NOTICE OF A
REGULAR MEETING OF THE
CALOPTIMA BOARD OF DIRECTORS

AUGUST 4, 2022
2:00 P.M.

505 CITY PARKWAY WEST, SUITE 108
ORANGE, CALIFORNIA 92868

BOARD OF DIRECTORS

Supervisor Andrew Do, Chair	Clayton Corwin, Vice Chair
Isabel Becerra	Supervisor Doug Chaffee
Clayton Chau, M.D.	Blair Contratto
José Mayorga, M.D.	J. Scott Schoeffel
Nancy Shivers, R.N.	Trieu Tran, M.D.

Supervisor Katrina Foley, Alternate

CHIEF EXECUTIVE OFFICER	OUTSIDE GENERAL COUNSEL	CLERK OF THE BOARD
Michael Hunn	James Novello Kennaday Leavitt	Sharon Dwiers

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

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

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

To ensure public safety and compliance with emergency declarations and orders related to the COVID-19 pandemic, individuals are encouraged not to attend the meeting in person. As an alternative, members of the public may:
Participate via Zoom Webinar at:
https://us06web.zoom.us/s/83057577028?pwd=bk5SOWxkSHkzNFFmMkV2MWljVE13Zz09 and Join the Meeting.
Webinar ID: 830 5757 7028
Passcode: 741253-- Webinar instructions are provided below.

CALL TO ORDER
Pledge of Allegiance
Establish Quorum

PRESENTATIONS/INTRODUCTIONS

MANAGEMENT REPORTS
1. Chief Executive Officer Report

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

CONSENT CALENDAR
2. Minutes
   a. Approve Minutes of the June 2, 2022 Regular Meeting of the CalOptima Board of Directors
   b. Receive and File Minutes of the March 9, 2022 Regular Meeting of the CalOptima Board of Directors' Quality Assurance Committee

3. Adopt Board Resolution No. 22-0804-01, Authorizing Remote Teleconference Meetings for the CalOptima Board of Directors and its Advisory Committees in Accordance with California Government Code section 54953, subdivision (e)

4. Ratify Amendment and Extension of Ancillary Services Contract with Infomedia Group Inc., dba Carenet Healthcare Services

5. Ratify Amendment to Contract with Newmark Knight Frank

6. Ratify a License Agreement with the County of Orange for Use of Space at the County Community Service Center

7. Actions for Contracts Related to Proposed Community Living and PACE Center in the City of Tustin

8. Authorize and Direct Execution of Amendments to CalOptima's Primary Agreement with the California Department of Health Care Services

9. Adopt Resolution Authorizing and Directing Execution of Contract MS-2223-41 with the California Department of Aging for the Multipurpose Senior Services Program

10. Authorize Actions Related to School Behavioral Health Incentive Program

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

12. Authorize Expenditures in Support of CalOptima Participation in Community Events

13. Receive and File:
    a. May and June 2022 Financial Summaries
    b. Compliance Report
    c. Federal and State Legislative Advocates Reports
    d. CalOptima Community Outreach and Program Summary

REPORTS/DISCUSSION ITEMS

14. Authorize a Rebrand of CalOptima to Include a Name Change to "CalOptima Health" and a New Logo Mark

15. Approve Amendments to CalOptima Bylaws

16. Approve Actions Related to Be Well Wellness Hubs

17. Authorize Amendments to the Voluntary Rate Range Intergovernmental Transfer Program for Calendar Year 2021 Health Plan Provider Agreements

18. Authorize the Chief Executive Officer (CEO) to Execute a new contract with The Burgess Group, LLC to implement their new cloud platform in support of our Digital Transformation Strategy. Ratify an Amendment to extend the current contract with The Burgess Group, LLC

19. Approve Actions Related to the Procurement of a Robotic Process Automation (RPA) Software Solution

20. Approve Modifications to CalOptima Administrative Policies

21. Modify Actions Related to the Administrative Fellowship Program

22. Approve New Vendor Management Contract Templates and Authorize Template Use for New Contracts

23. Approve Actions Related to the Procurement of a Customer Relations Management System

24. Approve of Actions Related to the Procurement of a Web Traffic Analytics Solution

25. Approve Amending the Applied Behavioral Analysis Provider Contracts to Increase Rates for Medi-Cal, and Use of Reserve Funds to Support the Increase

26. Authorize Amendments to CalOptima's OneCare and OneCare Connect Health Network Contracts, Except ARTA Western California Inc., Monarch Healthcare, A Medical Group Inc., Talbert Medical Group P.C., and Fee-for-Service OneCare, OneCare Connect, and PACE Contracts Except UCI Health, to Include Language for Sequestration and Recoupment

27. Authorize Amendments to CalOptima's OneCare and OneCare Connect Health Network Contracts for ARTA Western California Inc., Monarch Healthcare, A Medical Group Inc., and Talbert Medical Group P.C., Only to Include Language for Sequestration and Recoupment

28. Authorize Amendments to CalOptima's OneCare, OneCare Connect, and PACE Fee-for-Service Contracts for UCI Health Only to Include Language for Sequestration

ADVISORY COMMITTEE UPDATES

29. Special Joint Meeting of the Member Advisory, OneCare Connect Member Advisory, Provider Advisory, and Whole-Child Model Family Advisory Committees Update

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

ADJOURNMENT

TO JOIN THE MEETING

Please register for the Regular Meeting of the CalOptima Board of Directors on August 4, 2022 at 2:00 p.m. (PST)

Join from a PC, Mac, iPad, iPhone or Android device:
Please click this URL to join.
https://us06web.zoom.us/s/83057577028?pwd=bk5SOWxkSHkzNFFmMkV2MWljVE13Zz09

Or One tap mobile:
+16694449171,,83057577028#,,,,*741253# US
+17207072699,,83057577028#,,,,*741253# US (Denver)

Or join by phone:
Dial(for higher quality, dial a number based on your current location):
US: +1 669 444 9171 or +1 720 707 2699 or +1 253 215 8782 or +1 346 248 7799 or +1 386 347 5053 or +1 564 217 2000 or +1 646 558 8656 or +1 646 931 3860 or +1 301 715 8592 or +1 312 626 6799

Webinar ID: 830 5757 7028
Passcode: 741253

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

MEMORANDUM

DATE:	July 28, 2022
TO:	CalOptima Board of Directors
FROM:	Michael Hunn, Chief Executive Officer
SUBJECT:	CEO Report — August 4, 2022, Board of Directors Meeting
COPY:	Sharon Dwiers, Clerk of the Board; Member Advisory Committee; Provider Advisory Committee; OneCare Connect Member Advisory Committee; and Whole-Child Model Family Advisory Committee

a. New Deputy Chief Medical Officer Joins CalOptima

On July 25, Zeinab Dabbah, M.D., J.D., started as Deputy Chief Medical Officer. She is responsible for overseeing the health care delivery system, including development and implementation of strategies, programs, policies and procedures for all medical services. Dr. Dabbah has more than 27 years of experience as a primary care physician, medical group leader, managed care specialist and health plan executive. Most recently, she was Senior Medical Director for Blue Shield of California Promise Health Plan, which serves Medi-Cal beneficiaries. Prior to that, she held a variety of roles, including running a private practice as an internist, working as a consultant on medical and legal issues, and serving as a hospital attending physician. Dr. Dabbah earned her medical degree from Cairo University School of Medicine and completed her internal medicine residency at LAC+USC Medical Center. She also holds a Juris Doctor degree from Chapman University and is a Certified Health Insurance Executive.

