the minimum number of cases is not available in the universe the auditor may request additional information or documentation.

6. The Internal Audit auditor will notify the CalOptima Health department of samples selected, and documentation required seven (7) calendar days prior to the Audit when provided in electronic format, or when sample files are supplied in alternate formats.

    a. The Internal Audit auditor shall review sample cases and functional areas shall submit samples and documentation electronically whenever possible.

    b. The Internal Audit auditor may, at his or her discretion, request additional materials during the review.

7. The Audit will include validation of documentation, including but not limited to CalOptima Health policies and procedures, training, reports, systems, and file review(s) and universe(s).

8. The Internal Audit auditor shall discuss findings from the annual Audit with the respective CalOptima Health department and document findings in a preliminary audit report.

9. Preliminary Report and Rebuttal Process:

    a. A preliminary report outlining any non-compliant regulatory findings shall be issued to the internal business department(s) within five (5) business days of receipt of final evidence from the Document Request Form (DRF).

    b. If the internal business department disagrees with any of the preliminary results, the department may exercise their right to a rebuttal process.

    c. Rebuttals from the internal business department(s) are due to the Internal Audit Department within five (5) business days of the issuance of the preliminary report.

        i. The request for rebuttal must be submitted in writing and must include a detailed description, reason for the rebuttal, and supporting evidence to support the disagreement.

        ii. The Internal Audit Department will review the rebuttal and will provide a decision to overturn or uphold its initial decision in a formal memorandum within five (5) business days of receipt of the request.

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10. The final results summary with a CAP, if necessary, shall be issued:

    a. If the department receives a score of less than the established passing score for an individual audit element, a CAP or CAP(s) shall be developed in accordance with CalOptima Health Policy HH.2005: Corrective Action Plan.

    b. Within two (2) business days of the rebuttal period conclusion, if no CAP is filed; or

    c. On the sixth (6th) business day after the rebuttal period concludes if a CAP is filed.

11. The CAP(s) response will be due within ten (10) business days from the internal business department.

    a. The Internal Audit auditor is responsible for confirming remediation or interacting with the leadership of the audited department to ensure the department has documented and completed the remediation in accordance with CalOptima Health Policy HH.2005: Corrective Action Plan .

12. Audit findings and any CAPs, including the timeline for CAP remediation, will be presented to the Compliance Committee by the Internal Audit Department for the respective functional area reviewed. The Internal Audit Department shall determine any follow up activities, process improvement, and/or additional review based on the recommendations of the Internal Audit auditor.

    a. In the event the elements of the CAP are not successfully completed within the established timeframe, the Director of Internal Audit shall report status to the Compliance Committee following the CAP period. The Compliance Committee will review the outstanding CAP items to determine, at its discretion, whether the CAP deadline should be extended.

    b. The Internal Audit Department must demonstrate to the Compliance Committee the appropriateness for an extension and provide a detailed action plan to ensure that the items for correction are being addressed in a timely manner.

13. The Internal Audit Department shall determine whether ad hoc audits, reviews, and or other remediation or actions are necessary to confirm remediation of identified issues. Issues escalated will be reviewed by the Internal Audit Department, and the Compliance Committee, as applicable.

F. Ongoing Internal Oversight Process

1. The Internal Audit Department will conduct on-going Internal Oversight of the business areas outlined in Section III.C. of this policy based on the risk level determined during the Annual Risk Assessment, and as outlined on the Work Plan.

2. On a monthly basis, Internal Key Performance Indicators (KPI)/Dashboard Reporting data shall be used to Monitor processing timeliness, accuracy, business activities, goals, and measures.

    a. The Internal Audit Department shall Monitor KPI/Dashboard Reporting results and may make recommendations for corrective action if performance falls below the standard defined by Regulatory Affairs and the Compliance Committee.

    b. If there is a consistent pattern of non-compliance of a particular KPI measure, as defined in the Internal Audit Department's Monitoring Key Performance Indicators (KPI),

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Department File Review, and Compliance Oversight Activities (COA) Desktop Procedure (DTP) Section 5-6, the Internal Audit Department may conduct a Focused Review and issue a request for Corrective Action Plan, if necessary.

i. If the results of the Focused Review are unfavorable, the auditor will escalate for further action. This includes, but is not limited to, reporting the issue to the Compliance Committee for disciplinary action and/or development of a remediation plan with the internal business area.

G. Corrective Action Plan (CAP)

1. If any area of deficiency or non-compliance is identified through, including but not limited to, Member or Provider Complaints, readiness assessment reviews, regular reports, oversight reviews, and ongoing Monitoring, the Internal Audit Department will be required to issue a Corrective Action Plan (CAP) request, in accordance with CalOptima Health Policy HH.2005: Corrective Action Plan.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Compliance Plan
B. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima Health PACE Program Agreement
E. CalOptima Health Policy HH.2005: Corrective Action Plan
F. CalOptima Health Policy HH.4003: Annual Risk Assessment (Internal)
G. Title 42, Code of Federal Regulations (C.F.R.), §455.2
H. Welfare and Institutions Code, §14043.1(a)

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
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VIII. REVISION HISTORY

FC 20251106 BOD Review Only

Action	Date	Policy	Policy Title	Program(s)
Effective	12/01/2016	HH.4002	CalOptima Internal Oversight	Administrative
Revised	12/07/2017	HH.4002	CalOptima Internal Oversight	Administrative
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Revised	12/05/2019	HH.4002	CalOptima Internal Oversight	Administrative
Revised	12/03/2020	HH.4002	CalOptima Internal Oversight	Administrative
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Revised	12/31/2022	HH.4002	CalOptima Health Internal Oversight	Administrative
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Revised	05/01/2024	HH.4002	CalOptima Health Internal Oversight	Administrative
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IX. GLOSSARY

Term	Definition
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Term	Definition
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National Committee for Quality Assurance (NCQA)	An organization responsible for the accreditation of managed care plans and other health care entities and for developing and managing health care measures that assess the Quality of Care and services that Members receive.
Risk Assessment Tool	A tool utilized to stratify level of risk (high, medium, low) based upon Audit results and corrective actions issued to identify specific CalOptima Health functional areas vulnerable to potential Compliance risk.
Waste	The overutilization or inappropriate utilization of services and misuse of resources.

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Policy:	HH.4003
Title:	**Annual Risk Assessment (Internal)**
Department:	Office of Compliance
Section:	Internal Audit
CEO Approval:	*/s/*
Effective Date:	12/01/2016
Revised Date:	09/01/2025
Applicable to:	☒ Administrative ☐ Covered California [Effective 2027] ☐ Medi-Cal ☐ OneCare ☐ PACE

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I. PURPOSE

This policy describes the internal Annual Risk Assessment process conducted by the CalOptima Health Internal Audit Department (IAD) to identify specific areas vulnerable to potential compliance risk. Such areas are documented in CalOptima Health's Annual Risk Assessment Tool, which will influence the development of CalOptima Health's Internal Audit and Monitoring Work Plan.

II. POLICY

A. The Internal Audit Department (IAD) is responsible for completing a risk assessment, at least annually, to develop its Internal Audit and Monitoring Plan that provides a comprehensive assessment of CalOptima Health. In assessing risk, the Internal Audit Department shall consider the following:

1. Statutory, regulatory, and contractual compliance standards;
2. CalOptima Health's policies and procedures;
3. Business impact on Member care;
4. Past compliance issues (e.g., CAPs, Regulator Notices); and
5. Compliance dashboard results.

B. The Internal Audit Department shall stay current with all regulatory communication and guidance from Regulatory Agencies.

C. The Internal Audit Department shall present Annual Risk Assessment results and the proposed Internal Audit and Monitoring Work Plan to the Compliance Committee for review and approval by the end of the calendar year to be effective for the following calendar year.

III. PROCEDURE

A. The Internal Audit Department shall schedule meetings with all operational department leads to

complete the assessment.

1. Discovery and Analysis. The Internal Audit Department shall undertake a discovery process to determine which regulatory, statutory, contractual, and CalOptima Health policy requirements are completely implemented, their operational effectiveness, and how the practices and the documentation support compliance. The discovery process shall consist of document review, an interview process, and review of other relevant information. The analysis component of risk assessment is based on the evaluation of the data from the business area.

    a. In order to determine whether there are accurate and compliant processes and systems in place, the Internal Audit Department shall conduct the following activities:

        i. A review of CalOptima Health policies and procedures and other supporting documents, such as regulatory communications. For each internal area reviewed in the risk assessment process, the Internal Audit Department shall request from the applicable department the policies and procedures and supporting documentation that describe processes used to meet regulatory requirements. The Internal Audit Department shall evaluate the documents for compliance.

        ii. Conduct interrogatory or in-person interviews with internal functional area department management and relevant support staff to discuss the following:

            a) Processes that are supported by policies and procedures and other relevant documentation;

            b) Changes in laws, or regulations, in the previous year that impact their area;

            c) Changes in management and staffing;

            d) The degree to which the activities conducted by their area are subject to compliance risk from the standpoint of State and Federal regulatory requirements.

            e) The degree to which the activities conducted by their area impact CalOptima Health Members; and

            f) Material changes in processes that are expected to impact the functional areas.

B. The Internal Audit Department shall review the following information for internal areas, and the appropriate operational department shall review the following information as part of the risk assessment process:

1. Regulatory Agencies identify a particular area as problematic through enforcement actions, CalOptima Health Audit findings, notices of non-compliance, etc.;

2. Whether there is a Corrective Action Plan (CAP) in effect, and if so, its relative risk for the non-compliant area; and

3. CalOptima Health's Star Ratings scores for specific requirements, to be populated as applicable.

C. To validate compliance of the staff interviews, and review of other relevant information, the Internal Audit Department shall rely on data gathered using the Annual Risk Assessment, and conduct baseline risk assessment Audits evaluating file reviews, data collected from annual Audit results,

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and number of CAPs issued during the review period.

1. As data-driven analysis is significant to determine functional area risk to Members, the Internal Audit Department shall compile the data and then ranks the risks based on the greatest impact.

D. The Internal Audit Department shall prioritize those with greatest risk when developing the annual Audit and Monitoring Work Plan.

E. The Internal Audit Department shall present the internal risk assessment results and proposed Audit and Monitoring Work Plan following approval by the Compliance Committee.

F. The Internal Audit Department shall re-evaluate the risk plan based on internal changes (e.g., staffing and organizational structure changes, internal Audit results, Monitoring results) and external changes (e.g., regulatory changes, marketplace changes, regulatory agency Audits results).

G. Upon completion, the results of the internal risk assessment are presented to the Compliance Committee.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Compliance Plan

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

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VIII. REVISION HISTORY

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Revised	10/05/2023	HH.4003	Annual Risk Assessment (Internal)	Administrative
Revised	11/07/2024	HH.4003	Annual Risk Assessment (Internal)	Administrative
Revised	09/01/2025	HH.4003	Annual Risk Assessment (Internal)	Administrative

For 20251106 BOD Review Only

IX. GLOSSARY

Term	Definition
Abuse	Actions that may, directly or indirectly, resulting in unnecessary costs to a CalOptima Health program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from Fraud, because the distinction between "Fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.
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.
Annual Risk Assessment	A screening to stratify level of risk (high, medium, low) based upon vulnerability to potential non-compliance within applicable policies and procedures, regulatory standards, and contractual obligations. The risk assessment includes a questionnaire with ratings and comments about actions that can be taken to reduce risks, maintain compliance, and prevent deficiencies. A risk assessment should be performed at least annually.
Centers for Medicare & Medicaid Services (CMS)	The federal agency within the United States Department of Health and Human Services (DHHS) that administers the Federal Medicare program and works in partnership with state governments to administer Medicaid programs.
Compliance Committee	The committee designated by the Chief Executive Officer (CEO) to implement and oversee the Compliance Program and to participate in carrying out the provisions of the Compliance Plan. The composition of the Compliance Committee shall consist of Executive staff that may include, but is not limited to, the: Chief Executive Officer; Chief Medical Officer; Chief Operating Officer; Chief Financial Officer; Chief Compliance Officer; and Chief Human Resources Officer.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal Audits or Monitoring activities by CalOptima Health, the Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima Health departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima Health and its regulators.
Department of Health Care Services (DHCS)	The California Department of Health Care Services, the State agency that oversees California's Medicaid program, known as Medi-Cal.

For 2025 1106 BOD Review Only

Term	Definition
Fraud	An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law, in accordance with Title 42 Code of Federal Regulations section 455.2, Welfare and Institutions Code section 14043.1(i).
Internal Audit and Monitoring Work Plan	An outline of goals and objectives to define the Audit scope for internal functional areas to ensure health plan compliance, as well as conduct on-going performance measurements to determine opportunities for improvement and/or the effectiveness of interventions.
Member	A beneficiary enrolled in a CalOptima Health Program.
Monitoring	Regular reviews directed by management and performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective.
Regulatory Agencies	For the purposes of this policy, Regulatory Agencies include Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), Office of Inspector General (OIG), and Office of Civil Rights (OCR).
Waste	Overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Health Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

For 20251106 BOD Review Only

Policy:	HH.4003
Title:	**Annual Risk Assessment (Internal)**
Department:	Office of Compliance
Section:	Internal Audit
CEO Approval:	*/s/*
Effective Date:	12/01/2016
Revised Date:	09/01/2025
Applicable to:	☒ Administrative ☐ Covered California [Effective 2027] ☐ Medi-Cal ☐ OneCare ☐ PACE

For 20251106 BOD Review Only

I. PURPOSE

This policy describes the internal Annual Risk Assessment process conducted by the CalOptima Health Internal Audit Department (IAD) to identify specific areas vulnerable to potential compliance risk. Such areas are documented in CalOptima Health's Annual Risk Assessment Tool, which will influence the development of CalOptima Health's Internal Audit and Monitoring Work Plan.

II. POLICY

A. The Internal Audit Department (IAD) is responsible for completing a risk assessment, at least annually, to develop its Internal Audit and Monitoring Plan that provides a comprehensive assessment of CalOptima Health. In assessing risk, the Internal Audit Department shall consider the following:

1. Statutory, regulatory, and contractual compliance standards;

2. CalOptima Health's policies and procedures;

3. Business impact on Member care;

4. Past compliance issues (e.g., CAPs, Regulator Notices); and

5. Compliance dashboard results.

B. The Internal Audit Department shall stay current with all regulatory communication and guidance from Regulatory Agencies.

C. The Internal Audit Department shall present Annual Risk Assessment results and the proposed Internal Audit and Monitoring Work Plan to the Compliance Committee for review and approval by the end of the calendar year to be effective for the following calendar year.

III. PROCEDURE

A. The Internal Audit Department shall schedule meetings with all operational department leads to

complete the assessment.

1. Discovery and Analysis. The Internal Audit Department shall undertake a discovery process to determine which regulatory, statutory, contractual, and CalOptima Health policy requirements are completely implemented, their operational effectiveness, and how the practices and the documentation support compliance. The discovery process shall consist of document review, an interview process, and review of other relevant information. The analysis component of risk assessment is based on the evaluation of the data from the business area.

    a. In order to determine whether there are accurate and compliant processes and systems in place, the Internal Audit Department shall conduct the following activities:

        i. A review of CalOptima Health policies and procedures and other supporting documents, such as regulatory communications. For each internal area reviewed in the risk assessment process, the Internal Audit Department shall request from the applicable department the policies and procedures and supporting documentation that describe processes used to meet regulatory requirements. The Internal Audit Department shall evaluate the documents for compliance.

        ii. Conduct interrogatory or in-person interviews with internal functional area department management and relevant support staff to discuss the following:

            a) Processes that are supported by policies and procedures and other relevant documentation;

            b) Changes in laws, or regulations, in the previous year that impact their area;

            c) Changes in management and staffing;

            d) The degree to which the activities conducted by their area are subject to compliance risk from the standpoint of State and Federal regulatory requirements.

            e) The degree to which the activities conducted by their area impact CalOptima Health Members; and

            f) Material changes in processes that are expected to impact the functional areas.