b. Communication Efforts Focus on Benefits of Covered California Participation

The Orange County Board of Supervisors' second reading regarding CalOptima's proposal to offer a Covered California plan has been moved to August 23. In anticipation of this reading, CalOptima has engaged in targeted communications efforts. The proactive measures include providing a binder with extensive background information about the proposal to the Board of Supervisors and engaging media with a press release about the benefits of CalOptima offering a consumer health plan. Media outreach resulted in a Los Angeles Times/TimesOC article on July 20, with more coverage by other outlets expected in the coming weeks.

c. Public Health Emergency (PHE) Extended

On July 15, the COVID-19 public health emergency (PHE) was extended for an additional 90 days through October 13, 2022. It is not yet known if the PHE will be allowed to expire at that time or if it will be renewed once more. However, officials previously committed to providing states with a 60-day notice before terminating the PHE, so CalOptima will know if it is being extended again by September 13.

d. AB 2724 Signed Into Law

On June 30, Gov. Gavin Newsom signed into law Assembly Bill (AB) 2724, which authorizes the California Department of Health Care Services (DHCS) to enter into a direct, statewide Medi-Cal contract with Kaiser Permanente. Both CalOptima and the County of Orange had adopted positions of *Oppose Unless Amended* to prohibit the contract in counties with a County Organized Health System (COHS). The final bill did not include the requested amendment. Staff

is currently considering next steps, including any potential advocacy opportunities at the federal level.

e. Impacting CalOptima Board Governance, AB 498 Passed by Senate Committees

The Senate Health Committee and Senate Governance and Finance Committee have passed AB 498, the proposed legislation introduced by Assemblymember Sharon Quirk-Silva that places new restrictions on the CalOptima Board of Directors. AB 498 will be considered next by the Senate Appropriations Committee in early August after the Legislature reconvenes from recess. While some of CalOptima's requested amendments have been adopted, staff is working with Assemblymember Quirk-Silva's office to secure additional changes. Concurrently, CalOptima is meeting with other members of Orange County's state legislative delegation who have signed on as co-authors of AB 498.

f. Joint Legislative Audit Committee Approves Audit of CalOptima

In addition to authoring AB 498, Assemblymember Sharon Quirk-Silva submitted a request to the Joint Legislative Audit Committee (JLAC) to conduct a programmatic audit of CalOptima, including an examination of the budget, reserves, homeless services, timely access standards, executive changes, salaries and hiring practices. After meeting with JLAC staff, CalOptima submitted written responses to the questions in Assemblywoman Quirk-Silva's audit request. JLAC formally considered and approved the audit request at a hearing on June 27, after CalOptima was unable to provide verbal testimony since the item was placed on the consent calendar. CalOptima received the official audit notice from the California State Auditor on July 15. While a start date has not yet been set, the audit may last several months. The audit scope is publicly posted here.

g. Fiscal Year (FY) 2023 State Budget Finalized

Gov. Gavin Newsom signed into law the final Enacted State Budget for FY 2022–23 and related trailer bills. Effective July 1, the enacted budget appropriates a total of just over $300 billion, an increase of $37.4 billion compared with the FY 2021–22 enacted budget. Specifically, the budget includes $135.5 billion in Medi-Cal spending, an 11.2% increase from the current FY. Based on a record-high budget surplus, the budget allocates 93% toward one-time spending initiatives and $37.2 billion for reserves. Several major components that may impact CalOptima include:

- 24/7 mobile crisis intervention services as a new Medi-Cal benefit
- Additional provider funding, including new equity payments, elimination of most AB 97 rate cuts, continuation of most Proposition 56 programs and new incentive payments for skilled nursing facilities that meet quality benchmarks
- Alternative payment model for Federally Qualified Health Centers
- Continuous Medi-Cal eligibility for children up to 5 years of age
- Elimination of Medi-Cal premiums for higher-income pregnant women, children and disabled working adults
- Ensuring continuity of Medi-Cal coverage during redeterminations, including funding for additional county workloads, health enrollment navigators and outreach campaigns to collect updated member contact information
- Full-scope Medi-Cal for all income-eligible individuals ages 26–49, regardless of immigration status, no later than January 1, 2024
- Increased funding for reproductive health, children's behavioral health and homelessness, including Community Assistance, Recovery and Empowerment (CARE) Court

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- Permanent Medi-Cal telehealth policy that allows for both audio-video and audio-only telehealth encounters to be reimbursed at the same rate as in-person visits
- Retention payments of up to $1,500 each for hospital and skilled nursing facility workers

h. CalFresh Awareness Campaign Continues Momentum

CalOptima's CalFresh awareness campaign continues to have success in reaching members who may need food support. As of May, 21,438 members have joined CalFresh from the pool of more than 344,000 originally identified as potentially eligible but not enrolled. At the four CalFresh Enrollment Event and Resource Fairs in May and June, 7,000 community members attended. The County of Orange Social Services Agency (SSA) and representatives from community-based organizations were on site to process enrollments. CalOptima's advertising efforts continue with large bus wraps on 36 OCTA buses with routes in cities with the highest percentage of residents eligible for CalFresh. To date, Customer Service has received a total of 9,679 calls about CalFresh, with 2,831 members opting for a warm-line transfer to SSA. Further, more than 67,500 members have received text messages with a link to enrollment information.

i. Medi-Cal Pilot Program With Justice-Involved Members Set to Launch

CalOptima is co-designing and participating in a pilot with the Orange County Health Care Agency's Correctional Health Services Jail to Community Re-entry Program team. The pilot will focus on CalOptima's justice-involved members who are homeless and on medication assisted treatment (MAT) for a substance use disorder during their incarceration. The main goal will be to integrate and coordinate services to decrease barriers to care, including continuing MAT medications, behavioral health and substance use treatments, as well as addressing physical health needs, housing navigation and social determinants of health. CalOptima's Homeless Response Team will be participating in this pilot set to launch in the third quarter this year.

j. Chief Medical Officer Sends Letter to Providers Aimed at Rebuilding Relationships

Rebuilding productive relationships with CalOptima's provider community is a top priority. In just a few months, Chief Medical Officer Dr. Richard Pitts and his team have been able to make many positive changes to strengthen these partnerships. To communicate the achievements, he sent an open letter to set a new tone and reinforce CalOptima's commitment to collaboration. The message was distributed to the Orange County Medical Association as well as CalOptima's contracted health networks, hospitals and providers.

k. Vaccination and Wellness Events Benefit School-Age Children

CalOptima's Population Health Management department is partnering with Orange County Federally Qualified Health Centers, community clinics, community-based organizations and school districts to provide a series of public health and wellness events for school-age children. The July and August events offer immunizations and other health resources to CalOptima Medi-Cal members ages 5–15 years old. A separate private event will be held July 30 for children in families that are unhoused or living in hotels or shelters.

l. Percentage of Members Vaccinated Against COVID-19 Steadily Increases

As of July 18, 537,322 CalOptima members have now been vaccinated for COVID-19. This represents 70% of all members age 16+ and 58.7% of all members age 6 months and older. CalOptima has 62,835 members in the age category of 6 months to 4 years, which is the group most recently made eligible for vaccines.

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m. CalOptima Earns Significant Local, National Media Coverage

- On May 24, CalOptima issued a press release about Kelly Bruno-Nelson joining as Executive Director, Medi-Cal/CalAIM. The announcement was carried in Becker's Payer Issues and Payers and Providers. The news brought requests for interviews with Bruno-Nelson about CalAIM and the Community Supports benefit, with Becker's Payer Issues publishing an article on June 20 and State of Reform running a piece on June 22.
- On June 3, U.S. News published an article on the best diets for men and quoted CalOptima registered dietitian Jessie Fragoso.
- On June 8, U.S. News published an article on the merits of a high-protein, low-carb diet, quoting Ariadna Mendez, a registered dietitian and certified diabetes educator at CalOptima.
- On June 10, U.S. News published an article about choosing the right type of therapy, quoting Carmen Katsarov, Executive Director, Behavioral Health Integration.
- On June 15, the Orange County Register published an article on Orange County's $8.8 billion budget that included a mention of CalOptima's Street Medicine Program. It was syndicated by Excélsior and Sing Tao Daily.
- On June 21, Modern Healthcare published an article on insurers who are addressing social determinants of health, quoting Marie Jeannis, Executive Director, Quality & Population Health Management.
- On June 27, CalOptima issued a press release regarding Board approval of $64 million in additional provider support via supplemental payments for pandemic expenses and other funding. It was picked up by OC Breeze, Newsbreak and HealthLeaders. The press release was also shared with the provider community through emailed communications.
- On July 15, Healthline quoted Katsarov in an article about the mental health impact of inflation and financial anxiety.
- On July 18, Chief Medical Officer Richard Pitts, D.O., Ph.D., spoke about coronavirus issues in senior populations on a podcast by LeadingAge, a national nonprofit organization supporting aging services providers.
- On July 19, Illumination Foundation issued a press release that CalOptima contributed to regarding Orange County's selection for the California Health Care & Homelessness Learning Collaborative.
- On July 20, the Los Angeles Times/TimesOC published an article on CalOptima's proposal to offer a Covered California plan. As a follow-up to that piece, CalOptima issued a press release on PR Newswire on July 21. The release was subsequently published by Our Community Now. Additional media coverage of the Covered California plan is expected in the coming weeks.

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MINUTES
REGULAR MEETING
OF THE
CALOPTIMA BOARD OF DIRECTORS

June 2, 2022

A Regular Meeting of the CalOptima Board of Directors was held on June 2, 2022, at CalOptima, 505 City Parkway West, Orange, California. The meeting was held via teleconference (Zoom) in light of the COVID-19 public health emergency and Assembly Bill (AB) 361 (Chaptered September 16, 2021), which allows for temporary relaxation of certain Brown Act requirement related to teleconferenced meetings. Chairman Andrew Do called the meeting to order at 2:00 p.m., and Director Blair Contratto led the Pledge of Allegiance.

ROLL CALL

Members Present: Supervisor Andrew Do, Chairman; Clayton Corwin, Vice Chair; Isabel Becerra (at 2:09 p.m.); Supervisor Doug Chaffee; Clayton Chau, M.D. (non-voting); Blair Contratto; José Mayorga M.D.; Scott Schoeffel; Nancy Shivers; Trieu Tran, M.D.
(All Board Members participated in person except Director Becerra, Supervisor Chaffee, Director Mayorga, Director Schoeffel, and Director Shivers, who participated remotely)

Members Absent: None

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

Chairman Do announced that he will not be participating in Agenda Items 20, 22, 23, 24, and 25 due to conflicts of interest related to campaign contributions under the Levine Act and will pass the gavel to Vice Chair Corwin for those agenda items.

The Clerk noted for the record that Consent Calendar Item 11 has been continued to a future meeting.

PRESENTATIONS/INTRODUCTIONS

None

MANAGEMENT REPORTS

1. Chief Executive Officer Report

Michael Hunn, Chief Executive Officer, highlighted several items from his report. Mr. Hunn reported that on May 24 the Orange County Board of Supervisors voted 3-2 to support modification to CalOptima's ordinance that would allow CalOptima to participate in the California Health Benefit Exchange (Exchange). This will go back to the Orange County Board of Supervisors for another vote to formally adopt the amended ordinance. Mr. Hunn noted that once approved, CalOptima will then seek to update its Knox Keene license to offer health benefits on the Exchange.

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Mr. Hunn provided an update on the Governor Newsom's revised Fiscal Year (FY) 2022-23 budget proposal, noting that the budget included $135.5 billion in Medi-Cal spending, which is an increase of 11.2% from the current fiscal year.

Mr. Hunn also provided an update on the CalFresh program, noting that CalOptima currently has 250,837 individuals enrolled at the end of April. Thanks to the collaboration between CalOptima, the Social Services Agency, and community partners, another 1,144 individuals are enrolled in the CalFresh Program and another 2,196 applications are pending.

Mr. Hunn reported on the Enhanced Care Management (ECM), which is part of CalOptima's CalAIM initiatives, noting that CalOptima now has 1,700 members receiving ECM services. Mr. Hunn introduced Kelly Bruno-Nelson, CalOptima's new Executive Director of Medi-Cal/CalAIM who will be focusing on CalAIM initiatives, including recuperative care, housing navigation and deposits, and community supports.

Mr. Hunn also introduced Deanne Thompson, CalOptima's new Executive Director of Marketing and Communications, who will be responsible for overseeing CalOptima's communications and community relations and outreach. Ms. Thompson will advance CalOptima's member focused mission and key messages through both internal and external communications.

Chairman Do commented about an online editorial that he recently viewed, and he noted that as an elected official, he is used to receiving some negative comments; however, the editorial was also directed at CalOptima and felt that the Board should be aware of political reality that the agency is facing. In the editorial, CalOptima was described as being overly politicized and that narrative is being used to attack the agency in terms of joining the Exchange. Chairman Do opened the floor for other Board members to weigh in on the comments and voice support for what they believe is right for CalOptima with regard to joining the Exchange.

Director Contratto welcomed the two new Executive Directors and noted that if the Board could be copied on these types of media exposure, it would be helpful. She also noted her full support of CalOptima applying for a Knox Keene license to begin the process of joining the Exchange.

Director Chau noted that as a physician his only agenda is that the patient has community access to options and ensure that people have continuity of care.

Vice Chair Corwin, echoed Director Chau's comments and noted that he does not have hospital administration experience; however, he does place reliance on the experience of Mr. Hunn and his senior team and the rational explanation as why this is beneficial to the CalOptima members. Nothing that has been brought forward has supported the concern about a chilling effect competitively.

Director Becerra added that she sees joining the Exchange not just as an opportunity, but as a responsibility, since we know many CalOptima members will lose eligibility during the redetermination, and we are intentionally trying to ensure continuity of care. She also noted that she is in full support of taking steps to move forward and join the Exchange.

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Director Mayorga noted that he, as a physician, looks at this from the patient's perspective. The most important work that physicians do for their patients, particularly for the most vulnerable people in the community is trying to deliver the best care possible without any gap. Director Mayorga added that it is important to collaborate with all of CalOptima's partners, including hospital partners to understand the impacts this will have both from care and financial perspectives.

Director Shivers noted that her role on the CalOptima Board of Directors is representing the members, and as a nurse, she is wholeheartedly behind this move to join the Exchange to ensure continuity of care.

Director Tran also noted that his role on the CalOptima Board is representing physicians, and as a physician he sees CalOptima patients, and he sees people losing coverage all the time. He also agreed with Director Chau's assessment that the Exchange is not easy to navigate for this population, noting his office staff help many CalOptima members navigate the Exchange.

PUBLIC COMMENTS
There was no request for public comment.

CONSENT CALENDAR
2. Minutes

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

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

4 Adopt Board Resolution No. 22-0602-01, Authorizing Remote Teleconference Meetings for the CalOptima Board of Directors and its Advisory Committees in Accordance with California Government Code section 54953, subdivision (e)
The Clerk noted for the record that this Resolution was amended to be effective for the next 60 days instead of 30 days due to the timing of the next Board meeting.

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

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

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

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

9. Approve Proposed Changes to the CalAIM Community Supports Policy

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

11. Appointments to the CalOptima Board of Directors' Member Advisory Committee
This item was continued to a future meeting.