B. The Internal Audit Department shall review the following information for internal areas, and the appropriate operational department shall review the following information as part of the risk assessment process:

1. Regulatory Agencies identify a particular area as problematic through enforcement actions, CalOptima Health Audit findings, notices of non-compliance, etc.;

2. Whether there is a Corrective Action Plan (CAP) in effect, and if so, its relative risk for the non-compliant area; and

3. CalOptima Health's Star Ratings scores for specific requirements, to be populated as applicable.

C. To validate compliance of the staff interviews, and review of other relevant information, the Internal Audit Department shall rely on data gathered using the Annual Risk Assessment, and conduct baseline risk assessment Audits evaluating file reviews, data collected from annual Audit results,

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and number of CAPs issued during the review period.

1. As data-driven analysis is significant to determine functional area risk to Members, the Internal Audit Department shall compile the data and then ranks the risks based on the greatest impact.

D. The Internal Audit Department shall prioritize those with greatest risk when developing the annual Audit and Monitoring Work Plan.

E. The Internal Audit Department shall present the internal risk assessment results and proposed Audit and Monitoring Work Plan following approval by the Compliance Committee.

F. The Internal Audit Department shall re-evaluate the risk plan based on internal changes (e.g., staffing and organizational structure changes, internal Audit results, Monitoring results) and external changes (e.g., regulatory changes, marketplace changes, regulatory agency Audits results).

G. Upon completion, the results of the internal risk assessment are presented to the Compliance Committee.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Compliance Plan

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/06/2018	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
10/05/2023	Regular Meeting of the CalOptima Health Board of Directors
11/07/2024	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	12/01/2016	HH.4003	Annual Risk Assessment (Internal)	Administrative
Revised	12/07/2017	HH.4003	Annual Risk Assessment (Internal)	Administrative
Revised	12/06/2018	HH.4003	Annual Risk Assessment (Internal)	Administrative
Revised	12/05/2019	HH.4003	Annual Risk Assessment (Internal)	Administrative

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Action	Date	Policy	Policy Title	Program(s)
Revised	12/03/2020	HH.4003	Annual Risk Assessment (Internal)	Administrative
Revised	12/20/2021	HH.4003	Annual Risk Assessment (Internal)	Administrative
Revised	12/31/2022	HH.4003	Annual Risk Assessment (Internal)	Administrative
Revised	10/05/2023	HH.4003	Annual Risk Assessment (Internal)	Administrative
Revised	11/07/2024	HH.4003	Annual Risk Assessment (Internal)	Administrative
Revised	09/01/2025	HH.4003	Annual Risk Assessment (Internal)	Administrative

1

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IX. GLOSSARY

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Waste	Overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Health Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

1

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Policy:	HH.4004
Title:	**Grant Audits/Reviews**
Department:	Office of Compliance
Section:	Internal Audit
CEO Approval:	*/s/*
Effective Date:	01/01/2025
Revised Date:	
Applicable to:	☒ Administrative ☐ Covered California [Effective 2027] ☐ Medi-Cal ☐ OneCare ☐ PACE

For 20251106 BOD Review Only

I. PURPOSE

The purpose of a Grant Audits and Reviews are to provide independent and objective assurance that Grant funds are managed in accordance with applicable laws, regulations, and award requirements through Internal Controls in place to ensure the efficient, effective, and compliant use of funds. These internal reviews and audits promote transparency, accountability, and responsible stewardship of public and grantor resources.

II. POLICY

A. The objective of a Grant Audits and Reviews are to provide oversight to reassure CalOptima Health's Board and management to ensure compliance with Grant Award requirements and appropriate use of funds. This includes evaluating whether:

1. Grant expenditures are allowable, allocable, and reasonable under the Grant Award requirements, applicable laws and regulations, and promoting effective, reasonable, and cost effective Internal Controls.

2. Funds are used in accordance with the terms and conditions of the Grant Agreement.

3. Internal Controls support accurate and appropriate financial and performance reporting.

4. There is adequate oversight to prevent and detect fraud or waste.

5. Grant Objectives are being achieved in a manner consistent with Grantor expectations and CalOptima Health's policies, procedures, and a Grant Agreement.

6. Grant Management reporting is operating as an effective Internal Control.

7. Conducting special examinations and reviews upon the completion of Board approved Grants, or on an interim basis as needed.

8. Appropriate policies, procedures and industry best practices are present and being followed.

9. The use of Grant funding resources and recommending improvements in policy, procedures, and operations. In addition, the Internal Audit Department will be recommending the best practices and enhancements for Internal Controls that includes desktop procedures for Grant funds.

B. These internal audits are conducted in alignment with the Institute of Internal Auditors (IIA) Global Internal Audit Standards to provide independent assurance to the Board, management, grantors, and stakeholders responsible for Grant funding. These standards ensure that Grant internal audits are performed with integrity, objectivity, and professional competence. Internal Audit activities follow a risk-based approach and will include sufficient and appropriate procedures to support any conclusions or recommendations provided in Audit Reports.

C. Grants shall be established and administered in accordance with CalOptima Health Policy AA.1400: Grant Management.

D. Post-Award Grant Close-out occurs at the end of the Grant lifecycle at which point the awarding entity, CalOptima Health, determines that the Grantee has completed all applicable administrative actions. Grant Close-out Review is the final stage of the Grant Management process and is performed by the Sponsoring Department. Grant Close-out Review is achieved upon completion of:

1. Completion of all provisions and requirements outlined in the Grant Award Agreement, including all Attachments, Addendums, Extensions, and Modifications.

2. Issuance of a Grant Close-out Letter from the Sponsoring Department to the Grantee.

3. Grant Close-out Review as required by CalOptima Health Policy AA.1400: Grant Management.

E. Internal Audit Opinion Policy for Grant Auditing

1. In accordance with the IIA's Global Internal Audit Standards, internal Audit Reports for Grant-related engagements may include the following opinions or assessments:

a. Formal Opinion: A formal opinion is issued when sufficient, appropriate evidence has been obtained. This opinion will assess the effectiveness of Internal Controls, compliance with Grant requirements, and level of residual risk. Typical opinion descriptors include:

i. Adequate;

ii. Needs Improvement;

iii. Unsatisfactory; and/or

iv. Low / Moderate / High-Risk.

b. Narrative Assessment: If the engagement scope is limited or data is insufficient, the report may present descriptive findings and risks without issuing a formal opinion.

c. No Opinion: If the audit cannot be completed due to scope limitations or lack of evidence, the report will clearly state that no opinion is provided and disclose the reasons for the limitation.

III. PROCEDURE

A. Upon completion of the Grant Close-out Review, a Grant Audit may be performed to validate the attainment of financial and Grant Objectives as documented in the Grant Award Agreement and Grant Close-out Review.

1. Grants with aggregate payments of $50,000 or more shall be audited. Grants under $50,000 with incomplete or non-existent Grant Close-out Review documentation may also be selected for

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audit.

2. The Sponsoring Department shall provide a copy of the final Grant Close-out Review to CalOptima Health's Internal Audit department within thirty (30) calendar days of receiving it.

3. The Sponsoring Department shall provide the following documentary evidence to the Internal Audit Department within sixty (60) calendar days of completing the final Grant Close-out Review.

   a. CalOptima Health Board Action Request (COBAR) authorizing Grant or Grant Program.

   b. Internal presentations of the Grant or Grant Program to CalOptima Health's leadership.

   c. Sponsoring Department's Notice of Funding Opportunity (NOFO) document.

   d. Grant Application, including evidence of approval by the Evaluation Committee.

   e. Grant Approval Letter from the Sponsoring Department to the Grantee.

   f. Signed Grant Award Agreement, including all Addendums, Amendments, and Extensions.

   g. Evidence of Grantee's California DOJ Registry Status indicating a "Current" status.

   h. Periodic Progress Reports and Final Report as outlined in the Grant Award Agreement, including evidence of review and approval.

   i. Grant Budget and financial reporting, including supportive evidence such as invoices, etc.

   j. Audited Financial Statements, including Single Audits, if any, for the relevant Grant Term. Financial Statements should include supporting schedules of donor-restricted Net Assets.

   k. IRS Form 990 tax filing throughout the relevant Grant Term.

   l. Copies of all Check Requests and payments from CalOptima Health's Finance Department to the Grantee, including evidence of deposit by the Grantee.

   m. Internal newsletters, photographic material, or management reporting evidencing Grantee's attainment of the Grant Objectives as outlined in the Grant Award Agreement.

   n. Evidence that unspent Grant funds were recouped.

   o. Grant Close-out Letter issued by the Sponsoring Department to Grantee.

   p. The Internal Audit Department may request additional evidence directly from the Grantee.

4. The Sponsoring Department shall coordinate the collection of all relevant records for the audit, review such records, and provide records to the Internal Audit Department in a timely manner.

5. The Internal Audit Department shall design each Scope of Audit using a risk-based approach to align with the IIA Global Internal Audit Standards to ensure that Grant Objectives were achieved as reported and funds were appropriately used for their intended purpose. The Scope of Audit shall include and assess the following activities:

   a. Audit checklist of required documents and approvals.

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b. Complete and accurate fulfillment of the Grant Management process.

c. The Grantee's obligations were completed according to the Grant Award Agreement.

d. Grant expenditures are appropriately tied to the Grant Budget, aligned with the Grant Objectives, and supported by appropriate and legitimate documentation.

e. Grant funds were wholly used for the Grant's intended purpose without any evidence of fraud, waste or abuse.

f. Unused Grant funds were wholly refunded to CalOptima Health.

g. Grant Close-out Review completed with a Final Report to CalOptima Health's leadership.

h. The Scope of Audit may be as broad or restricted as required to meet the organization's needs.

6. The Grant Audit shall begin within sixty (60) calendar days of receiving the Grant Close-Out Review and conclude within ninety (90) calendar days of beginning the audit.

7. Upon completion of the Grant Audit, the Internal Audit Department shall provide a report to CalOptima Health's Chief Operating Officer, Chief Compliance Officer, and the Grant's Sponsoring Department. The Audit Report shall include the following:

a. Executive Summary;

b. General Information;

c. Participants;

d. Definitions;

e. Scope, Activities, and Methodology;

f. Documents and Evidence Reviewed;

g. Observations;

h. Recommendations; and

i. Conclusions: The Audit Report shall contain an opinion concerning the overall reasonableness that expenditures were appropriately supported and accounted foradequacy of controls, operational procedures, and outcomes.

8. The Internal Audit Department will coordinate with and inform management of the results of all audits, the submission of audit responses, and implementation of audit recommendations.

9. The Internal Auditor Department may report the status of completed audits to the Compliance Committee. The Internal Audit Department will also submit written updates directly to the Committee Chairperson as they are completed throughout the quarter.

10. Observations, Findings, or Conclusions could result in a request for a Corrective Action Plan. Corrective Action Plans shall be administered in accordance with CalOptima Health Policy HH.2005: Corrective Action Plan.

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11. The Chief Compliance Officer may choose to outsource any or all functions of the Grant Audit and appoint the Director of the Internal Audit Department to facilitate all communications and audit work with the engaged external auditor. Supplemental Grant Audits may be contracted to perform independent validation and audit procedures, which would primarily leverage/review the audit work performed by the Internal Audit Department.

12. Objectivity is essential to the Grant Audit process. Internal Audit Department personnel shall avoid actual and apparent conflicts of interest. Internal Audit Department personnel should not be involved in the development and installation of any Grant systems or procedures, preparation of records, or other activities that the Internal Audit staff may review or appraise that could be subject to a Grant Audit. Internal Audit personnel may be consulted on the design or adequacy of controls incorporated into new systems and procedures or on revisions to existing systems.

13. Grant Audits shall be performed with absolute independence and control over the audit work. Friendships, personal or business relations, reputations, outside influence, or other factors must not be allowed to alter the Scope of Audit or outcomes.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Policy AA.1400: Grant Management
B. CalOptima Health Policy HH.2005: Corrective Action Plan

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
02/06/2025	Regular Meeting of the CalOptima Health Board of Directors
	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2025	HH.4004	Grant Auditing	Administrative
Revised		HH.4004	Grant Audits/Reviews	Administrative

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IX. GLOSSARY

Term	Definition
Audit Report	Formal written opinion issued by an independent auditor as an assurance service in order to make decisions based on results and conclusions derived from the audit.
Check Request	A warrant device authorizing payment to a designated beneficiary on demand or after a specific date.
Corrective Action Plan	Step-by-step plan that outlines how to address issues and deficiencies in a program or process. The goal of a CAP is to resolve issues and improve operations and processes.
Evaluation Committee	A Committee of qualified staff and subject matter experts appointed by CalOptima Health's Grants Management department to review and assess Grant Applications and program proposals.
Final Report	Document providing information about the Grant project or program's final progress in achieving the goals and objectives of the Grant provided by the Grantee to CalOptima Health. The schedule of submission is set in the Grant Award Agreement.
Financial Statements	Written records that summarize a company's financial activities and position over a specific period of time. They are used to assess an organization's financial health and help with decision-making.
Grant	Financial award given by CalOptima Health to an eligible recipient to achieve a particular purpose or project. Grants are generally not expected to be repaid by the recipient when appropriately used for an approved Grant project.
Grant Application	An application submitted by a Grant applicant to CalOptima Health and used to formally request funding for a specific project.
Grant Approval Letter	Written document informing a Grantee that the Grant Application they submitted has been approved.
Grant Audit/ Review	An independent and comprehensive review of a Grant after close-out to ensure that Grant funds were used in accordance with the Grant Award Agreement's terms and conditions. A Grant Review is generally smaller in scope and seeks to provide a fast track validation of specific activities, achievements, and/or expenditures of the Grant.
Grant Award	The total dollar amount awarded to the Grantee by CalOptima Health through the Grant Management Policy and Procedure.
Grant Award Agreement	Funding agreement between CalOptima Health and the Grantee that sets the terms, conditions, and requirements of a Grant.
Grant Budget	Financial plan that outlines the estimated expenses and income for a project or program that is seeking funding. A Grant budget demonstrates how Grant funds will be used to achieve the project's goals and objectives.
Grant Close-out Letter	A written document that informs the Grantee that all requirements of the Grant have been fulfilled and that the Grant Term has concluded.
Grant Close-out Review	The process by which the awarding entity determines that all required work and administrative actions for a Grant have been completed. It's the final phase of a Grant's lifecycle and marks the end of the awarding entity's relationship with the Grantee.
Grant Management	CalOptima Health's Sponsoring Department's overall exercise of Grant administration throughout the phases of pre-award, award, post-award, and close-out.
Grant Objectives	Statements and milestones that describe the intended outcomes of a Grant-funded project or program.
Grant Program	Funding mechanism to award single or multiple Grants in service to common projects and ideas that support the community as stated in the Notice of Funding Opportunity.
Grant Term	The duration of time in which the Grantee is expected to achieve the Grant's goals and objectives as stated in the Grant Award Agreement.
Grantee	A recipient of a Grant funds.
Internal Controls	Internal Controls means a process, implemented by a Grant Awardee, designed to provide reasonable assurance regarding the achievement of objectives in the following

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	categories: (1) Effectiveness and efficiency of operations; (2) Reliability of reporting for internal and external use; and (3) Compliance with applicable laws and regulations.
Notice of Funding Opportunity (NOFO)	CalOptima Health's formally issued announcement of the availability of a Board-approved and authorized Grant opportunity through one of its Community Investment programs. The announcement provides eligibility, evaluation criteria, funding priorities, and submission information.
Post-Award	The period of time in-between the date of the Grant Approval Letter and the date of the Grant Close-out Letter.
Progress Report	Document providing information about the project or program's progress in achieving the goals and objectives of the Grant provided by the Grantee. The frequency of submission is set in the Grant Award Agreement.
Scope of Audit	Set of boundaries that define what the Grant Audit will cover. It's a critical step in the audit planning process that helps ensure the audit is efficient, effective, and focused.
Sponsoring Department	CalOptima Health department responsible for informing the design and development of the Grant Program and reviewing Progress Reports and the Final Report to ensure specific Grant Program objectives and outcomes are achieved. The Sponsoring Department will work with Grants Management on the operationalizing and monitoring of the Grant.