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

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

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

15. Receive and File:

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

Action: ***On motion of Vice Chair Corwin, seconded and carried, the Board of Directors approved Consent Calendar as presented. (Motion carried 9-0-0 (except as noted above))***

REPORTS/DISCUSSION ITEMS

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

Finance and Audit Committee (FAC) Chair Becerra provided opening comments on CalOptima's proposed Fiscal Year (FY) 2022-23 budget. She congratulated Nancy Huang, Chief Financial Officer, and her team for putting together a robust budget.

CEO Hunn provided a high-level overview and highlighted the budget objectives: 1) Member focused: improve access and quality of care; 2) balanced operating budget; and 3) resources to build infrastructure and capacity to support CalOptima's new Mission and Vision statements and Strategic Plan. Mr. Hunn thanked the Finance and Audit Committee members for their support.

Ms. Huang provided an update on the FY 2022-23 Operating Budget and highlighted key changes to the budget for the upcoming fiscal year. Ms. Huang reported that overall, for the Operating Budget for FY 2022-23 the projected revenue is $4,002,166,212, the projected expenses are $3,962,697,914; and the Operating Income/Margin is estimated at $39,468,298 and indicates a balanced operating budget. Ms. Huang reviewed details of the budget and responded to Board questions. After which, the Board took the following action:

Action: ***On motion of Vice Chair Corwin, seconded and carried, the Board of Directors: 1.) Approved the CalOptima Fiscal Year (FY) 2022-23 Operating Budget, as reflected in Attachment A: Fiscal Year 2022-23 Operating Budget for all Lines of Business; and 2.) Authorized the***

expenditures and appropriated the funds for the items listed in Attachment B: Administrative Budget Details and Attachment B1: Digital Transformation Administrative Budget Details, which shall be procured in accordance with CalOptima Policy GA.5002: Purchasing Policy. (Motion carried 9-0-0)

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

Ms. Huang presented the FY 2022-23 Capital and Digital Transformation Year One Budget and highlighted changes from the previous fiscal year's budget.

Ms. Huang reported that the Routine Capital budget is estimated at $13,688,363 and is Operating Budget funded; the Digital Transformation Capital is estimated at $34,196,000 and is funded from reserves; and the Total Capital is estimated at $47,884,363.

Action: ***On motion of Director Schoeffel, seconded and carried, the Board of Directors: 1.) Approved the CalOptima Fiscal Year (FY) 2022-23 Capital and Digital Transformation Year One Capital Budgets; and 2.) Authorized the expenditures and appropriated the funds for the following items, which shall be procured in accordance with CalOptima Board-approved policies: a.) Attachment A: FY 2022-23 Capital Budget by Project; and b.) Attachment A1: FY 2022-23 Digital Transformation Year One Capital Budget by Project. (Motion carried 9-0-0)***

18. Adopt Strategic and Tactical Priorities for 2022-2025

Action: ***On motion of Director Contratto, seconded and carried, the Board of Directors: 1.) Adopted the Strategic and Tactical Priorities for 2022-2025 (Motion carried 9-0-0)***

19. Authorize the CalOptima Administrative Fellowship Program

Action: ***On motion of Vice Chair Corwin, seconded and carried, the Board of Directors authorized the Chief Executive Officer to launch the CalOptima Administrative Fellowship Program effective September 1, 2022 (Motion carried 9-0-0)***

As noted at the top of the meeting, Chairman Do abstained from Agenda Items 20, 22, 23, 24, and 25 and passed the gavel to Vice Chair Corwin. The Chairman also noted that after Agenda Item 25, the Board would consider Agenda Item 21 and then continue with the remaining items on the agenda.

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

Chairman Do did not participate in the discussion and vote on this item due to conflicts of interest related to campaign contributions under the Levine Act. Director Schoeffel did not participate in this item due to potential conflicts of interest.

Action: ***On motion of Director Contratto, seconded and carried, the Board of Directors: 1.) Approved the new OneCare health network Health Maintenance Organization (HMO), Shared-Risk Group (SRG), Physician Hospital Consortia-Physician (PHC-P), and Physician Hospital Consortia-Hospital (PHC-H) contract templates, effective January 1, 2023; and 2.) Authorized the Chief Executive Officer (CEO) to use the new OneCare contract templates to execute contracts with currently participating OneCare and OneCare Connect health networks (except ARTA Western California Inc., Talbert Medical Group P.C., Monarch Healthcare, A Medical Group, and Monarch Health Plan Inc.) effective January 1, 2023, within the parameters set forth in the Fiscal Year (FY) 2022-23 Operating Budget as approved by the Board of Directors. (Motion carried 7-0-1; Chairman Do abstained and Director Schoeffel recused)***

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

Chairman Do did not participate in the discussion and vote on this item due to conflicts of interest related to campaign contributions under the Levine Act. Director Schoeffel did not participate in this item due to potential conflicts of interest.

Action: ***On motion of Director Tran, seconded and carried, the Board of Directors approved amendment to Ancillary Services Contract to extend reimbursement for in-home Community-Based Adult Services (CBAS) through December 31, 2022. (Motion carried 7-0-1; Chairman Do abstained and Director Schoeffel recused)***

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

Chairman Do did not participate in the discussion and vote on this item due to conflicts of interest related to campaign contributions under the Levine Act. Director Mayorga did not participate in this item due to his role as Executive Director at UC Irvine Health. Director Schoeffel did not participate in this item due to potential conflicts of interest. Director Tran did not participate in this item due to his service as a specialist physician serving CalOptima members.

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Action: ***On motion of Director Contratto, seconded and carried, the Board of Directors: Authorized: 1.) Extension of a temporary, short-term supplemental payment increase of 5% from Fiscal Year (FY)2021-22 original budgeted funding levels for compliant, contracted Medi-Cal fee-for-service (FFS) primary care, specialist, and ancillary providers for certain medically necessary services provided to CalOptima Community Network (CCN) and CalOptima Direct (COD) Medi-Cal members for dates of service July 1, 2022, through June 30, 2023; and 2.) Extension of a temporary, short-term supplemental payment increase of 5% from FY 2021-22 original budgeted funding levels for compliant, contracted Medi-Cal FFS behavioral health providers for services provided to all CalOptima Medi-Cal members for dates of service July 1, 2022, through June 30, 2023. (Motion carried 5-0-1; Chairman Do abstained; Directors Mayorga, Schoeffel and Tran recused)***

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

Director Becerra did not participate in this item due to her affiliation with the Orange County Coalition of Community Health Centers. Chairman Do did not participate in the discussion and vote on this item due to conflicts of interest related to campaign contributions under the Levine Act. Director Mayorga did not participate in this item due to his role as Executive Director at UC Irvine Health. Director Schoeffel did not participate in this item due to potential conflicts of interest.

Action: ***On motion of Vice Chair Corwin, seconded and carried, the Board of Directors Authorized an extension of a temporary, short-term supplemental payment increase of 5% from Fiscal Year (FY) 2021-22 original budgeted funding levels, for compliant, contracted CalOptima Community Network (CCN) and CalOptima Direct-Administrative (COD-A) Medi-Cal Fee-for-Service (FFS) Community Health Centers, for certain medically necessary services provided to CCN and COD-A Medi-Cal members on dates of service July 1, 2022, through June 30, 2023. (Motion carried 5-0-1; Chairman Do abstained; Directors Becerra, Mayorga, and Schoeffel recused)***

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

Chairman Do did not participate in the discussion and vote on this item due to conflicts of interest related to campaign contributions under the Levine Act. Director Schoeffel did not participate in this item due to potential conflicts of interest.

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Action: ***On motion of Director Contratto, seconded and carried, the Board of Directors: 1.) Authorized an extension of capitation rate increases for all contracted Physician Hospital Consortia (PHC), Shared Risk Group (SRG), and Health Maintenance Organization (HMO) Medi-Cal health networks, except ARTA Western California Inc. (ARTA), Monarch Health Plan Inc. (Monarch), Talbert Medical Group P.C. (Talbert), and Kaiser Foundation Health Plan Inc. (Kaiser) on Child, Adult and Seniors and Persons with Disabilities (SPD) Categories of Aid (COA) by 7.5% from Fiscal Year (FY) 2021-22 original budgeted base rates for the period of July 1, 2022, through June 30, 2023; and 2.) Authorized the Chief Executive Officer (CEO) to execute amendments to Medi-Cal PHC, SRG, and HMO health network contracts except ARTA, Monarch, Talbert, and Kaiser, to implement health network capitation rate adjustments. (Motion carried 7-0-1; Chairman Do abstained and Director Schoeffel recused)***

Vice Chair Corwin passed the gavel back to Chairman Do.

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

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

Action: ***On motion of Director Becerra, seconded and carried, the Board of Directors: 1.) Approved the new OneCare health network Health Maintenance Organization (HMO), Shared-Risk Group (SRG), Physician Hospital Consortia-Physician (PHC-P), and Physician Hospital Consortia-Hospital (PHC-H) contract templates, effective January 1, 2023; and 2.) Authorized the Chief Executive Officer (CEO) to use the new OneCare contract templates to execute contracts with ARTA Western California Inc., Talbert Medical Group P.C., Monarch Healthcare, A Medical Group, and Monarch Health Plan Inc., effective January 1, 2023, within the parameters set forth in the Fiscal Year (FY) 2022-23 Operating Budget as approved by the Board of Directors (Motion carried 7-0-0; Directors Schoeffel and Shivers recused)***

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

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

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Action: ***On motion of Vice Chair Corwin, seconded and carried, the Board of Directors: 1.) Authorized an extension of capitation rate increases for the ARTA Western California Inc. (ARTA), Monarch Health Plan Inc. (Monarch), and Talbert Medical Group P.C (Talbert) Medi-Cal health networks, on Child, Adult and Seniors and Persons with Disabilities (SPD) Categories of Aid (COA) by 7.5% from Fiscal Year (FY) 2021-22 original budgeted base rates for the period of July 1, 2022, through June 30, 2023; and 2.) Authorized the Chief Executive Officer (CEO) to execute amendments to the ARTA, Monarch, and Talbert Medi-Cal health network contracts, to implement health network capitation rate adjustments. (Motion carried 7-0-0; Director Shivers and Director Schoeffel recused)***

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

Vice Chair Corwin will not participate in this item due to his affiliation with Pomona Valley Hospital. Director Mayorga did not participate in this item due to his role as Executive Director at UC Irvine Health. Director Schoeffel did not participate in this item due to potential conflicts of interest.

Action: ***On motion of Director Contratto, seconded and carried, the Board of Directors Authorized an extension of a temporary, short-term supplemental payment increase of 5% from Fiscal Year (FY) 2021-22 original budgeted funding levels for compliant CalOptima Community Network (CCN) and CalOptima Direct-Administrative (COD-A) Medi-Cal fee-for-service (FFS) hospitals, for certain medically necessary services provided to CCN and COD-A Medi-Cal members for dates of service July 1, 2022, through June 30, 2023. (Motion carried 6-0-0; Vice Chair Corwin, Directors Mayorga and Schoeffel recused)***

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

Action: ***On motion of Director Becerra, seconded and carried, the Board of Directors: 1.) Adopted resolution approving updated CalOptima policies: a.) GA. 8020: 9/80 Work Schedule; b.) GA. 8027: Anti-Harassment Policy; c.) GA. 8036: Education Reimbursement; d.) GA. 8042: Supplemental Compensation; e.) GA. 8050: Confidentiality; and f.) GA. 8058. Salary Schedule; and 2.) Appropriated funds and authorized unbudgeted expenditures in an amount up to $58,050 from existing reserves to fund the Supplemental Compensation Internet Stipend for the period of June 5, 2022, through June 30, 2022. (Motion carried 9-0-0)***

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

Action: ***On motion of Vice Chair Corwin, seconded and carried, the Board of Directors elected Supervisor Andrew Do as Board Chair for a term effective July 1, 2022, through June 30, 2023, or until the election of a successor(s), unless the Board Chair or Vice Chair shall sooner resign or be removed from office. (Motion carried 9-0-0)***

Action: ***On motion of Chairman Do, seconded and carried, the Board of Directors elected Clayton Corwin as Vice Chair for a term effective July 1, 2022, through June 30, 2023, or until the election of a successor(s), unless the Board Chair or Vice Chair shall sooner resign or be removed from office. (Motion Carried 9-0-0)***

ADVISORY COMMITTEE UPDATES

30. OneCare Connect Member Advisory Committee Update

Patty Mouton, OneCare Connect Member Advisory Committee (OCC MAC) Chair, provided an update on the recent activities of the Committee. Ms. Mouton noted that the OCC MAC's last meeting will be in December, as the Cal MediConnect pilot sunsets at the end of the year.

Chairman Do thanked Committee for their work and dedication to serving on the OCC MAC.

31. Provider Advisory Committee Update

Dr. Junie Lazo Pearson, Provider Advisory Committee (PAC) Chair, provided an update on the recent activities of the Committee. Dr. Lazo Pearson also thanked the Board for approving the PAC candidates.

32. Member Advisory Committee Update

Christine Tolbert, Member Advisory Committee (MAC) Chair, provided an update on recent activities of the Committee. Ms. Tolbert also noted that the MAC and PAC will be meeting jointly starting next fiscal year.

CLOSED SESSION

The Board adjourned to Closed Session at 3:59 p.m. pursuant to Government Code section 54956.8, CONFERENCE WITH REAL PROPERTY NEGOTIATIORS, to discuss property located at 14851 Yorba Street & 165 N. Myrtle Avenue Tustin, CA 92780. Agency negotiators: David Kluth, John Scruggs and Mai Hu, Newmark Knight Frank. Negotiating parties: Yorba Myrtle LLC. Under negotiation were price and terms of payments.

The Board reconvened to Open Session at 4:44 p.m. with no reportable actions taken in Closed Session.

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BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

Director Chau provided an update on COVID-19 vaccination and therapies available for COVID-19 patients and asked CalOptima to work with its health networks on providing these new therapies to CalOptima members since administering the therapies are time sensitive and access to the therapies are limited.

Director Contratto, who is also a member of the Finance and Audit Committee, thanked Ms. Huang and her team for doing the hard work in zero-based budgeting.

Chairman Do concurred, noting that he appreciated the robust budget discussions.

ADJOURNMENT

Hearing no further business, Chairman Do adjourned the meeting at 4:51 pm.

/s/ Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: August 4, 2022

MINUTES

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

CALOPTIMA
505 CITY PARKWAY WEST
ORANGE, CALIFORNIA

March 9, 2022

A Regular Meeting of the CalOptima Board of Directors' Quality Assurance Committee was held on March 9, 2022, at CalOptima, 505 City Parkway West, Orange, California. The meeting was held via teleconference (Zoom Webinar) in light of the COVID-19 public health emergency and of Assembly Bill (AB) 361 (Chaptered September 16, 2021), which allows for temporary relaxation of certain Brown Act requirements related to teleconferenced meetings.

Chair Trieu Tran, called the meeting to order at 3:02 p.m. and Director Shivers led the Pledge of Allegiance.

CALL TO ORDER

Members Present: Trieu Tran, M.D., Chair; Nancy Shivers, R.N. (all members participated via teleconference)

Members Absent: José Mayorga, M.D.