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Policy:	HH.4004
Title:	**Grant Audits/Reviews**
Department:	Office of Compliance
Section:	Internal Audit
CEO Approval:	*/s/*
Effective Date:	01/01/2025
Revised Date:	
Applicable to:	☒ Administrative ☐ Covered California [Effective 2027] ☐ Medi-Cal ☐ OneCare ☐ PACE

For 20251106 BOD Review Only

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The purpose of a Grant Audits and Reviews are to provide independent and objective assurance that Grant funds are managed in accordance with applicable laws, regulations, and award requirements through Internal Controls in place to ensure the efficient, effective, and compliant use of funds. These internal reviews and audits promote transparency, accountability, and responsible stewardship of public and grantor resources.

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2. Funds are used in accordance with the terms and conditions of the Grant Agreement.

3. Internal Controls support accurate and appropriate financial and performance reporting.

4. There is adequate oversight to prevent and detect fraud or waste.

5. Grant Objectives are being achieved in a manner consistent with Grantor expectations and CalOptima Health's policies, procedures, and a Grant Agreement.

6. Grant Management reporting is operating as an effective Internal Control.

7. Conducting special examinations and reviews upon the completion of Board approved Grants, or on an interim basis as needed.

8. Appropriate policies, procedures and industry best practices are present and being followed.

9. The use of Grant funding resources and recommending improvements in policy, procedures, and operations. In addition, the Internal Audit Department will be recommending the best practices and enhancements for Internal Controls that includes desktop procedures for Grant funds.

B. These internal audits are conducted in alignment with the Institute of Internal Auditors (IIA) Global Internal Audit Standards to provide independent assurance to the Board, management, grantors, and stakeholders responsible for Grant funding. These standards ensure that Grant internal audits are performed with integrity, objectivity, and professional competence. Internal Audit activities follow a risk-based approach and will include sufficient and appropriate procedures to support any conclusions or recommendations provided in Audit Reports.

C. Grants shall be established and administered in accordance with CalOptima Health Policy AA.1400: Grant Management.

D. Post-Award Grant Close-out occurs at the end of the Grant lifecycle at which point the awarding entity, CalOptima Health, determines that the Grantee has completed all applicable administrative actions. Grant Close-out Review is the final stage of the Grant Management process and is performed by the Sponsoring Department. Grant Close-out Review is achieved upon completion of:

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E. Internal Audit Opinion Policy for Grant Auditing

1. In accordance with the IIA's Global Internal Audit Standards, internal Audit Reports for Grant-related engagements may include the following opinions or assessments:

a. Formal Opinion: A formal opinion is issued when sufficient, appropriate evidence has been obtained. This opinion will assess the effectiveness of Internal Controls, compliance with Grant requirements, and level of residual risk. Typical opinion descriptors include:

i. Adequate;

ii. Needs Improvement;

iii. Unsatisfactory; and/or

iv. Low / Moderate / High-Risk.

b. Narrative Assessment: If the engagement scope is limited or data is insufficient, the report may present descriptive findings and risks without issuing a formal opinion.

c. No Opinion: If the audit cannot be completed due to scope limitations or lack of evidence, the report will clearly state that no opinion is provided and disclose the reasons for the limitation.

III. PROCEDURE

A. Upon completion of the Grant Close-out Review, a Grant Audit may be performed to validate the attainment of financial and Grant Objectives as documented in the Grant Award Agreement and Grant Close-out Review.

1. Grants with aggregate payments of $50,000 or more shall be audited. Grants under $50,000 with incomplete or non-existent Grant Close-out Review documentation may also be selected for

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audit.

2. The Sponsoring Department shall provide a copy of the final Grant Close-out Review to CalOptima Health's Internal Audit department within thirty (30) calendar days of receiving it.

3. The Sponsoring Department shall provide the following documentary evidence to the Internal Audit Department within sixty (60) calendar days of completing the final Grant Close-out Review.

   a. CalOptima Health Board Action Request (COBAR) authorizing Grant or Grant Program.

   b. Internal presentations of the Grant or Grant Program to CalOptima Health's leadership.

   c. Sponsoring Department's Notice of Funding Opportunity (NOFO) document.

   d. Grant Application, including evidence of approval by the Evaluation Committee.

   e. Grant Approval Letter from the Sponsoring Department to the Grantee.

   f. Signed Grant Award Agreement, including all Addendums, Amendments, and Extensions.

   g. Evidence of Grantee's California DOJ Registry Status indicating a "Current" status.

   h. Periodic Progress Reports and Final Report as outlined in the Grant Award Agreement, including evidence of review and approval.

   i. Grant Budget and financial reporting, including supportive evidence such as invoices, etc.

   j. Audited Financial Statements, including Single Audits, if any, for the relevant Grant Term. Financial Statements should include supporting schedules of donor-restricted Net Assets.

   k. IRS Form 990 tax filing throughout the relevant Grant Term.

   l. Copies of all Check Requests and payments from CalOptima Health's Finance Department to the Grantee, including evidence of deposit by the Grantee.

   m. Internal newsletters, photographic material, or management reporting evidencing Grantee's attainment of the Grant Objectives as outlined in the Grant Award Agreement.

   n. Evidence that unspent Grant funds were recouped.

   o. Grant Close-out Letter issued by the Sponsoring Department to Grantee.

   p. The Internal Audit Department may request additional evidence directly from the Grantee.

4. The Sponsoring Department shall coordinate the collection of all relevant records for the audit, review such records, and provide records to the Internal Audit Department in a timely manner.

5. The Internal Audit Department shall design each Scope of Audit using a risk-based approach to align with the IIA Global Internal Audit Standards to ensure that Grant Objectives were achieved as reported and funds were appropriately used for their intended purpose. The Scope of Audit shall include and assess the following activities:

   a. Audit checklist of required documents and approvals.

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b. Complete and accurate fulfillment of the Grant Management process.

c. The Grantee's obligations were completed according to the Grant Award Agreement.

d. Grant expenditures are appropriately tied to the Grant Budget, aligned with the Grant Objectives, and supported by appropriate and legitimate documentation.

e. Grant funds were wholly used for the Grant's intended purpose without any evidence of fraud, waste or abuse.

f. Unused Grant funds were wholly refunded to CalOptima Health.

g. Grant Close-out Review completed with a Final Report to CalOptima Health's leadership.

h. The Scope of Audit may be as broad or restricted as required to meet the organization's needs.

6. The Grant Audit shall begin within sixty (60) calendar days of receiving the Grant Close-Out Review and conclude within ninety (90) calendar days of beginning the audit.

7. Upon completion of the Grant Audit, the Internal Audit Department shall provide a report to CalOptima Health's Chief Operating Officer, Chief Compliance Officer, and the Grant's Sponsoring Department. The Audit Report shall include the following:

   a. Executive Summary;

   b. General Information;

   c. Participants;

   d. Definitions;

   e. Scope, Activities, and Methodology;

   f. Documents and Evidence Reviewed;

   g. Observations;

   h. Recommendations; and

   i. Conclusions: The Audit Report shall contain an opinion concerning the overall adequacy of controls, operational procedures, and outcomes.

8. The Internal Audit Department will coordinate with and inform management of the results of all audits, the submission of audit responses, and implementation of audit recommendations.

9. The Internal Auditor Department may report the status of completed audits to the Compliance Committee. The Internal Audit Department will also submit written updates directly to the Committee Chairperson as they are completed throughout the quarter.

10. Observations, Findings, or Conclusions could result in a request for a Corrective Action Plan. Corrective Action Plans shall be administered in accordance with CalOptima Health Policy HH.2005: Corrective Action Plan.

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11. The Chief Compliance Officer may choose to outsource any or all functions of the Grant Audit and appoint the Director of the Internal Audit Department to facilitate all communications and audit work with the engaged external auditor. Supplemental Grant Audits may be contracted to perform independent validation and audit procedures, which would primarily leverage/review the audit work performed by the Internal Audit Department.

12. Objectivity is essential to the Grant Audit process. Internal Audit Department personnel shall avoid actual and apparent conflicts of interest. Internal Audit Department personnel should not be involved in the development and installation of any Grant systems or procedures, preparation of records, or other activities that the Internal Audit staff may review or appraise that could be subject to a Grant Audit. Internal Audit personnel may be consulted on the design or adequacy of controls incorporated into new systems and procedures or on revisions to existing systems.

13. Grant Audits shall be performed with absolute independence and control over the audit work. Friendships, personal or business relations, reputations, outside influence, or other factors must not be allowed to alter the Scope of Audit or outcomes.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Policy AA.1400: Grant Management
B. CalOptima Health Policy HH.2005: Corrective Action Plan

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
02/06/2025	Regular Meeting of the CalOptima Health Board of Directors
	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2025	HH.4004	Grant Auditing	Administrative
Revised		HH.4004	Grant Audits/Reviews	Administrative

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IX. GLOSSARY

Term	Definition
Audit Report	Formal written opinion issued by an independent auditor as an assurance service in order to make decisions based on results and conclusions derived from the audit.
Check Request	A warrant device authorizing payment to a designated beneficiary on demand or after a specific date.
Corrective Action Plan	Step-by-step plan that outlines how to address issues and deficiencies in a program or process. The goal of a CAP is to resolve issues and improve operations and processes.
Evaluation Committee	A Committee of qualified staff and subject matter experts appointed by CalOptima Health's Grants Management department to review and assess Grant Applications and program proposals.
Final Report	Document providing information about the Grant project or program's final progress in achieving the goals and objectives of the Grant provided by the Grantee to CalOptima Health. The schedule of submission is set in the Grant Award Agreement.
Financial Statements	Written records that summarize a company's financial activities and position over a specific period of time. They are used to assess an organization's financial health and help with decision-making.
Grant	Financial award given by CalOptima Health to an eligible recipient to achieve a particular purpose or project. Grants are generally not expected to be repaid by the recipient when appropriately used for an approved Grant project.
Grant Application	An application submitted by a Grant applicant to CalOptima Health and used to formally request funding for a specific project.
Grant Approval Letter	Written document informing a Grantee that the Grant Application they submitted has been approved.
Grant Audit/ Review	An independent and comprehensive review of a Grant after close-out to ensure that Grant funds were used in accordance with the Grant Award Agreement's terms and conditions. A Grant Review is generally smaller in scope and seeks to provide a fast track validation of specific activities, achievements, and/or expenditures of the Grant.
Grant Award	The total dollar amount awarded to the Grantee by CalOptima Health through the Grant Management Policy and Procedure.
Grant Award Agreement	Funding agreement between CalOptima Health and the Grantee that sets the terms, conditions, and requirements of a Grant.
Grant Budget	Financial plan that outlines the estimated expenses and income for a project or program that is seeking funding. A Grant budget demonstrates how Grant funds will be used to achieve the project's goals and objectives.
Grant Close-out Letter	A written document that informs the Grantee that all requirements of the Grant have been fulfilled and that the Grant Term has concluded.
Grant Close-out Review	The process by which the awarding entity determines that all required work and administrative actions for a Grant have been completed. It's the final phase of a Grant's lifecycle and marks the end of the awarding entity's relationship with the Grantee.
Grant Management	CalOptima Health's Sponsoring Department's overall exercise of Grant administration throughout the phases of pre-award, award, post-award, and close-out.
Grant Objectives	Statements and milestones that describe the intended outcomes of a Grant-funded project or program.
Grant Program	Funding mechanism to award single or multiple Grants in service to common projects and ideas that support the community as stated in the Notice of Funding Opportunity.
Grant Term	The duration of time in which the Grantee is expected to achieve the Grant's goals and objectives as stated in the Grant Award Agreement.
Grantee	A recipient of a Grant funds.
Internal Controls	Internal Controls means a process, implemented by a Grant Awardee, designed to provide reasonable assurance regarding the achievement of objectives in the following

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	categories: (1) Effectiveness and efficiency of operations; (2) Reliability of reporting for internal and external use; and (3) Compliance with applicable laws and regulations.
Notice of Funding Opportunity (NOFO)	CalOptima Health's formally issued announcement of the availability of a Board-approved and authorized Grant opportunity through one of its Community Investment programs. The announcement provides eligibility, evaluation criteria, funding priorities, and submission information.
Post-Award	The period of time in-between the date of the Grant Approval Letter and the date of the Grant Close-out Letter.
Progress Report	Document providing information about the project or program's progress in achieving the goals and objectives of the Grant provided by the Grantee. The frequency of submission is set in the Grant Award Agreement.
Scope of Audit	Set of boundaries that define what the Grant Audit will cover. It's a critical step in the audit planning process that helps ensure the audit is efficient, effective, and focused.
Sponsoring Department	CalOptima Health department responsible for informing the design and development of the Grant Program and reviewing Progress Reports and the Final Report to ensure specific Grant Program objectives and outcomes are achieved. The Sponsoring Department will work with Grants Management on the operationalizing and monitoring of the Grant.

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Policy:	MA.9124
Title:	**Self-Disclosure of Non-Compliance Issues**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance
CEO Approval:	*/s/*
Effective Date:	08/01/2014
Revised Date:	10/01/2025
Applicable to:	☐ Administrative ☐ Covered California [Effective 2027] ☒ Medi-Cal ☒ OneCare ☒ PACE

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I. PURPOSE

This policy establishes a process for self-disclosing incidences of significant non-compliance to CalOptima Health's Office of Compliance, and in turn to, its regulatory entities. Regulatory entities include, but are not limited to, Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), and Department of Managed Health Care (DMHC).

II. POLICY

A. CalOptima Health follows the guidelines and regulations set forth by its regulatory entities regarding self-disclosures, where applicable.

B. The Office of Compliance oversees and implements an effective Compliance Program to prevent, detect, and correct non-compliance.

C. This policy encourages CalOptima Health Employees and First Tier, Downstream and Related Entities (FDRs) to voluntarily identify, disclose, and correct non-compliance incidents to meet program guidelines and regulations set forth by CalOptima Health's regulating entities.

1. For purposes of this policy, a CalOptima Health Employee shall refer to leadership staff such as Manager, Director, Executive Director, Chief, or other applicable leadership.

D. Self–reported non-compliance incidents reported to the Office of Compliance are investigated and Corrective Action Plans (CAPs) issued and responded to, as promptly as the severity level assigned to the non-compliance incident requires, and as described in CalOptima Health Policy HH.2005: Corrective Action Plan.

E. For the Medi-Cal Program, CalOptima Health reports any significant instances (i.e., in terms of gravity, scope and/or frequency) of noncompliance, imposition of corrective actions, or financial sanctions, as required under contract with DHCS, within three (3) working days of the discovery or imposition.

III. PROCEDURE

Back to Agenda Back to Item

A. Submitting a Self-Disclosure

1. The CalOptima Health Employee or FDR has five (5) calendar days (once an incident is identified) to Self-Disclose a non-compliance incident to the Office of Compliance. In severe non-compliance incidents impacting and threatening a Member's state of health, the non-compliance Self-Disclosure report must be completed as soon as it is identified.

2. The CalOptima Health Employee or FDR liaison must document the non-compliant incident and submit the Self-Disclosure to the Office of Compliance.

   a. While the initial Self-Disclosure may be completed via phone or in-person, the Office of Compliance may require additional information and/or form(s) to be submitted electronically.

   b. CalOptima Health Employees may submit their disclosure to an Office of Compliance team member, the Chief Compliance Officer, or complete the necessary disclosure form located on the Office of Compliance page of the CalOptima Health Intranet (InfoNet).

   c. FDRs may submit their disclosure by contacting their CalOptima Health liaison, or any of the reporting methods stated in CalOptima Health policy HH.2019: Reporting Suspected or Actual Fraud, Waste, or Abuse (FWA), Violations of Applicable Laws and Regulations, and/or CalOptima Health Policies and providing, at minimum, the information stated in Section B of this policy.

3. Depending on the severity of the incident being reported, the Office of Compliance shall review the submission and respond within five (5) business days to the submitting party either accepting, or rejecting, the disclosure.

4. The Office of Compliance will confirm whether the issue to be non-compliant and deemed significant for reporting to the regulators; for the Medi-Cal Program, as required under contract with DHCS, CalOptima will have 3 working days to report to DHCS.

B. Required Information Related to the Self-Disclosing Incident

1. To Self-Disclose a non-compliant incident to the Office of Compliance, the submitting party must provide the following information in the Self-Disclosure report:

   a. Contact information

      i. Submitter must provide contact name, phone number, email, and address (for FDR/external submitters), and area of non-compliance (For example: Enrollment, Pharmacy, Customer Service, Sales).

   b. Summary of Issue

      i. A brief description/summary of the identified non-compliant incident, including specific time frames during which the internal or external party might have been out of compliance. All applicable supporting documentation must be included.

      ii. A brief description of why the internal or external party believes they are out of compliance with the identified area.

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iii. If applicable, the dates, or range of dates, whereby the non-compliance was cured and if any claims or services were, or have been, impacted.

c. Details on how the issue was identified

i. Circumstances under which the non-compliance was discovered (For example: Grievance, complaint, Audits, or through a business data analysis), and actions taken, if any, to correct the non-compliance upon discovery of the incident.

ii. Date issue was discovered.

iii. Date of incident or first known occurrence. This may also include a range of dates, if applicable.

d. Root Cause Analysis

i. The root cause analysis must include the impact on risks to health, safety, or quality of care posed by the incident disclosed with sufficient information to allow the Office of Compliance to assess the severity of the non-compliance incident or risk.

e. As applicable, any remediating measures taken to address the issue of non-compliance (for example, this can include employee training, updated policies/procedures, increased oversight efforts; a description of member/provider impact, as applicable).

C. Office of Compliance Investigation & Corrective Action Plan (CAP)

1. Upon receipt of a Self-Disclosure submission, the Office of Compliance will begin its investigation into the disclosed information. The extent of the investigation will depend upon the severity of the incident and evidence, or documentation provided in the Self-Disclosure report.

2. If a CAP is required, the Office of Compliance will request the information necessary in accordance with CalOptima Health policy HH.2005: Corrective Action Plan.

3. If a financial sanction should result, CalOptima Health shall disclose such information in accordance with CalOptima Health policies HH.2005: Corrective Action Plan and HH.2002: Sanction.

D. Findings and Self-Disclosure to Regulatory Entities

1. Upon completion of the investigation, the Office of Compliance will communicate a recommendation on Self-Disclosure to regulatory entities to the Chief Compliance Officer (CCO) for review and sign off.

2. Following the CCO approval, CalOptima Health shall report the incident to the regulatory entity as follows:

a. Self-Disclosures significantly impacting CalOptima Health's Medi-Cal program shall be reported within three (3) working days of the discovery of confirmed non-compliance, in accordance with All-Plan Letter (APL) 23-006.

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b. Self-Disclosures impacting CalOptima Health's OneCare and PACE program shall be reported within a reasonable timeframe after its discovery and sufficient details have been obtained.

3. Once a disclosure is made, the Office of Compliance may report the Self-Disclosure to the impacted business areas, FDR liaison, or committee (i.e. Compliance Committee, Board of Directors), etc., as necessary.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Health Contract with DHCS for D-SNPs - State Medicaid Agency Contract (SMAC)
C. CalOptima Health PACE Program Agreement
D. CalOptima Health Contract with DHCS for PACE
E. CalOptima Health Contract with DHCS for Medi-Cal
F. All-Plan Letter 23-006: Delegation and Subcontractor Network Certification
G. CalOptima Health Compliance Plan
H. CalOptima Health Policy HH.2005: Corrective Action Plan
I. "CMS Consideration of Self-Disclosure by Plan Sponsors of Non-Compliance Conduct in the Determination of Compliance Actions," Health Plan Management System, Issued 02/27/2013.
J. Medicare Managed Care Manual, Chapter 21
K. Medicare Prescription Drug Benefit Manual, Chapter 9
L. Title 42, Code of Federal Regulations (C.F.R.), §§422.503(b)(4)(vi)(G)
M. Title 42, Code of Federal Regulations (C.F.R.), §§423.504(b)(4)(vi)(G)

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/06/2018	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
12/01/2022	Regular Meeting of the CalOptima Health Board of Directors
11/07/2024	Regular Meeting of the CalOptima Health Board of Directors
11/06/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	08/01/2014	MA.9124	CMS Self Disclosure	OneCare

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Action	Date	Policy	Policy Title	Program(s)
Revised	12/01/2014	MA.9124	CMS Self Disclosure	OneCare
Revised	09/01/2015	MA.9124	CMS Self Disclosure	OneCare OneCare Connect PACE
Revised	12/01/2016	MA.9124	CMS Self Disclosure	OneCare OneCare Connect PACE
Revised	12/07/2017	MA.9124	CMS Self-Disclosure	OneCare OneCare Connect PACE
Revised	12/06/2018	MA.9124	CMS Self-Disclosure	OneCare OneCare Connect PACE
Revised	12/05/2019	MA.9124	CMS Self-Disclosure	OneCare OneCare Connect PACE
Revised	12/03/2020	MA.9124	CMS Self-Disclosure	OneCare OneCare Connect PACE
Revised	12/20/2021	MA.9124	CMS Self-Disclosure	OneCare OneCare Connect PACE
Revised	12/31/2022	MA.9124	CMS Self-Disclosure	OneCare PACE
Revised	09/01/2023	MA.9124	CMS Self-Disclosure	OneCare PACE
Revised	11/07/2024	MA.9124	CMS Self-Disclosure	OneCare PACE
Revised	10/01/2025	MA.9124	Self-Disclosure of Non-Compliance Issues	Medi-Cal OneCare 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
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.
Compliance Program	A comprehensive program that incorporates the fundamental elements identified by the state and federal governments and CalOptima Health as necessary to prevent and detect violations of ethical standards, contractual obligations, and applicable laws and the involvement of CalOptima Health's governing body and executive staff. Elements of the Compliance Program include standards, oversight, training, reporting, monitoring, enforcement, and remediation. The Compliance Program applies to CalOptima Health's Board of Directors, employees, and contractors including delegated entities, providers, and suppliers.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal Audits or monitoring activities by CalOptima Health, the Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services, or designated representatives. FDRs and/or CalOptima Health departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima Health and its regulators.
Department of Health Care Services (DHCS)	OneCare: The single State Department responsible for administration of the Medi-Cal program, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs. PACE: The single State Department responsible for administration of the federal Medicaid (referred to as Medi-Cal in California) Program.
Designee	A person selected or designated to carry out a duty or role. The assigned Designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Grievance	OneCare: An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. A grievance does not include, and is distinct from, a dispute of the appeal of an organization determination or coverage determination or an LEP determination.

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Term	Definition
	PACE: A complaint, either written or oral, expressing dissatisfaction with service delivery or the quality of care furnished, as defined by the federal PACE regulation 42 CFR Section 460.120.
Member	A beneficiary enrolled in a CalOptima Health Program.
Provider	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) 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.
Self-Disclosure	The act of voluntarily disclosing a non-compliance incident.

1

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Policy:	MA.9124
Title:	**Self-Disclosure of Non-Compliance Issues**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance
CEO Approval:	*/s/*
Effective Date:	08/01/2014
Revised Date:	10/01/2025
Applicable to:	☐ Administrative ☐ Covered California [Effective 2027] ☒ Medi-Cal ☒ OneCare ☒ PACE

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I. PURPOSE

This policy establishes a process for self-disclosing incidences of significant non-compliance to CalOptima Health's Office of Compliance, and in turn to, its regulatory entities. Regulatory entities include, but are not limited to, Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), and Department of Managed Health Care (DMHC).

II. POLICY

A. CalOptima Health follows the guidelines and regulations set forth by its regulatory entities regarding self-disclosures, where applicable.

B. The Office of Compliance oversees and implements an effective Compliance Program to prevent, detect, and correct non-compliance.

C. This policy encourages CalOptima Health Employees and First Tier, Downstream and Related Entities (FDRs) to voluntarily identify, disclose, and correct non-compliance incidents to meet program guidelines and regulations set forth by CalOptima Health's regulating entities.

1. For purposes of this policy, a CalOptima Health Employee shall refer to leadership staff such as Manager, Director, Executive Director, Chief, or other applicable leadership.

D. Self–reported non-compliance incidents reported to the Office of Compliance are investigated and Corrective Action Plans (CAPs) issued and responded to, as promptly as the severity level assigned to the non-compliance incident requires, and as described in CalOptima Health Policy HH.2005: Corrective Action Plan.

E. For the Medi-Cal Program, CalOptima Health reports any significant instances (i.e., in terms of gravity, scope and/or frequency) of noncompliance, imposition of corrective actions, or financial sanctions, as required under contract with DHCS, within three (3) working days of the discovery or imposition.

III. PROCEDURE

Back to Agenda Back to Item

A. Submitting a Self-Disclosure

1. The CalOptima Health Employee or FDR has five (5) calendar days (once an incident is identified) to Self-Disclose a non-compliance incident to the Office of Compliance. In severe non-compliance incidents impacting and threatening a Member's state of health, the non-compliance Self-Disclosure report must be completed as soon as it is identified.

2. The CalOptima Health Employee or FDR liaison must document the non-compliant incident and submit the Self-Disclosure to the Office of Compliance.

   a. While the initial Self-Disclosure may be completed via phone or in-person, the Office of Compliance may require additional information and/or form(s) to be submitted electronically.

   b. CalOptima Health Employees may submit their disclosure to an Office of Compliance team member, the Chief Compliance Officer, or complete the necessary disclosure form located on the Office of Compliance page of the CalOptima Health Intranet (InfoNet).

   c. FDRs may submit their disclosure by contacting their CalOptima Health liaison, or any of the reporting methods stated in CalOptima Health policy HH.2019: Reporting Suspected or Actual Fraud, Waste, or Abuse (FWA), Violations of Applicable Laws and Regulations, and/or CalOptima Health Policies and providing, at minimum, the information stated in Section B of this policy.

3. Depending on the severity of the incident being reported, the Office of Compliance shall review the submission and respond within five (5) business days to the submitting party either accepting, or rejecting, the disclosure.

4. The Office of Compliance will confirm whether the issue to be non-compliant and deemed significant for reporting to the regulators; for the Medi-Cal Program, as required under contract with DHCS, CalOptima will have 3 working days to report to DHCS.

B. Required Information Related to the Self-Disclosing Incident

1. To Self-Disclose a non-compliant incident to the Office of Compliance, the submitting party must provide the following information in the Self-Disclosure report:

   a. Contact information

      i. Submitter must provide contact name, phone number, email, and address (for FDR/external submitters), and area of non-compliance (For example: Enrollment, Pharmacy, Customer Service, Sales).

   b. Summary of Issue

      i. A brief description/summary of the identified non-compliant incident, including specific time frames during which the internal or external party might have been out of compliance. All applicable supporting documentation must be included.

      ii. A brief description of why the internal or external party believes they are out of compliance with the identified area.

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iii. If applicable, the dates, or range of dates, whereby the non-compliance was cured and if any claims or services were, or have been, impacted.

c. Details on how the issue was identified

i. Circumstances under which the non-compliance was discovered (For example: Grievance, complaint, Audits, or through a business data analysis), and actions taken, if any, to correct the non-compliance upon discovery of the incident.

ii. Date issue was discovered.

iii. Date of incident or first known occurrence. This may also include a range of dates, if applicable.

d. Root Cause Analysis

i. The root cause analysis must include the impact on risks to health, safety, or quality of care posed by the incident disclosed with sufficient information to allow the Office of Compliance to assess the severity of the non-compliance incident or risk.

e. As applicable, any remediating measures taken to address the issue of non-compliance (for example, this can include employee training, updated policies/procedures, increased oversight efforts; a description of member/provider impact, as applicable).

C. Office of Compliance Investigation & Corrective Action Plan (CAP)

1. Upon receipt of a Self-Disclosure submission, the Office of Compliance will begin its investigation into the disclosed information. The extent of the investigation will depend upon the severity of the incident and evidence, or documentation provided in the Self-Disclosure report.

2. If a CAP is required, the Office of Compliance will request the information necessary in accordance with CalOptima Health policy HH.2005: Corrective Action Plan.

3. If a financial sanction should result, CalOptima Health shall disclose such information in accordance with CalOptima Health policies HH.2005: Corrective Action Plan and HH.2002: Sanction.

D. Findings and Self-Disclosure to Regulatory Entities

1. Upon completion of the investigation, the Office of Compliance will communicate a recommendation on Self-Disclosure to regulatory entities to the Chief Compliance Officer (CCO) for review and sign off.

2. Following the CCO approval, CalOptima Health shall report the incident to the regulatory entity as follows:

a. Self-Disclosures significantly impacting CalOptima Health's Medi-Cal program shall be reported within three (3) working days of the discovery of confirmed non-compliance, in accordance with All-Plan Letter (APL) 23-006.

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b. Self-Disclosures impacting CalOptima Health's OneCare and PACE program shall be reported within a reasonable timeframe after its discovery and sufficient details have been obtained.