Others Present: Yunkyung Kim, Chief Operating Officer; Richard Pitts, M.D., Chief Medical Officer; Monica Macias, Director PACE, Marsha Choo, Interim Director of Quality Implementation; Sharon Dwiers, Clerk of the Board

PUBLIC COMMENTS

There were no requests for public comment.

CONSENT CALENDAR

1. Approve the Minutes of the December 8, 2021 Regular Meeting of the CalOptima Board of Directors' Quality Assurance Committee

2. Approve Modifications to CalOptima Quality Improvement Policies: GG. 1603, GG. 1607, GG. 1650, FF. 1651, and GG. 1655

Action: ***On motion of Director Shivers, seconded and carried, the Committee approved the Consent Calendar as presented. (Motion carried 2-0-0; Director Mayorga absent)***

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REPORTS

3. Receive and File 2021 CalOptima Quality Improvement Program Evaluation and Recommend Board of Directors Approval of the 2022 Quality Improvement Program and 2022 Quality Improvement Program

Marsha Choo, Interim Director, Quality Improvement, introduced the item and provided an overview of the 2021 Quality Improvement Program Evaluation. Ms. Choo highlighted several accomplishments achieved in 2021, which included the following: in July 2021, achieved National Committee for Quality Assurance (NCQA) accreditation through 2024; in September 2021, received 4 out of 5 in NCQA's Medicaid Health Plan rating, also in September 2021, received a mPulse award for Achieving Health Equity related to health care innovation, and received Orange County Chapter of the Public Relations Society of America's Award of Excellence for COVID-19 response. Ms. Choo added, that in October 2021, Assemblywoman Cottie Petrie-Norris recognized CalOptima's Program of All-Inclusive Care for the Elderly (PACE) program for its use of telehealth technology, and in November 2021, CalOptima received the Department of Health Care Services (DHCS) 2021 Consumer Satisfaction Award for the Adult population for a large-scale health plan.

Ms. Choo noted that the 2021 evaluation is used to help staff formulate the 2022 Quality Improvement Program and Workplan. For 2022, CalOptima will incorporate social determinants of health (SDOH) and health equity in targeted quality initiatives. Ms. Choo reviewed the goals for 2022, which also include working closely with CalOptima's health networks, providers, and community stakeholders.

Action: ***On motion of Director Shivers, seconded and carried, the Committee recommended that the Board of Directors: Receive and File 2021 CalOptima Quality Improvement Program Evaluation; and Approval of the 2022 Quality Improvement Program. (Motion carried 2-0-0; Director Mayorga absent)***

4. Receive and File 2021 CalOptima Program of All-Inclusive Care for the Elderly Quality Assessment and Performance Improvement Plan Evaluation and Recommend Board of Directors Approval of the 2022 CalOptima Program of All-Inclusive Care for the Elderly Quality Improvement Plan

Monica Macias, Director, PACE, introduced the item and provided and overview of the 2021 CalOptima Program of All-Inclusive Care for the Elderly (PACE) Quality Assessment and Performance Improvement Plan Evaluation. Ms. Macias highlighted several of the 2021 PACE accomplishments, which included the following: 100% medication reconciliation rate following a hospital discharge; 91% of participants had a Physician's Order for Life-sustaining Treatment (POLST) completed; 99% on-time performance for transportation with 30,696 one-ways trips; Overall participant satisfaction score of 91% compared to national average of 88.5%; and PACE met 25 of 29 work plan element goals.

Ms. Macias noted the 2021 Quality Assessment and Performance Improvement Plan Evaluation assists staff in developing the 2022 PACE Quality Improvement Plan. She reviewed the several of the quality initiatives and goals for 2022, which included the following: adding a COVID-19 booster related quality initiative for 2022; monitoring participants with Osteoporosis diagnosis to ensure that they are receiving treatment to prevent fractions; and added an advanced health care directive as a

new quality initiative for 2022. Ms. Macias also reported that 2022 PACE Quality Improvement Plan aligns with CalOptima's vision and mission and focuses on optimal health outcomes for its participants.

Action: ***On motion of Director Tran, seconded and carried, the Committee recommended that the Board of Directors: Receive and File 2021 CalOptima PACE Quality Improvement Plan Evaluation, and Approval of the 2022 PACE Quality Improvement Plan (Motion carried 2-0-0; Director Mayorga absent)***

INFORMATION ITEMS

5. Program of All-Inclusive Care for the Elderly Member Advisory Committee Update
Ms. Macias provided an update on the recent activities of the PACE Member Advisory Committee.

The following items were accepted as presented.

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

COMMITTEE MEMBER COMMENTS
The Committee members thanked staff for the work that went into preparing for the meeting.

ADJOURNMENT
Hearing no further business, Chair Tran adjourned the meeting at 3:36 p.m.

/s/ Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: June 8, 2022

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 4, 2022
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

3. Adopt Board Resolution No. 22-0804-01, Authorizing Remote Teleconference Meetings for the CalOptima Board of Directors and its Advisory Committees in Accordance with California Government Code section 54953, subdivision (e)

Contact

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

Recommended Action

Adopt Board Resolution No. 22-0804-01, authorizing remote teleconference meetings for the CalOptima Board of Directors and its advisory committees in accordance with Government Code section 54953, subdivision (e).

Background

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

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

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

> (A) The legislative body holds a meeting during a proclaimed state of emergency, and state or local officials have imposed or recommended measures to promote social distancing; or
>
> (B) The legislative body holds a meeting during a proclaimed state of emergency for the purpose of determining, by majority vote, whether as a result of the emergency, meeting in person would present imminent risks to the health or safety of attendees; or
>
> (C) The legislative body holds a meeting during a proclaimed state of emergency and has determined, by majority vote, pursuant to subparagraph (B), that, as a result of the emergency, meeting in person would present imminent risks to the health or safety of attendees.

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

Discussion

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

(A) The legislative body has reconsidered the circumstances of the state of emergency.
(B) Any of the following circumstances exist:
(i) The state of emergency continues to directly impact the ability of the members to meet safely in person; or
(ii) State or local officials continue to impose or recommend measures to promote social distancing.

Given the continued active declaration of emergency arising from the COVID-19 pandemic, there is an ongoing need for holding teleconference meetings for the CalOptima Board of Directors and its advisory committees. In addition, the County of Orange Health Officer issued "Orders and Strong Recommendations," updated as of June 15, 2022, to strongly recommend preventative measures such as wearing masks in all public spaces and businesses, and engaging in social distancing for vulnerable populations. For CalOptima to continue the teleconference meetings, the required findings are set forth in the attached Resolution No. 22-0804-01.

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

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

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

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

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

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Board Resolution No. 22-0804-01, Authorizing Remote Teleconference Meetings for the CalOptima Board of Directors and its Advisory Committees in Accordance with Government Code section 54953, subdivision (e)
2. March 4, 2020, Proclamation of a State of Emergency
3. June 15, 2022, Orange County Health Officer's Orders and Strong Recommendations
4. Government Code section 54953, as amended by AB 361

/s/ Michael Hunn *07/28/2022*
Authorized Signature **Date**

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RESOLUTION NO. 22-0804-01

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

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

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

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

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

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

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

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

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

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

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

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

WHEREAS, on June 15, 2022, the County of Orange Health Officer issued a revised "Orders and Strong Recommendations," which includes strong recommendations for preventative measures, such

as wearing masks in all public spaces and businesses, and engaging in social distancing for vulnerable populations;

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

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

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

NOW, THEREFORE, BE IT RESOLVED:

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

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

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

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

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a. CalOptima, this 4th day of August, 2022.