3. Once a disclosure is made, the Office of Compliance may report the Self-Disclosure to the impacted business areas, FDR liaison, or committee (i.e. Compliance Committee, Board of Directors), etc., as necessary.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Health Contract with DHCS for D-SNPs - State Medicaid Agency Contract (SMAC)
C. CalOptima Health PACE Program Agreement
D. CalOptima Health Contract with DHCS for PACE
E. CalOptima Health Contract with DHCS for Medi-Cal
F. All-Plan Letter 23-006: Delegation and Subcontractor Network Certification
G. CalOptima Health Compliance Plan
H. CalOptima Health Policy HH.2005: Corrective Action Plan
I. "CMS Consideration of Self-Disclosure by Plan Sponsors of Non-Compliance Conduct in the Determination of Compliance Actions," Health Plan Management System, Issued 02/27/2013.
J. Medicare Managed Care Manual, Chapter 21
K. Medicare Prescription Drug Benefit Manual, Chapter 9
L. Title 42, Code of Federal Regulations (C.F.R.), §§422.503(b)(4)(vi)(G)
M. Title 42, Code of Federal Regulations (C.F.R.), §§423.504(b)(4)(vi)(G)

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/06/2018	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
12/01/2022	Regular Meeting of the CalOptima Health Board of Directors
11/07/2024	Regular Meeting of the CalOptima Health Board of Directors
11/06/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	08/01/2014	MA.9124	CMS Self Disclosure	OneCare

For 20251106 BOD Review Only

Action	Date	Policy	Policy Title	Program(s)
Revised	12/01/2014	MA.9124	CMS Self Disclosure	OneCare
Revised	09/01/2015	MA.9124	CMS Self Disclosure	OneCare OneCare Connect PACE
Revised	12/01/2016	MA.9124	CMS Self Disclosure	OneCare OneCare Connect PACE
Revised	12/07/2017	MA.9124	CMS Self-Disclosure	OneCare OneCare Connect PACE
Revised	12/06/2018	MA.9124	CMS Self-Disclosure	OneCare OneCare Connect PACE
Revised	12/05/2019	MA.9124	CMS Self-Disclosure	OneCare OneCare Connect PACE
Revised	12/03/2020	MA.9124	CMS Self-Disclosure	OneCare OneCare Connect PACE
Revised	12/20/2021	MA.9124	CMS Self-Disclosure	OneCare OneCare Connect PACE
Revised	12/31/2022	MA.9124	CMS Self-Disclosure	OneCare PACE
Revised	09/01/2023	MA.9124	CMS Self-Disclosure	OneCare PACE
Revised	11/07/2024	MA.9124	CMS Self-Disclosure	OneCare PACE
Revised	10/01/2025	MA.9124	Self-Disclosure of Non-Compliance Issues	Medi-Cal OneCare 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
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.
Compliance Program	A comprehensive program that incorporates the fundamental elements identified by the state and federal governments and CalOptima Health as necessary to prevent and detect violations of ethical standards, contractual obligations, and applicable laws and the involvement of CalOptima Health's governing body and executive staff. Elements of the Compliance Program include standards, oversight, training, reporting, monitoring, enforcement, and remediation. The Compliance Program applies to CalOptima Health's Board of Directors, employees, and contractors including delegated entities, providers, and suppliers.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal Audits or monitoring activities by CalOptima Health, the Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services, or designated representatives. FDRs and/or CalOptima Health departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima Health and its regulators.
Department of Health Care Services (DHCS)	OneCare: The single State Department responsible for administration of the Medi-Cal program, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs. PACE: The single State Department responsible for administration of the federal Medicaid (referred to as Medi-Cal in California) Program.
Designee	A person selected or designated to carry out a duty or role. The assigned Designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Grievance	OneCare: An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. A grievance does not include, and is distinct from, a dispute of the appeal of an organization determination or coverage determination or an LEP determination.

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Term	Definition
	PACE: A complaint, either written or oral, expressing dissatisfaction with service delivery or the quality of care furnished, as defined by the federal PACE regulation 42 CFR Section 460.120.
Member	A beneficiary enrolled in a CalOptima Health Program.
Provider	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) 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.
Self-Disclosure	The act of voluntarily disclosing a non-compliance incident.

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For 20251106 BOD Review Only

CalOptima Health Board Action Agenda Referral

Action To Be Taken November 6, 2025
Regular Meeting of the CalOptima Health Board of Directors

Report Item

15. Authorize Amendments to the CalOptima Health Behavioral Health Professional Services Contracts for the Medi-Cal Program

Contacts

Yunkyung Kim, Chief Operating Officer, (714) 923-8834
Michael Gomez, Executive Director, Network Operations, (714) 347-3292

Recommended Actions

1. Authorize the Chief Executive Officer, or designee, to negotiate and execute amendments to the CalOptima Health behavioral health Professional Services Contracts for therapeutic repetitive transcranial magnetic stimulation services for the Medi-Cal program, effective on or after December 1, 2025.
2. Authorize reimbursement for covered therapeutic repetitive transcranial magnetic stimulation services at the lesser of billed charges or 100% of local Medicare fee schedule rates for dates of service on and after July 1, 2024.

Background

On April 9, 2025, DHCS notified CalOptima Health regarding an update to the therapeutic repetitive transcranial magnetic stimulation (TMS) benefit. DHCS updated its Medi-Cal non-specialty mental health (NSMH) benefit policy to allow coverage of medically necessary TMS services when rendered by qualified and specially trained NSMH providers. TMS is a noninvasive procedure that uses magnetic fields to stimulate nerve cells in the brain, primarily to treat mental and behavioral health conditions. This coverage was retroactively effective as of July 1, 2024.

Per DHCS directive, under the Medi-Cal NSMH coverage policy, MCPs, like CalOptima, must offer the same broad-based benefit package as Medi-Cal fee-for-service (FFS) and are obligated under federal law and DHCS contract requirements to perform utilization management to ensure medical necessity. Therefore, CalOptima Health must ensure the TMS benefit is available for Medi-Cal members and qualified NSMH providers are reimbursed for the service.

Discussion

For the Medi-Cal program, CalOptima Health contracts with behavioral health professionals on a FFS basis to render NSMH services that are not carved out to the county behavioral health delivery system or Drug Medi-Cal program. CalOptima Health extends contracts to providers who successfully meet all CalOptima Health's credentialing and participation requirements.

CalOptima Health reimburses medically necessary covered behavioral health services according to CalOptima Health's Medi-Cal Mental Health Fee Schedule, as outlined in the Professional Services Contract for behavioral health providers. Currently, the CalOptima Health Medi-Cal Mental Health Fee Schedule does not include rates for the TMS benefit. To ensure timely access to TMS services for CalOptima Health Medi-Cal members, staff seek to establish equitable rates, not to exceed local Medicare fee schedule rates, and amend contracts to address the benefit.

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Therefore, staff requests authority to negotiate and amend the Professional Services Contracts for behavioral health, as applicable, at established rates for the TMS benefit and reimburse for covered services rendered on or after July 1, 2024, accordingly.

Fiscal Impact

The recommended action to authorize reimbursement for the TMS benefit for dates of service beginning on and after July 1, 2024, has an estimated fiscal impact of approximately $21,000 for Fiscal Year (FY) 2024-25 based on actual utilization, and an approximate $23,000 for FY 2025-26 based on forecasted utilization. There is no net fiscal impact as the forecasted expense trend included in the FY 2025-26 Operating Budget will be sufficient to cover the anticipated costs. Staff will monitor the actual cost and utilization of the new benefit as it is implemented.

Rationale for Recommendation

The requested action will support continued access for Medi-Cal members to a network of providers that enables members to receive necessary TMS services as required by DHCS.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Entities Covered by this Recommended Board Action
2. Behavioral Health Professional Services Contract Amendment

Board Actions

Board Meeting Dates	Action
May 2, 2024	1.Direct the Chief Executive Officer, or designees, to make a commitment of up to $526 million from undesignated reserves to support provider rates to ensure longer-term provider network stability, network adequacy, and access to care for CalOptima Health members throughout Orange County; and 2.As part of this initiative, authorize the Chief Executive Officer, or designees, to develop and implement rate increases to contracted fee for service behavioral health, applied behavior analysis, ancillary and other providers, to be implemented July 1, 2024, through December 31,2026; and 3.Sunset the temporary, short-term supplemental Medi-Cal payment increases of up to 7.5% for contracted fee for service behavioral health, applied behavior analysis, ancillary and other providers to support expenses for services provided to members during the transition out of the Public Health Emergency, effective for dates of service on and after July 1, 2024.
October 6, 2022	Authorize amendments to the Medi-Cal fee-for-service mental health provider contracts to reflect increases to reimbursement rates effective January 1, 2023.

/s/ Michael Hunn *10/30/2025*
Authorized Signature **Date**

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Attachment to the November 6, 2025, Board of Directors Meeting – Agenda Item 15

CONTRACTED/ IMPACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
3 Prong *dba* Wellity Health	39159 Paseo Padre Pkwy, Suite 121	Fremont	CA	94538
Addis Medical Group, A Medical Corporation	10802 College Place	Cerritos	CA	90703
Advantage Neuropsychiatric Assoc	1010 W Chapman Ave.	Orange	CA	92868
Afsaneh K Alisobhani, PsyD, a Marriage and Family Therapy Professional Corporation dba South Coast Psychotherapy, P.C.	1101 Dove St., Suite 165	Newport Beach	CA	92660
AIDS Services Foundation Orange County dba Radiant Health Centers	17982 Sky Park Circle, Suite J	Irvine	CA	92614
Alfonsos Bustamante Psy. D.	17291 Irvine Blvd., Suite 430	Tustin	CA	92780
Aliuddin Khaja, MD Inc. *dba* Choice Psychiatric Medical Group	770 Magnolia Ave., Suite 2F	Corona	CA	92879
Alliance Psychiatric Group Inc., A Medical Corporation	2082 Business Center Dr., Suite 255	Irvine	CA	92612
ALLIED PSYCHIATRY AND MENTAL HEALTH	1401 Dove St., Suite 410	Newport Beach	CA	92660
Allied Psychological Services PC	4740 Von Karman Ave., Suite 120	Newport Beach	CA	92660
Altamed Health Services Corporation	2720 S Bristol St., Suite 110	Santa Ana	CA	92840
Amirnaz Novid *dba* Sharing Light Counseling	4000 Barranca Parkway, Suite 250	Irvine	CA	92604
Andrea Carasquero *dba* Carasquero Nursing, Inc	11 Mareblu, Suite 220F	Aliso Viejo	CA	92656
Andrew N. Schwartz, Ph.D.	23120 Alicia Parkway, Suite 241	Mission Viejo	CA	92692
Anita C. Grutbo *dba* Starfish Center for Counseling	265 S Randolph, Suite 290	Brea	CA	92821
Anita Torund Vermund *dba* Anita Vermund Ph.D.	19742 MacArthur Blvd., Suite 235	Irvine	CA	92612
Antoinette M. Eimers	228 W Main St.	Tustin	CA	92780
AR Suzuki, MD a Professional Corporation	1 Jenner, Suite 210	Irvine	CA	92618

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Name	Address	City	State	Zip Code
Arash A. Shahangian	105 Thornhurst	Irvine	CA	92620
Arlene K. Unger Ph.D.	34145 Pacific Coast Hwy, Suite 821	Dana Point	CA	92629
Arthur E. Holden, Jr.	20101 Southwest Birch St., Suite 240	Newport Beach	CA	92660
Arthur Montes Licensed Clinical Social Worker, Inc.	5000 Birch St West Tower Suite 3000	Newport Beach	CA	92660
Arthur Montes Licensed Clinical Social Worker, Inc.	5000 Birch St., West Tower, Suite 3000	Newport Beach	CA	92660
Ashely Paculba LMFT Prof Corp dba Resilient Overcomer Counseling Services	35070 Orchard Crest Ct.	Winchester	CA	92596
Ashvind N. Adkins Singh *dba* AHWI Psychology Group, PC	4712 E 2nd St., Suite 234	Long Beach	CA	90803
Atlas Psychological Family Counseling & Wellness Svcs	1513 E Chapman Ave.	Fullerton	CA	92831
Attentive Cognitive and Mental Health Services Psychology Inc	111 Deerwood Rd., Suite 200	San Ramon	CA	94583
Bahar K. Delaram, MFT	1682 Langley Ave.	Irvine	CA	92614
Barbara J. Colitz	3614 W Cobalt Ct.	Sun Tan Valley	AZ	85144
Barbara J. Wayne	3111 N Tustin St.	Orange	CA	92865
Behavior Builders	5500 Bolsa Ave., Suite 135	Huntington Beach	CA	92649
Bernous Psychological Services, Inc.	17762 Cowan, Suite 100	Irvine	CA	92614
Betty Duong Inc.	17011 Beach Blvd., Suite 837	Huntington Beach	CA	92647
BJE Esterman PC dba Orange Coast Psychiatry	1720 W Ball Rd., Suite 4C	Anaheim	CA	92804
Blue Horizon Marriage and Family Inc. *dba* Blue Horizon Counseling	2922 E Chapman, Suite 202 E	Orange	CA	92869
Brian Dean Thompson, LMFT	28202 Cabot Rd., Suite 331	Laguna Niguel	CA	92677
Brian Lam	16052 Beach Blvd., Suite 214	Huntington Beach	CA	92647
Brian W. Lynn *dba* Brian W. Lynn, Ph.D.	8695 El Cerro Circle	Fountain Valley	CA	92708
Camino Health Center	22481 Aspan St., Suite A	Lake Forest	CA	92675

AMENDMENT «TMS_Amendment» TO
PROFESSIONAL SERVICES CONTRACT

This Amendment «TMS_Amendment» to the Professional Services Contract ("**Amendment**") shall become effective on the first day of the first month following execution of this Amendment by both parties, ("**Amendment Effective Date**"), by and between Orange County Health Authority, a public agency, dba CalOptima Health ("**CalOptima**"), and «Provider_Name» ("**Professional**"). CalOptima and Professional may each be referred to herein as a "**Party**" and collectively as the "**Parties**".

RECITALS

A. CalOptima and Professional have entered into a Professional Services Contract, originally effective «Actual_Effective_Date», ("**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 the Contract on the terms and conditions set forth herein.

AGREEMENT

NOW, THEREFORE, the Parties agree as follows:

1. Delete Attachment B, *Compensation*, of the Contract in its entirety and replace it with the new Attachment B, *Compensation*, attached to this Amendment and incorporated into the Contract by this reference.
2. This Amendment may be executed in multiple counterparts and counterpart signature pages may be assembled to form a single, fully executed document. Capitalized terms not otherwise defined in this Amendment shall have the same meanings ascribed to them in the Contract.
3. If there is any conflict or inconsistency between this Amendment and the Contract, the provisions of this Amendment shall control and govern. Except as otherwise amended by this Amendment, all of the terms and conditions of the Contract will remain in full force and effect. After the Amendment Effective Date, any reference to the Contract shall mean the Contract as amended and supplemented by this Amendment. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

Draft pending Board approval

IN WITNESS WHEREOF, the Parties have executed this Amendment.

FOR PROFESSIONAL:	FOR CALOPTIMA:
Signature	Signature
Print Name	Print Name
Title	Title
Date	Date

Draft pending Board approval

ATTACHMENT B

COMPENSATION

Upon submission of a Clean Claim, CalOptima shall pay Professional pursuant to this Contract, CalOptima Policies, Government Contracts, and applicable laws, and Professional shall accept as payment in full from CalOptima for services provided under this Contract the amounts set forth in this Attachment B.

1. Medi-Cal Program.

1.1. For Covered Services provided to referred Medi-Cal Members, CalOptima shall reimburse Professional, and Professional shall accept as payment in full from CalOptima, the lesser of:

1.1.1. Billed charges or;

1.1.2. The rates outlined in Table 1: Medi-Cal Mental Health Fee Schedule ("**Table 1**") below.

Table 1: Medi-Cal Mental Health Fee Schedule

		Physician (MD/DO)	Licensed Clinical Psychologist (PsyD or PhD)	Master's Level (Licensed Clinical Social Worker (LCSW), Licensed Mariage and Family Therapist (LMFT), Licensed Professional Clinical Counselor (LPCC)	Nurse Practitioner (NP), Clinical Nurse Specialist (CNS), or Physician Assistant (PA)	Licensed Psychological Associate (LPA), Associate Clinical Social Worker (ASW), Associate Marriage and Family Therapist (AMFT), Associate Professional Clinical Counselor (APCC)
CPT	**Procedure Description**	**AF Modifier**	**AH Modifier**	**AJ or HO Modifier**	**AS Modifier**	**HL Modifier**
90785	PSYCHOTHERAPY COMPLEX INTERACTIVE	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
90791	PSYCHIATRIC DIAGNOSTIC EVALUATION	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
90792	PSYCHIATRIC DIAGNOSTIC EVAL W/MEDICAL SERVICES	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
90832	PSYCHOTHERAPY W/PATIENT 30 MINUTES	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
90833	PSYCHOTHERAPY W/PATIENT W/E&M SRVCS 30 MIN	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Draft pending Board approval

		Physician (MD/DO)	Licensed Clinical Psychologist (PsyD or PhD)	Master's Level (Licensed Clinical Social Worker (LCSW), Licensed Mariage and Family Therapist (LMFT), Licensed Professional Clinical Counselor (LPCC)	Nurse Practitioner (NP), Clinical Nurse Specialist (CNS), or Physician Assistant (PA)	Licensed Psychological Associate (LPA), Associate Clinical Social Worker (ASW), Associate Marriage and Family Therapist (AMFT), Associate Professional Clinical Counselor (APCC)
CPT	**Procedure Description**	**AF Modifier**	**AH Modifier**	**AJ or HO Modifier**	**AS Modifier**	**HL Modifier**
90834	PSYCHOTHERAPY W/PATIENT 45 MINUTES	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
90837	PSYCHOTHERAPY W/PATIENT 60 MINUTES	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
90839	PSYCHOTHERAPY FOR CRISIS INITIAL 60 MINUTES	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
90840	PSYCHOTHERAPY FOR CRISIS EACH ADDL 30 MINUTES	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
90846	FAMILY PSYCHOTHERAPY W/O PATIENT PRESENT 50 MINS	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
90847	FAMILY PSYCHOTHERAPY W/PATIENT PRESENT 50 MINS	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
90849	MULTIPLE FAMILY GROUP PSYCHOTHERAPY	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
90853	GROUP PSYCHOTHERAPY	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
90880	HYPNOTHERAPY	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
96110	DEVELOPMENTAL SCREEN W/SCORING & DOC STD INSTRM	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
96112	DEVELOPMENTAL TST ADMIN PHYS/QHP 1ST HOUR	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
96113	DEVELOPMENTAL TST ADMIN PHYS/QHP EA ADDL 30 MIN	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
96116	NEUROBEHAVIORAL STATUS XM PHYS/QHP 1ST HOUR	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Draft pending Board approval

		Physician (MD/DO)	Licensed Clinical Psychologist (PsyD or PhD)	Master's Level (Licensed Clinical Social Worker (LCSW), Licensed Mariage and Family Therapist (LMFT), Licensed Professional Clinical Counselor (LPCC)	Nurse Practitioner (NP), Clinical Nurse Specialist (CNS), or Physician Assistant (PA)	Licensed Psychological Associate (LPA), Associate Clinical Social Worker (ASW), Associate Marriage and Family Therapist (AMFT), Associate Professional Clinical Counselor (APCC)
CPT	**Procedure Description**	**AF Modifier**	**AH Modifier**	**AJ or HO Modifier**	**AS Modifier**	**HL Modifier**
96121	NEUROBEHAVIORAL STATUS XM PHYS/QHP EA ADDL HOUR	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
96127	BEHAV ASSMT W/SCORE & DOCD/STAND INSTRUMENT	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
96130	PSYCHOLOGICAL TST EVAL SVC PHYS/QHP FIRST HOUR	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
96131	PSYCHOLOGICAL TST EVAL SVC PHYS/QHP EA ADDL HOUR	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
96132	NEUROPSYCHOLOGICAL TST EVAL PHYS/QHP 1ST HOUR	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
96133	NEUROPSYCHOLOGICAL TST EVAL PHYS/QHP EA ADDL HR	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
96136	PSYL/NRPSYCL TST PHYS/QHP 2+ TST 1ST 30 MIN	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
96137	PSYCL/NRPSYCL TST PHYS/QHP 2+ TST EA ADDL 30 MIN	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
96138	PSYCL/NRPSYCL TST TECH 2+ TST 1ST 30 MIN	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
96139	PSYCL/NRPSYCL TST TECH 2+ TST EA ADDL 30 MIN	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
96146	PSYCL/NRPSYCL TST ELEC PLATFORM AUTO RESULT	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Draft pending Board approval

		Physician (MD/DO)	Licensed Clinical Psychologist (PsyD or PhD)	Master's Level (Licensed Clinical Social Worker (LCSW), Licensed Mariage and Family Therapist (LMFT), Licensed Professional Clinical Counselor (LPCC)	Nurse Practitioner (NP), Clinical Nurse Specialist (CNS), or Physician Assistant (PA)	Licensed Psychological Associate (LPA), Associate Clinical Social Worker (ASW), Associate Marriage and Family Therapist (AMFT), Associate Professional Clinical Counselor (APCC)
CPT	**Procedure Description**	**AF Modifier**	**AH Modifier**	**AJ or HO Modifier**	**AS Modifier**	**HL Modifier**
96156	HEALTH BEHAVIOR ASSESSMENT/RE-ASSESSMENT	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
99203	OFFICE/OUTPATIENT NEW LOW MDM 30-44 MINUTES	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
99204	OFFICE/OUTPATIENT NEW MODERATE MDM 45-59 MINUTES	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
99205	OFFICE/OUTPATIENT NEW HIGH MDM 60-74 MINUTES	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
99211	OFFICE/OUTPATIENT EST PT MAY NOT REQ PHYS/QHP	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
99212	OFFICE/OUTPATIENT ESTABLISHED SF MDM 10-19 MIN	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
99213	OFFICE/OUTPATIENT ESTABLISHED LOW MDM 20-29 MIN	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
99214	OFFICE/OUTPATIENT ESTABLISHED MOD MDM 30-39 MIN	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
99215	OFFICE/OUTPATIENT ESTABLISHED HIGH MDM 40-54 MIN	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
99241	OFFICE CONSULTATION NEW/ESTAB PATIENT 15 MIN	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
99242	OFFICE CONSULTATION NEW/ESTAB PATIENT 30 MIN	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Draft pending Board approval

		Physician (MD/DO)	Licensed Clinical Psychologist (PsyD or PhD)	Master's Level (Licensed Clinical Social Worker (LCSW), Licensed Mariage and Family Therapist (LMFT), Licensed Professional Clinical Counselor (LPCC)	Nurse Practitioner (NP), Clinical Nurse Specialist (CNS), or Physician Assistant (PA)	Licensed Psychological Associate (LPA), Associate Clinical Social Worker (ASW), Associate Marriage and Family Therapist (AMFT), Associate Professional Clinical Counselor (APCC)
CPT	**Procedure Description**	**AF Modifier**	**AH Modifier**	**AJ or HO Modifier**	**AS Modifier**	**HL Modifier**
99243	OFFICE CONSULTATION NEW/ESTAB PATIENT 40 MIN	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
99244	OFFICE CONSULTATION NEW/ESTAB PATIENT 60 MIN	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
99251	INITIAL INPATIENT CONSULT NEW/ESTAB PATIENT 20 MIN	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
99252	INITIAL INPATIENT CONSULT NEW/ESTAB PATIENT 40 MIN	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
99253	INITIAL INPATIENT CONSULT NEW/ESTAB PATIENT 55 MIN	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
99254	INITIAL INPATIENT CONSULT NEW/ESTAB PATIENT 80 MIN	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
99255	INITIAL INPATIENT CONSULT NEW/ESTAB PATIENT 110 MIN	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
99304	INITIAL NURSING FACILITY CARE/DAY 25 MINUTES	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
99305	INITIAL NURSING FACILITY CARE/DAY 35 MINUTES	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
99306	INITIAL NURSING FACILITY CARE/DAY 45 MINUTES	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Draft pending Board approval

		Physician (MD/DO)	Licensed Clinical Psychologist (PsyD or PhD)	Master's Level (Licensed Clinical Social Worker (LCSW), Licensed Mariage and Family Therapist (LMFT), Licensed Professional Clinical Counselor (LPCC)	Nurse Practitioner (NP), Clinical Nurse Specialist (CNS), or Physician Assistant (PA)	Licensed Psychological Associate (LPA), Associate Clinical Social Worker (ASW), Associate Marriage and Family Therapist (AMFT), Associate Professional Clinical Counselor (APCC)
CPT	**Procedure Description**	**AF Modifier**	**AH Modifier**	**AJ or HO Modifier**	**AS Modifier**	**HL Modifier**
99308	SBSQ NURSING FACIL CARE/DAY MINOR COMPLJ 15 MIN	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
99309	SBSQ NURSING FACIL CARE/DAY NEW PROBLEM 25 MIN	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
99327	DOMICIL/REST HOME NEW PT VISIT HI SEVER 60 MIN	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
99348	HOME VISIT EST PT LOW-MOD SEVERITY 25 MINUTES	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
99349	HOME VISIT EST PT MOD-HI SEVERITY 40 MINUTES	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
99367	TEAM CONFERENCE NON-FACE-TO-FACE PHYSICIAN	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
99368	TEAM CONFERENCE NON-FACE-TO-FACE NONPHYSICIAN	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
99406	TOBACCO USE CESSATION INTERMEDIATE 3-10 MINUTES	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
99407	TOBACCO USE CESSATION INTENSIVE >10 MINUTES	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
G0442	ANNUAL ALCOHOL MISUSE SCREENING 15 MINUTES	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
G9919	SCREENING PERF & POS & PROVISION RECOMMENDATIONS	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Draft pending Board approval

CPT	Procedure Description	Physician (MD/DO)	Licensed Clinical Psychologist (PsyD or PhD)	Master's Level (Licensed Clinical Social Worker (LCSW), Licensed Mariage and Family Therapist (LMFT), Licensed Professional Clinical Counselor (LPCC)	Nurse Practitioner (NP), Clinical Nurse Specialist (CNS), or Physician Assistant (PA)	Licensed Psychological Associate (LPA), Associate Clinical Social Worker (ASW), Associate Marriage and Family Therapist (AMFT), Associate Professional Clinical Counselor (APCC)
		AF Modifier	AH Modifier	AJ or HO Modifier	AS Modifier	HL Modifier
G9920	SCREENING PERFORMED AND NEGATIVE	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

1.2. Codes Not on CalOptima Medi-Cal Mental Health Fee Schedule. Any CPT or HCPCS code not contained in Table 1 at the time of service shall default at [redacted] percent ([redacted]%) of the current CalOptima Medi-Cal Fee Schedule, as defined in CalOptima Policies for those services. Medi-Cal billing rules and payment and authorization policies and guidelines for billing and payment will apply.

1.2.1. Claims not submitted with the appropriate modifier are not reimbursable and will be denied.

1.3. Claims Requirements.

1.3.1. Discipline levels will vary from state to state. "**N/B**" indicates a non-billable service for the discipline level.

1.3.2. Reimbursement is based on the treating provider's licensure, certification, and CalOptima credentialing requirements for that discipline, and is not based on provider's academic credentials alone.

1.3.3. Rates include reimbursement for travel time and expense.

1.3.4. Rates for all services are subject to the provisions and limitations of the Member's benefit plan including authorization requirements. Nothing in this schedule should be construed as altering Member's benefits.

1.3.5. The coding definitions (*e.g.*, DRGs, ICD codes, procedures, CPT codes) assigned in this Contract shall be considered automatically updated based on revised codes and newly introduced codes consistent with guidance provided from the organization(s) responsible for code set updates (*e.g.*, DHS, AMA, WHO, etc.), as applicable, and consistent with industry standards. If codes are changed by addition or deletion as stated in the current year's coding publications, the Parties agree that services will automatically convert to the new code(s) that best apply to the service.

Draft pending Board approval

1.4. Targeted Rate Increase Services. If applicable, for services subject to the TRI provided by a qualified professional, Professional will be reimbursed at the greater of the contracted rates, outlined above plus any applicable supplemental payments, or the Medi-Cal TRI fee schedule rate in effect for the date of service; provided, however, in no event will Professional be reimbursed at less than the Medi-Cal TRI fee schedule in effect for the date of service. Reimbursement for TRI services shall comply with DHCS Program requirements, applicable laws, and CalOptima Policies. This provision is retroactive to TRI services provided beginning January 1, 2024, or as otherwise specified by DHCS.

1.5. Transcranial Magnetic Stimulation (TMS) Services. For any TMS Covered Services provided by Professional under this Agreement and within the scope of Professional's licensure, CalOptima will reimburse Professional for those TMS services at the rate of the lesser of either Professional's billed charges or [redacted] percent ([redacted]%) of the Participating Allowable Medicare fee schedule for Locality 18 in effect on the date Professional provided the TMS service. The parties hereto shall ensure billing and reimbursement for TMS services under this Contract complies with Medicare requirements, including billing rules and guidelines, applicable laws, and CalOptima Policies. This provision is retroactive to covered TMS services provided by Professional, with dates of service July 01, 2024, or as otherwise specified by DHCS.

2. OneCare Program.

2.1. For Covered Services provided to OneCare Members, CalOptima shall reimburse Professional the lesser of:

2.1.1. Billed charges or;

2.1.2. The rates outlined in Table 2: OneCare Mental Health Fee Schedule ("**Table 2**") as outlined below.

Table 2: OneCare Mental Health Fee Schedule

Physician (MD/DO)	Licensed Clinical Psychologist (PsyD or PhD)	Nurse Practitioner (NP), Physician Assistant (PA)	Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT), Licensed Professional Clinical Counselor (LPCC)
[redacted]% of the current year CalOptima Medicare Allowable Participating Fee Schedule for locality 26.	[redacted]% of the current year CalOptima Medicare Allowable Participating Fee Schedule for locality 26.	[redacted]% of the current year CalOptima Medicare Allowable Participating Fee Schedule for locality 26.	[redacted]% of the current year CalOptima Medicare Allowable Participating Fee Schedule for locality 26.

2.2. Claims Requirements. Prior authorization rules apply for payment of services. Medicare billing rules and payment policies and guidelines for billing and payment will apply.

2.3. 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:

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2.3.1. "**By Report & Unlisted**" codes that CalOptima has provided authorization for Professional to provide such service will be paid at forty percent (40%) of billed charges and must follow applicable Medicare billing rules and guidelines. When billing CalOptima for these codes, Professional shall include documentation of Covered Services provided, as required by this Contract, CalOptima policies, and applicable laws.

2.3.2. Should Medicare consider a service as non-Covered Service, then Medi-Cal guidelines and reimbursement shall be applied in accordance to the guidelines identified in this contract. Professional may need to resubmit claim in accordance with Medi-Cal codes, billing rules, Policies, and guidelines for reimbursement.

2.4. Sequestration. If CMS reduces payment to CalOptima under the CMS Contract by more than two percent (2%) at any time during the term of the Contract, CalOptima may, upon written notice to Professional, reduce payment to Professional under this Attachment B 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 of the Contract.

3. Payment Procedures.

3.1. Health Network. If a Health Network is financially responsible under its contract with CalOptima for the services a Professional rendered to a Member, Professional shall look solely to Health Network for payment for those services, and CalOptima and Member shall not be liable to Professional for those services.