AYES: _____

NOES: _____

ABSENT: _____

ABSTAIN: _____

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

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

EXECUTIVE DEPARTMENT
STATE OF CALIFORNIA

PROCLAMATION OF A STATE OF EMERGENCY

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

IT IS HEREBY ORDERED THAT:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

GAVIN NEWSOM
Governor of California

ATTEST:

ALEX PADILLA
Secretary of State

REGINA CHINSIO-KWONG, DO
COUNTY HEALTH OFFICER

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

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COUNTY OF ORANGE HEALTH OFFICER'S ORDERS AND STRONG RECOMMENDATIONS

(Revised June 15, 2022)

In light of recent Face Mask Guidance issued by the California Department of Public Health (CDPH) and certain recent orders issued by the State Public Health Officer regarding COVID-19 vaccine requirements, the following Orders and Strong Recommendations shall revise and replace the prior Orders and Strong Recommendations of the County Health Officer that were issued on March 11, 2022. The Orders and Strong Recommendations issued on March 24, 2022, are no longer in effect as of June 15, 2022.

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

ORDERS

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

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

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

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

   If you do not have any COVID-19 symptoms (as defined below in this Order) but test positive for COVID-19, you shall immediately isolate yourself in your home or another suitable place for at least 5 days from the date you test positive and may end your self-isolation after day 5:

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

   Exceptions.

   1) If you are unable or choose not to test on day 5 or after, or if you test positive after day 5, you shall continue your self-isolation through day 10 from the date of your initial positive test and may end your self-isolation after 10 days from the date of your initial positive test.
   2) If you develop COVID-19 symptoms during the time of your self-isolation, you shall isolate yourself for at least 10 days from the date of symptom(s) onset. You may end your self-isolation sooner if a diagnostic specimen collected on day 5 (or later) from the date of symptom(s) onset tests negative.

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

2. Persons who have COVID-19 symptoms.

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

   - If a diagnostic specimen collected as early as the date of your symptom(s) onset tests negative.

II. While an antigen test, nucleic acid amplification test (NAAT), or LAMP test are acceptable, use of an antigen test is recommended. Use of Over-the-Counter tests are also acceptable to end isolation.

- Note: A negative PCR or antigen test collected on day 1-2 of symptom onset should be repeated in 1-2 days to confirm negative status. While isolation may end after the first negative test, it is strongly recommended to end isolation upon negative results from the repeat test.

III. If you obtain an alternative diagnosis from a healthcare provider.

Exception:

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

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

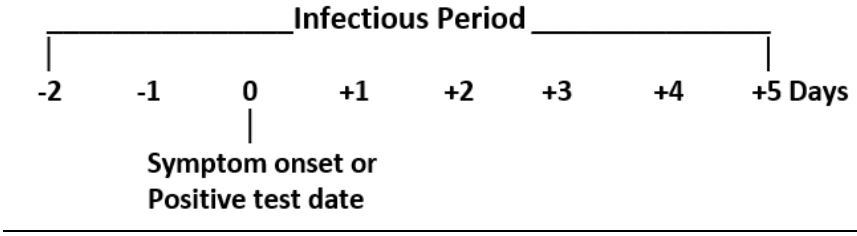
All persons who have COVID-19 symptoms should continue to wear a well-fitting mask at all times around other people through at least Day 10.

Additional Considerations for Self-Isolation.

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

- Rebound: Regardless of whether an individual has been treated with an antiviral agent, risk of transmission during COVID-rebound can be managed by following CDC's guidance on isolation (https://www.cdc.gov/coronavirus/2019-ncov/your-health/quarantine-isolation.html). An individual with rebound may end re-isolation after 5 full days of isolation with resolution of their fever for 24 hours without the use of fever-reducing medication and if symptoms are improving. The individual should wear a mask for a total of 10 days after rebound symptoms started.
    - More information can be found at https://www.cdph.ca.gov/Programs/OPA/Pages/CAHAN/CAHAN-Paxlovid-Recurrence-06-07-22.aspx.

Timing for "Day 0"- As noted in CDPH Isolation and Quarantine Q&A, the 5-day clock for isolation period starts on the date of symptom onset or (day 0) for people who test positive after symptoms develop, or initial test positive date (day 0) for those who remain asymptomatic. If an asymptomatic person develops symptoms, and test positive, date of symptom onset is day 0.



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

Definition.

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

- Fever or chills
- Cough
- Shortness of breath or difficulty breathing
- Fatigue
- Muscle or body aches
- Headache
- New loss of taste or smell
- Sore throat
- Congestion or runny nose
- Nausea or vomiting
- Diarrhea
- The list above does not include all possible symptoms.

IV. Face-Coverings/Masks:

To help prevent the spread of droplets containing COVID-19, all County residents and visitors are required to wear face coverings in accordance with the Guidance for the Use of Face Coverings issued by CDPH, dated April 20, 2022. The Guidance is attached herein as Attachment "**A**" and can be found at:

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

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

- Emergency shelters and cooling and heating centers.
- Healthcare settings (applies to all healthcare settings, including those that are not covered by State Health Officer Order issued on July 26, 2021).

- Local correctional facilities and detention centers.
- Long Term Care Settings & Adult and Senior Care Facilities.

NOTE:

1) When using public transit, individuals shall follow the guidance and requirements set by the Federal government. More information about the guidance on public transportation can be found at https://www.cdc.gov/quarantine/masks/face-masks-public-transportation.html.

2) In workplaces, employers are subject to the Cal/OSHA COVID-19 Prevention Emergency Temporary Standards (ETS) or in some workplaces the Cal/OSHA Aerosol Transmissible Diseases (ATD) Standard (PDF) and should consult those regulations for additional applicable requirements, as modified by the Governor's Executive Order N-5-22. Additional information about how CDPH isolation and quarantine guidance affects ETS-covered workplaces may be found in Cal/OSHA FAQs.

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

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

Exemptions to masks requirements.

- The following individuals are exempt from this mask order:
  - Persons younger than two years old.
  - Persons with a medical condition, mental health condition, or disability that prevents wearing a mask. This includes persons with a medical condition for whom wearing a mask could obstruct breathing or who are unconscious, incapacitated, or otherwise unable to remove a mask without assistance.

- Persons who are hearing impaired, or communicating with a person who is hearing impaired, where the ability to see the mouth is essential for communication.
- Persons for whom wearing a mask would create a risk to the person related to their work, as determined by local, state, or federal regulators or workplace safety guidelines.
- Additional exceptions to masking requirements in high-risk settings can be found at https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Face-Coverings-QA.aspx.

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

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

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

Facilities covered by this order include:

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

- Hospice Facilities
- Pediatric Day Health and Respite Care Facilities
- Residential Substance Use Treatment and Mental Health Treatment Facilities

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

VI. Requirements and Guidance for Specific Facilities

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

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

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

Facilities covered by this order include:

- Acute Health Care and Long-Term Care Settings:
  - General Acute Care Hospitals
  - Skilled Nursing Facilities (including Subacute Facilities)
  - Intermediate Care Facilities
- High-Risk Congregate Settings:
  - Adult and Senior Care Facilities
  - Homeless Shelters
  - State and Local Correctional Facilities and Detention Centers
- Other Health Care Settings:
  - Acute Psychiatric Hospitals
  - Adult Day Health Care Centers
  - Adult Day Programs Licensed by the California Department of Social Services
  - Program of All-Inclusive Care for the Elderly (PACE) and PACE Centers

- Ambulatory Surgery Centers
- Chemical Dependency Recovery Hospitals
- Clinics & Doctor Offices (including behavioral health, surgical)
- Congregate Living Health Facilities
- Dental Offices
- Dialysis Centers
- Hospice Facilities
- Pediatric Day Health and Respite Care Facilities
- Residential Substance Use Treatment and Mental Health Treatment Facilities

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

   To prevent the further spread of COVID-19 in K-12 school settings, all public and private schools serving students in transitional kindergarten through grade 12 shall comply with the State Health Officer Order, effective August 11, 2021, regarding verification of COVID-19 vaccination status and COVID-19 testing of all workers. A copy of the State Health Officer Order is attached herein as Attachment "**D**" and can be found at the following link:

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

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

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

   To prevent the further spread of COVID-19 in local correctional facilities and detention centers, all individuals identified in the State Health Officer Order, effective February 22, 2022, shall comply with the State Health Officer's Order with regards to obtaining COVID-19 vaccination and booster doses. A copy of the State Health Officer Order is attached herein as Attachment "**E**" and can be found at the following link:

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

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

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

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

Individuals covered by this order include:

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

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

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

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

V. Seasonal Flu Vaccination Order:

Seasonal Flu Vaccination for Certain County Residents.