3.2. Billing and Claims Submission. Professional shall submit to CalOptima an accurate, complete, descriptive, and timely Claim that includes the Member's name, and identification number, description of services, and date(s) of service. Professional may not submit a Claim before the delivery of service. In accordance with CalOptima Policies, Professional shall submit all Claims electronically or by mail to CalOptima at Attention: Accounting Department 505 City Parkway West, Orange, CA 92868. Professional is not eligible for payment on Professional is solely responsible for reimbursing its Contracted Providers for providing Covered Services for Professional under this Contract and shall ensure that all Contracted Providers agree to accept payment from Professional as payment in full for Covered Services provided to Members.

3.3. Payment Codes and Modifiers. Professional shall utilize current payment codes and modifiers for Medi-Cal or Medicare, as applicable, when billing CalOptima. CPT or HCPC codes not contained in the Medi-Cal fee schedule or Medicare fee schedule, as applicable, at the time of service are not reimbursable.

3.4. Claims Requiring Additional Justification. 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.

3.5. Prompt Payment. CalOptima shall make payments to Professional in the time and manner set forth in CalOptima Policies and Procedures.

3.6. Claims Deficiencies. CalOptima shall deny payment for any Claim that fails to meet requirements set forth in CalOptima Policies and applicable laws for Claims processing,

Draft pending Board approval

and CalOptima shall notify Professional of any denial pursuant to CalOptima Policies and applicable laws.

3.7. Claims Auditing. Professional acknowledges CalOptima's right to conduct post-payment billing audits under this Contract. Professional and its Contracted Providers will cooperate with CalOptima's audits of Claims and payments by providing access at reasonable times to requested Claims information, all supporting records and other related data. CalOptima will use established industry standards and federal and State guidelines to determine the appropriateness of the billing, coding, and payment. This section will survive any termination of the Contract.

3.8. Coordination of Benefits (COB). Professional acknowledges that Medi-Cal is the payor of last resort. Professional shall coordinate benefits with other programs or entitlements recognizing where Other Health Coverage ("**OHC**") is primary coverage in accordance with CalOptima Program requirements.

3.9. Crossover Claims. The Medi-Cal reimbursement rates in this Contract will not apply to Crossover Claims for Dual Eligible Members. For Crossove Claims, CalOptima will reimburse Professional in accordance with CalOptima Policies, Government Contracts, Medi-Cal and Medicare program requirements, and state and federal laws and regulations. California law limits Medi-Cal program reimbursement for a Crossover Claim to an amount that, when combined with the Medicare or OHC payment, does not exceed Medi-Cal's maximum allowed for similar services as required by Welfare and Institutions Code § 14109.5. "**Crossover Claim(s)**" means claims for Dual Eligible Members where Medi-Cal is the secondary payer and Medicare or OHC is the primary payor for dates of service during which the Dual Eligible Member was not assigned to one of CalOptima's programs. "**Dual Eligible Members**" means members who are eligible for both Medicare or OHC and Medi-Cal benefits.

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CalOptima Health Board Action Agenda Referral

Action To Be Taken November 6, 2025
Regular Meeting of the CalOptima Health Board of Directors

Report Item

16. Consider a Request to Support a Proposed Amendment to CalOptima Health's Governing Ordinance

Contact

Michael Hunn, Chief Executive Officer, (657) 900-1481

Recommended Action

Consider a request to support a proposed amendment to CalOptima Health's governing ordinance regarding contracting with acute care hospitals.

Background

As a county-organized health system, CalOptima Health provides publicly-funded health care services to approximately 885,000 Medi-Cal beneficiaries living in Orange County – more than 1 in 4 residents. These services are delivered through a robust network of contracts with nearly 10,000 providers in every corner of the county. As of October 24, 2025, this includes 1,288 primary care providers, 7,728 specialists, 496 pharmacies, 42 acute care and rehabilitation hospitals, 71 community health centers, and 227 long-term care facilities.

On October 29, 2025, CalOptima Health received notification from the office of Orange County Supervisor Janet Nguyen regarding a proposed amendment to CalOptima Health's governing ordinance that would place additional stipulations regarding CalOptima Health's ability and discretion to contract with acute care hospitals in Orange County. The notification also requested CalOptima Health's consideration of supporting the amendment. The proposed amendment (Attachment 1) is being considered by the Orange County Board of Supervisors for a first reading on November 4, 2025, and a tentative second reading on November 18, 2025.

CalOptima Health previously opposed a proposed state bill – Senate Bill (SB) 1268 (2024) authored by then-State Senator Janet Nguyen – that would have placed similar stipulations on all Medi-Cal managed care plans. At the time, it was determined that SB 1268 conflicted with the following priority in CalOptima Health's 2023-24 Legislative Priorities, as previously approved by the CalOptima Health Board of Directors (Board): "Remove barriers to provider contracting…" (see Attachment 4). SB 1268 was subsequently pulled from consideration. For reference, CalOptima Health's opposition letters to two amended versions of SB 1268 are included as Attachments 2 and 3.

Discussion

The proposed amendment to CalOptima Health's governing ordinance raises several questions as to its potential impact on the underlying purpose and structure of the managed care system that now largely governs the Medi-Cal program, which recognizes that some providers deliver higher quality and more cost-effective care. Prescribing contracting relationships and language in county

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ordinance could also impact the ability of CalOptima Health and acute care hospitals to negotiate and enter mutually agreeable terms in good faith. To that end, when determining whether to authorize or terminate provider contracts, CalOptima Health currently considers several factors, including a provider's quality of care, access and availability, accreditation statuses, non-compliance with regulatory requirements, existence of settlement or corporate integrity agreements, and engagement in fraud, waste, and abuse, including but not limited to anti-kickback schemes and the submission of false claims.

Placing additional stipulations on CalOptima Health's ability to consider such critical factors and other universally recognized credentialing standards could impact quality of care for CalOptima Health's members, as well as CalOptima Health's oversight and accountability over the expenditure of billions of dollars of taxpayer funds.

CalOptima Health's Fiscal Year 2025-26 Public Policy Priorities, as recently approved by the Board on October 2, 2025, continue to retain the following aforementioned priority: "Remove barriers to provider contracting…" (see Attachment 5).

Given that the proposed amendment to CalOptima Health's governing ordinance includes requiring Board authority to terminate an acute care hospital contract as well as 60-day advance written notice to the Orange County Board of Supervisors, staff is seeking Board direction on the proposed amendment.

Fiscal Impact
The recommended action has no fiscal impact.

Rationale for Recommendation
Considering the ordinance amendment affecting CalOptima Health's ability to contract with acute care hospitals may have a significant impact on access to and quality of care for all members.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

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Attachment

1. Proposed Amendment to CalOptima Health's Governing Ordinance (to be considered at a first reading on November 4, 2025)
2. CalOptima Health's Opposition Letter (dated April 15, 2024) to SB 1268 (2024), as amended on March 20, 2024
3. CalOptima Health's Opposition Letter (dated April 17, 2024) to SB 1268 (2024), as further amended on April 15, 2024
4. CalOptima Health's 2023–24 Legislative Priorities
5. CalOptima Health's Fiscal Year 2025–26 Public Policy Priorities

/s/ Michael Hunn *10/31/2025*
Authorized Signature **Date**

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ORDINANCE NO._____

AN ORDINANCE OF THE COUNTY OF ORANGE, CALIFORNIA, AMENDING SECTIONS 4-11-2, 4-11-7, AND 4-11-16 OF THE CODIFIED ORDINANCES OF THE COUNTY OF ORANGE, REGARDING CONTRACTING BY THE ORANGE COUNTY HEALTH AUTHORITY

The Board of Supervisors of the County of Orange ordains as follows:

SECTION 1. Sections 4-11-2, 4-11-7 and 4-11-16 of the Codified Ordinances of the County of Orange are hereby amended to read as follows:

Sec. 4-11-2. - Purpose.

(a) The purpose of the Health Authority is to negotiate exclusive contracts specified in Welfare and Institutions Code section 14087.5 with the California Department of Health Care Services and to arrange for the provision of health care services provided pursuant to chapter 7 of part 3 of division 9 of the Welfare and Institutions Code, and to participate in any other publicly supported health care program the Health Authority is permitted to participate in under state and federal law that are intended to assist low income or indigent residents in obtaining healthcare.

(b) The Health Authority shall design and operate a program that:

(1) Incorporates managed care concepts; gives high priority to prevention, education and early intervention services; and improves access to primary care and related specialty and ancillary services for enrolled recipients.

(2) Includes mechanisms for assuring that the program is culturally appropriate and linguistically competent, provides for continuity of care and geographic access to health care services, and meets appropriate quality of care standards.

(3) Recognizes the importance of institutions providing medical, nursing and allied health education.

(4) Provides a system for enrolled recipients to select their primary care provider.

(5) Includes special care management components and a system of assignment to such components assuring that the health care needs of enrolled recipients with special requirements are met.

(6) Incorporates a plan of service delivery and implements reimbursement mechanisms which will assure the long-term viability of a locally operated Medi-Cal managed care system and maintain access to all acute care hospitals for Medi-Cal recipients in the County of Orange.

(7) Implements a financial plan which includes the creation of a prudent reserve within three

years of commencing operation, and which provides that if additional surplus funds accrue, such funds shall be used to expand access, improve benefits and/or augment provider reimbursement.

(8) Includes mechanisms that protect against arbitrary or capricious formation and termination of contracts.

~~(8)~~(9) Ensures that all program obligations, statutory, contractual or otherwise, shall be obligations of the program and shall not be the obligations of the County of Orange.

(c) The Health Authority shall have the power to contract with providers for services, including, but not limited to, contracts where services are provided on a capitation and other risk-sharing basis. The Health Authority may contract with public and private insurers, purchasers of health insurance, and fiscal intermediaries to administer its health care program.

(d) After commencement of operations of the Health Authority finance program for Medi-Cal recipients, the Health Authority shall design and implement a plan through separate contracts to include within the program it administers those eligible indigent persons for whom the County of Orange is responsible under part 5 (commencing with section 17000) of division 9 of the Welfare and Institutions Code. Unless otherwise provided by the Health Authority, providers contracting with the Health Authority shall serve all CalOptima eligible populations.

(e) The Health Authority shall have the power to contract with the California Managed Risk Medical Insurance Board, or other state approved Board as a participating health plan under California's Healthy Families Plan (part 6.2 of division 2 of the Insurance Code, commencing with section 12693).

(f) The Health Authority shall have the power to contract with the Centers for Medicare & Medicaid Services, or other applicable federal or state approved organization, and to execute such other agreements and documents to effectuate health care delivery systems for any of the following persons:

(1) Persons who are eligible to receive medical benefits under both Title 18 of the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.) and Title 19 of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.).

(2) Persons who are eligible to receive medical benefits under Title 18 of the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.); and

(3) Other individuals or groups in the service area, including, but not limited to, public agencies, private businesses, and uninsured or indigent persons. The Health Authority shall not use any payment or reserve from Medi-Cal program for purposes of this subparagraph.

(g) The Health Authority shall have the power to enter into contracts for provision of health care services to individuals in the service area who are eligible to receive medical benefit under any publicly supported program, such as Medi-Cal and Healthy Families, if the following

requirements are both met:~~, but only if the Health Authority and participating providers acting pursuant to subcontracts with the Health Authority agree to hold harmless the beneficiaries of the publicly supported programs if the contract between the sponsoring government agency and the Health Authority does not ensure sufficient funding to cover program costs. The Health Authority shall not use any payments or reserve from the Medi-Cal program for this purpose.~~

(1) The Health Authority and participating providers acting pursuant to subcontracts with the Health Authority agree to hold harmless the beneficiaries of the publicly supported programs if the contract between the sponsoring government agency and the Health Authority does not ensure sufficient funding to cover program costs. The Health Authority shall not use any payments or reserve from the Medi-Cal program for this purpose.

(2) The Health Authority shall offer all acute care hospitals designated by the Orange County Emergency Medical Services as emergency receiving centers and physically located and operating within the County of Orange, a network contract for emergency and post-stabilization care, on the same terms and conditions as the Health Authority requires for these services from other acute care hospitals. The Health Authority shall maintain network contracts, containing those same terms and conditions for these services, with all acute care hospitals designated by the Orange County Emergency Medical Services as emergency receiving centers who accept that offer.

(A) Notwithstanding the requirements of this subsection (g)(2), the Health Authority may offer a network contract with different terms and conditions as the Health Authority requires from other acute care hospitals upon an affirmative vote of the Health Authority's governing body and 60 calendar days' advance written notice to the Orange County Board of Supervisors.

(B) Notwithstanding the requirements of this subsection (g)(2), the Health Authority may terminate, and not maintain, a network contract with an acute care hospital designated by the Orange County Emergency Medical Services as emergency receiving centers, upon an affirmative vote of the Health Authority's governing body and 60 calendar days' advance written notice to the Orange County Board of Supervisors.

(g) ~~(h)~~ The Health Authority shall have the power to participate in the California Health Benefit Exchange (commonly known as Covered California) as a health care service plan in accordance with Title 22 of the California Government Code (commencing with Section 100500) and Title 10 of the California Code of Regulations. The Health Authority shall have the power to participate in any other publicly supported health care program that the Health Authority is permitted to participate in under state and federal law that are intended to assist low income or indigent residents in obtaining healthcare. Nothing in this subsection (h) shall be construed to limit the power of the Health Authority to enter into contracts for the programs described in subsections (a) through (g) of this section. Nothing in this subsection (h) shall limit the Health Authority from coordinating the referral of Orange County residents who have applied to a Health Benefit Exchange and are eligible for enrollment in the Medi-Cal, Healthy Families or other similar programs authorized by state or federal law for low income or indigent persons offered by the Health Authority.

~~(g)~~(h) Subject to state and federal laws, any authorized representative of the County of Orange

may, in coordination with the governing body of the Health Authority, be provided access to such books, documents, or records as are reasonably necessary to review the Health Authority's compliance with Section 4-11-2. A copy of the findings from any such review shall be provided to the governing body of the Health Authority.

Sec. 4-11-7. - Restrictions.

(a) Any contract entered into by the Health Authority shall contain a provision that any Health Authority obligation created by the contract shall not be an obligation of the County of Orange.

(b) Subject to state and federal laws, any authorized representative of the County of Orange shall be given access to any books, documents or other records of the Health Authority pertinent to the enforcement of this section.

Section 4-11-16 – Findings; conflict of interest.

(a) Pursuant to Welfare and Institutions Code section 14087.57(a) and section 18707.4 .of title 2 of the California Code of Regulations, it is determined that health care providers appointed to the Board of Directors of the Health Authority are intended to represent and further the interest of a health care industry, trade or profession, and that such representation and furtherance will ultimately serve the public interest. Accordingly, it is determined that for purposes of health care providers who are members of the Board of Directors of the Health Authority, a health care industry, trade or profession is tantamount to and constitutes the public generally within the meaning of section 87103 of the California Government Code.

(b) As used in this section, "health care industry, trade or profession" shall mean physicians, health care practitioners, hospitals, pharmacies, or other health care organizations, including managed care organizations, and trade or professional associations.

(c) A member of the Health Authority Board of Directors shall not be deemed to be interested in a contract entered into by the Health Authority within the meaning of article 4 (commencing with section 1090) of chapter 1 of division 4 of title 1 of the Government Code if all of the requirements set forth in Welfare and Institutions Code section 14087.57 are satisfied.

~~(b)~~(d) Subject to state and federal laws, any authorized representative of the County of Orange may, in coordination with the governing body of the Health Authority, be provided access to such books, documents, or records as are reasonably necessary to review the Health Authority's compliance with Section 4-11--16. A copy of the findings from any such review shall be provided to the governing body of the Health Authority.

CalOptima Health
A Public Agency
505 City Parkway West
Orange, CA 92868
☎ 714-246-8400
TTY: 711
caloptima.org

April 15, 2024

The Honorable Richard D. Roth
Chair, Senate Health Committee
1021 O Street, Room 3310
Sacramento, CA 95814

RE: Senate Bill (SB) 1268 (Nguyen) — OPPOSE

Dear Chairman Roth:

CalOptima Health must regretfully oppose SB 1268. As a county-organized health system, CalOptima Health provides publicly-funded health care services to more than 930,000 Medi-Cal beneficiaries living in Orange County — nearly 1 in 3 residents. We deliver these services through a robust network of contracts with more than 11,000 providers in every corner of the county. As of February 29, 2024, this includes 1,232 primary care providers, 9,465 specialists, 553 pharmacies, 39 acute care and rehabilitation hospitals, 52 community health centers, and 112 long-term care facilities.

SB 1268 would prohibit contracted safety-net providers and Medi-Cal managed care plans (MCPs), such as CalOptima Health, from terminating their contracts without stating the "cause" of the termination. For any contract termination, the "cause" could not be based on any material fact or condition known to both parties and which existed at the time the contract was effectuated. If signed into law, this bill would significantly disrupt the ability for both Medi-Cal MCPs and providers to negotiate and enter mutually agreeable contracts in good faith. It would also create an unlevel playing field by requiring a two-tiered contracting system for safety-net and non-safety-net providers — on top of the administrative burdens of potentially re-negotiating thousands of existing contracts. Moreover, this bill would likely lead to costly litigation and expenditure of Medi-Cal resources better used to serve Medi-Cal beneficiaries, given that what was known and what existed at the time of a contract negotiation could — and likely would be — argued to one side's advantage. In addition, since standard provider contracts do not typically include expiration dates, a Medi-Cal MCP's board of directors would be obligated to the actions of past boards, regardless of the evolving needs and circumstances of its members, communities and provider networks.

Prescribing contract language in state statute would impede thousands of health care entities across California from negotiating and entering future contracts, likely reducing total network availability and risking access to care for millions of Medi-Cal beneficiaries throughout the state. For these reasons, CalOptima Health must oppose SB 1268.

Sincerely,



Michael Hunn
Chief Executive Officer

CC: Members, Senate Health Committee
Jen Flory, Principal Consultant, Senate Health Committee
Tim Conaghan, Policy Consultant, Senate Republican Caucus
Joe Parra, Policy Consultant, Senate Republican Caucus

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April 17, 2024

The Honorable Richard D. Roth
Chair, Senate Health Committee
1021 O Street, Room 3310
Sacramento, CA 95814

RE: Senate Bill (SB) 1268 (Nguyen) — OPPOSE

Dear Chairman Roth:

CalOptima Health must regretfully continue to oppose SB 1268, as amended on April 15, 2024. As a county-organized health system, CalOptima Health provides publicly-funded health care services to more than 930,000 Medi-Cal beneficiaries living in Orange County — nearly 1 in 3 residents. We deliver these services through a robust network of contracts with more than 11,000 providers in every corner of the county. As of February 29, 2024, this includes 1,232 primary care providers, 9,465 specialists, 553 pharmacies, 39 acute care and rehabilitation hospitals, 52 community health centers, and 112 long-term care facilities.

SB 1268 would mandate Medi-Cal managed care plans (MCPs), such as CalOptima Health, to contract with all willing safety-net providers under the same terms and conditions of similar providers in their respective service areas. A contract could only be terminated if a provider's license is revoked or suspended or if the California Department of Health Care Services (DHCS) determines a specific provider to be a threat to patient health. If signed into law, this bill would fundamentally undermine the purpose and structure of the "managed care" system that now largely governs the Medi-Cal program, which recognizes that some providers deliver higher quality and more cost-effective care. SB 1268 would also significantly disrupt the ability for both Medi-Cal MCPs and providers to negotiate and enter mutually agreeable terms in good faith, create an unlevel playing field with a two-tiered contracting system for safety-net and non-safety-net providers, and destabilize provider networks by potentially requiring the re-negotiation of thousands of existing contracts that vary by provider. Moreover, the bill's proposed definition of safety-net provider is ambiguous and open to legal interpretation.

Perhaps most concerning is the removal of any and all reasons for a Medi-Cal MCP to initiate a contract termination. In doing so, Medi-Cal MCPs would be prohibited from assessing a provider's quality of care, access and availability, accreditation statuses, non-compliance with regulatory requirements, existence of settlement or corporate integrity agreements, and engagement in fraud, waste, and abuse, including but not limited to anti-kickback schemes and the submission of false claims. Ignoring such critical factors and other universally recognized credentialing standards would risk the well-being of millions of Medi-Cal beneficiaries and remove oversight and accountability over the expenditure of billions of dollars of taxpayer funds. DHCS would not have the ability or capacity to assume such MCP

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responsibilities and evaluate thousands of providers to make contracting determinations at the level of patient risk dictated in the proposed language. As such, this bill would likely lead to unnecessary and costly litigation and expenditure of Medi-Cal resources better used to serve vulnerable beneficiaries.

Prescribing contracting relationships and language in state statute would impede thousands of health care entities across California from negotiating such contracts as well as risk the quality of care for millions of Medi-Cal beneficiaries throughout the state. For these reasons, CalOptima Health must continue to oppose SB 1268.

Sincerely,



Michael Hunn
Chief Executive Officer

CC: Members, Senate Health Committee
Jen Flory, Principal Consultant, Senate Health Committee
Tim Conaghan, Policy Consultant, Senate Republican Caucus
Joe Parra, Policy Consultant, Senate Republican Caucus

2023–24 Legislative Priorities

Behavioral Health

- Support improved parity between physical and mental health care, including rates and coverage of preventive services without diagnoses.
- Support stable, sustainable funding streams for behavioral health services.
- Increase funding for Medi-Cal member access to Be Well Orange County campuses.
- Remove barriers to accessing behavioral health services, including mobile crisis and telehealth-only.
- Incentivize all applicable providers to treat behavioral health conditions within their scope of service.
- Improve the system and capacity for complex discharge management of members with behavioral health diagnoses.
- Enhance integration between specialty and non-specialty Medi-Cal mental health services.
- Support policies to prevent and address substance use disorders, including medication access.

California Advancing and Innovating Medi-Cal (CalAIM)

- Allow health plan discretion to determine member and provider eligibility for Enhanced Care Management (ECM) and Community Supports (CS).
- Simplify pathway for Medi-Cal plans to develop and offer additional CS options to members.
- Incorporate CS into covered benefits to ensure long-term funding and sustainability.
- Invest in infrastructure, training and other supports to prepare providers for CalAIM initiatives.
- Support continuous Medi-Cal coverage for justice-involved individuals.
- Streamline health plan assessment and reporting requirements for CalAIM measures and outcomes.

Data Sharing

- Increase funding, guidance, timeline certainty and implementation flexibility for health care entities to launch data-sharing and infrastructure initiatives, including the Data Exchange Framework, interoperability and the expansion of and connection to regional health information exchanges (HIEs).
- Standardize and ease requirements for data sharing and consent management of health records across payors, providers and public agencies to improve care coordination.

Financing

- Oppose changes to current Medical Loss Ratio (MLR) methodology.
- Ensure Managed Care Organization (MCO) tax revenue prioritizes funding for the Medi-Cal program.
- Ensure future rate changes are beneficial to CalOptima Health and its contracted providers.
- Incorporate audio-only telehealth encounters into the calculation of Medicare risk adjustment payments.
- Reform the use of risk corridors by increasing transparency, accounting for administrative complexity and reducing the number of overlapping corridors.
- Preserve the use of intergovernmental transfer (IGT) funds to offer non-covered Medi-Cal and Medicare benefits.

Older Adults

- Promote overall integration of the Medi-Cal and Medicare programs.
- Support enrollment of full and partial dual-eligible beneficiaries into exclusively aligned enrollment Dual Eligible Special Needs Plans (EAE D-SNPs).
- Align Medi-Cal and Medicare policies that limit the frequency of plan switching to improve continuity of care.
- Support the creation and sustainability of Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs) consistent with EAE D-SNP enrollment policies.
- Expand access to home- and community-based services, including the Program of All-Inclusive Care for the Elderly (PACE), for older adults, including those experiencing or at risk of homelessness.

- Preserve current flexibilities to virtually assess prospective and current PACE participants.
- Expand onsite access to COVID-19 vaccines at PACE facilities.
- Allow PACE organizations to utilize ride-sharing services to supplement transportation vendors.
- Increase PACE funding to address telehealth barriers, such as member access to devices, internet and training.

Operations and Administration

- Preserve the county-organized health system (COHS) and delegated managed care delivery models.
- Oppose requiring COHS to obtain a Knox-Keene Act license.
- Oppose the elimination or carving out of Medi-Cal managed care benefits, such as the Whole-Child Model (WCM).
- Promote efforts to advance health equity and reduce health disparities through current and future Medi-Cal and Medicare initiatives.
- Support 12-month continuous eligibility for all Medi-Cal beneficiaries.
- Reform Medi-Cal Rx policies to improve prior authorization and appeals processes.
- Incentivize health networks to implement same-day prior authorizations.
- Oppose policies that restrict health plan use of prior authorizations.
- Expand the ability for health plans to communicate with members to support care coordination.
- Implement clear, consistent and reasonable timelines for the implementation and evaluation of new covered benefits, programs, initiatives and audits.

Provider Support

- Increase Medi-Cal reimbursement rates, especially for behavioral health services and major organ transplants.
- Remove barriers to provider contracting, including expanding allowable provider types.
- Invest in the development of a diverse health care workforce, including training, education and certification programs, and remove barriers to program enrollment, completion and subsequent hiring.
- Invest in public health infrastructure to better prepare for future pandemics and other health crises.
- Permanently extend Medicare telehealth flexibilities enacted during the COVID-19 pandemic, including use of video and audio-only modalities, virtual establishment of new patients, and payment parity with in-person visits.

Quality Improvement

- Improve alignment between state and federal regulators and the National Committee for Quality Assurance (NCQA), including quality metrics, data collection, network adequacy and value-based programs.
- Incorporate dual-eligible status into risk adjustment, Star Ratings and Consumer Assessment of Healthcare Providers and Systems (CAHPS) scores.
- Allow more flexible distance standards for specialty care providers.
- Improve CAHPS survey to account for delegated delivery model and new forms of health care services, including CS and telehealth utilization.

Social Determinants of Health (SDOH)

- Support policies, funding and flexibility to address SDOH, such as housing, transportation and food insecurity.
- Support the construction and permitting of supportive housing and recuperative care facilities.
- Remove barriers to Medi-Cal enrollment, services and access to care for individuals experiencing homelessness.
- Improve collection and sharing of SDOH and demographic data across public agencies, health plans, utility providers and community-based organizations.

Fiscal Year 2025–26 Public Policy Priorities

Access to Care

- Remove barriers to Medi-Cal enrollment, services and access to care for individuals experiencing homelessness.
- Support policies that allow Section 1115 demonstration waivers to be catalysts for innovations in Medi-Cal, resulting in comprehensive whole-person care.
- Mitigate potential impacts of H.R. 1 (2025) that may restrict the ability of eligible Medi-Cal beneficiaries to newly enroll, maintain enrollment and access high-quality care in the most appropriate setting.
- Support proposals that remove administrative barriers to accessing health and social services benefits.
- Support sustaining coverage expansions and subsidies enacted by the Affordable Care Act.
- Reauthorize and extend the enhanced levels of Advance Premium Tax Credits (APTCs) for purchasing health insurance through Covered California.
- Support the preservation of Covered California enrollment policies that minimize administrative burdens for current and potential beneficiaries

Behavioral Health

- Support improved parity between physical and mental health care, including rates and coverage for preventive services without diagnoses.
- Support increased, sustainable funding streams for behavioral health services.
- Remove barriers to accessing behavioral health services, including mobile crisis and telehealth-only.
- Incentivize all applicable providers to treat behavioral health conditions within their scope of service.
- Promote systematic improvement and increase capacity for complex discharge management of members with behavioral health diagnoses.
- Enhance integration between specialty and non-specialty Medi-Cal mental health services.
- Support policies to prevent and address substance use disorders, including medication surveillance.

California Advancing and Innovating Medi-Cal (CalAIM)

- Allow health plan discretion to determine member and provider eligibility for Enhanced Care Management (ECM) and Community Supports (CS).
- Simplify pathway for Medi-Cal plans to develop and offer additional CS options to members.
- Incorporate CS into covered benefits to ensure long-term funding and sustainability.
- Invest in infrastructure, training and other supports to prepare providers for CalAIM initiatives.
- Support continuous Medi-Cal coverage for justice-involved individuals.
- Streamline health plan assessment and reporting requirements for CalAIM measures and outcomes.
- Support the construction and permitting of supportive housing and recuperative care facilities.

Data Sharing

- Increase funding, guidance, timeline certainty and implementation flexibility for health care entities to launch data-sharing and infrastructure initiatives, including the Data Exchange Framework, interoperability and the expansion of and connection to regional health information exchanges (HIEs).
- Standardize and ease requirements for data sharing and consent management of health records across payors, providers and public agencies to improve care coordination.
- Improve collection and sharing of social determinants of health (SDOH) and demographic data across public agencies, health plans, utility providers and community-based organizations.

Older Adults

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- Preserve current flexibilities to virtually assess prospective and current PACE participants.
- Increase PACE funding to address telehealth barriers, such as member access to devices, internet and training.

Operations and Administration

- Preserve the county-organized health system (COHS) and delegated managed care delivery models.
- Oppose requiring COHS to obtain a Knox-Keene Act license.
- Oppose the elimination or carving out of Medi-Cal managed care benefits, such as the Whole-Child Model (WCM).
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- Support 12-month continuous eligibility for all Medi-Cal beneficiaries.
- Reform Medi-Cal Rx policies to improve prior authorization and appeals processes.
- Incentivize health networks to implement same-day prior authorizations.
- Oppose policies that restrict health plan use of prior authorizations.
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Quality Improvement

- Improve alignment between state and federal regulators and the National Committee for Quality Assurance (NCQA), including quality metrics, data collection, network adequacy and value-based programs.
- Incorporate dual-eligible status into risk adjustment, Star Ratings and Consumer Assessment of Healthcare Providers and Systems (CAHPS) scores.
- Allow more flexible distance standards for specialty care providers.
- Improve CAHPS survey to account for delegated delivery model and new forms of health care services, including CS and telehealth utilization.

Safety Net Funding and Financing

- Support preserving current Medicaid, Medicare and Marketplace funding levels and oppose reductions in federal funding.
- Support the protection of California's current Federal Medical Assistance Percentage (FMAP) for all populations.
- Support maintaining current levels of provider taxes and state-directed payments.
- Support ongoing funding to community clinics through the federal Community Health Center Fund
- Oppose changes to current Medical Loss Ratio (MLR) methodology.

- Ensure Managed Care Organization (MCO) tax revenue prioritizes funding for the Medi-Cal program.
- Ensure future rate changes are beneficial to CalOptima Health and its contracted providers.
- Incorporate audio-only telehealth encounters into the calculation of Medicare risk adjustment payments.
- Reform the use of risk corridors by increasing transparency, accounting for administrative complexity and reducing the number of overlapping corridors.
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