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

- *Emergency responder* shall mean military or national guard; law enforcement officers; correctional institution personnel; fire fighters; emergency medical services personnel; physicians; nurses; public health personnel; emergency medical technicians; paramedics; emergency management personnel; 911 operators; child welfare workers and service providers; public works personnel; and persons with skills or training in operating specialized equipment or other skills needed to provide aid in a declared emergency; as well as individuals who work for such facilities employing these individuals and whose work is necessary to maintain the operation of the facility.
- *Health care provider* shall mean physicians; psychiatrists; nurses; nurse practitioners; nurse assistants; medical technicians; any other person who is employed to provide diagnostic services, preventive services, treatment services

or other services that are integrated with and necessary to the provision of patient care and, if not provided, would adversely impact patient care; and employees who directly assist or are supervised by a direct provider of diagnostic, preventive, treatment, or other patient care services; and employees who do not provide direct heath care services to a patient but are otherwise integrated into and necessary to the provision those services – for example, a laboratory technician who processes medical test results to aid in the diagnosis and treatment of a health condition. A person is not a health care provider merely because his or her employer provides health care services or because he or she provides a service that affects the provision of health care services. For example, IT professionals, building maintenance staff, human resources personnel, cooks, food services workers, records managers, consultants, and billers are not health care providers, even if they work at a hospital of a similar health care facility.

STRONG RECOMMENDATIONS

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

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

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

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

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

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

- **Workplaces**
  - In workplaces, employers are subject to the Cal/OSHA COVID-19 Prevention Emergency Temporary Standards (ETS) or in some workplaces the Cal/OSHA Aerosol Transmissible Diseases (ATD) Standard (PDF) and should consult those regulations for additional applicable requirements, as modified by the Governor's Executive Order N-5-22. Additional information about how CDPH isolation and quarantine guidance affects ETS-covered workplaces may be found in Cal/OSHA FAQs.

Exposed to COVID-19 or exposure to COVID-19 means sharing the same indoor space (e.g. home, clinic waiting room, airplane, etc.) for a cumulative total of 15 minutes or more over a 24-hour period (for example, three individual 5- minute exposures for a total of 15 minutes) during an infected person's (laboratory-confirmed or a clinical diagnosis) infectious period.

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

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

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

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

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

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

GENERAL PROVISIONS

1. The Orders and Strong Recommendations, above, shall not supersede any conflicting or more restrictive orders issued by the State of California or federal government. If any portion of this document or the application thereof to any person or circumstance is held to be invalid, the remainder of the document, including the application of such part or provision to other persons or circumstances, shall not be affected and shall continue in full force and effect. To this end, the provisions of the orders and strong recommendations are severable.

2. The Orders contained in this document may be enforced by the Orange County Sheriff or Chiefs of Police pursuant to California Health and Safety Code section 101029, and California Government Code sections 26602 and 41601. A violation of a health order is subject to fine, imprisonment, or both (California Health and Safety Code section 120295).

REASONS FOR THE ORDERS AND STRONG RECOMMENDATIONS

1. On February 26, 2020, the County of Orange Health Officer declared a Local Health Emergency based on an imminent and proximate threat to public health from the introduction of COVID-19 in Orange County.

2. On February 26, 2020, the Chairwoman of the Board of Supervisors, acting as the Chair of Emergency Management Council, proclaimed a Local Emergency in that the imminent and proximate threat to public health from the introduction of COVID-19 created conditions of extreme peril to the safety of persons and property within the territorial limits of Orange County.

3. On March 2, 2020, the Orange County Board of Supervisors adopted Resolutions No. 20-011 and No. 20-012 ratifying the Local Health Emergency and Local Emergency, referenced above.

4. On March 4, 2020, the Governor of the State of California declared a State of Emergency to exist in California as a result of the threat of COVID-19.

5. As of March 23, 2022, the County has reported a total of 546,125 recorded confirmed COVID-19 cases and 6,857 of COVID-19 related deaths.

6. As of June 15, 2022, the County has reported a total of 586,120 recorded confirmed COVID-19 cases and 7,076 of COVID-19 related deaths.

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

8. The CDPH issued a revised Guidance for the Use of Face Coverings, effective April 20, 2022, available at: https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/guidance-for-face-coverings.aspx.

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

10. The Orders and the Strong Recommendations contained in this document are based on the following facts, in addition to the facts stated under the foregoing paragraphs: (i) Safe and effective FDA authorized COVID-19 vaccines have become widely available, but newer circulating variants are demonstrating immune escape (ii) the current consensus among public health officials for slowing down the transmission of and avoiding severe COVID illness for at-risk persons is to complete a COVID-19 vaccination series and receive a booster if eligible, wear well-fitted mask in poorly ventilated settings when around others outside of their household, practice distancing, frequently wash hands with soap (iii) some individuals who contract COVID-19 have no symptoms or have only mild symptoms and so are unaware that they carry the virus and are transmitting it to others; (iv) older adults and individuals with medical conditions are at higher risk of severe illness- (v) individuals at higher risk for severe illness should seek medical attention for consideration of COVID therapeutics to reduce risk of hospitalization or death; (vi) sustained COVID-19 community transmission continues to occur; (vii) the age, condition, and health of a portion of Orange County's residents place them at risk for serious health complications, including hospitalization and death, from COVID-19; (vii) younger and otherwise healthy people are also at risk for serious negative health outcomes and for transmitting the novel coronavirus to others.

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

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

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

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

15. The California Health and Safety Code section 120130 (d) authorizes the County of Orange Health Officer to require strict or modified isolation, or quarantine, for any case of contagious, infectious, or communicable disease, when such action is necessary for the protection of the public health.

IT IS SO ORDERED:

Date: June 15, 2022

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

GOVERNMENT CODE - GOV

TITLE 5. LOCAL AGENCIES [50001 - 57607] *(Title 5 added by Stats. 1949, Ch. 81.)*
DIVISION 2. CITIES, COUNTIES, AND OTHER AGENCIES [53000 - 55821] *(Division 2 added by Stats. 1949, Ch. 81.)*
PART 1. POWERS AND DUTIES COMMON TO CITIES, COUNTIES, AND OTHER AGENCIES [53000 - 54999.7] *(Part 1 added by Stats. 1949, Ch. 81.)*

CHAPTER 9. Meetings [54950 - 54963] *(Chapter 9 added by Stats. 1953, Ch. 1588.)*

54953. (a) All meetings of the legislative body of a local agency shall be open and public, and all persons shall be permitted to attend any meeting of the legislative body of a local agency, except as otherwise provided in this chapter.

(b) (1) Notwithstanding any other provision of law, the legislative body of a local agency may use teleconferencing for the benefit of the public and the legislative body of a local agency in connection with any meeting or proceeding authorized by law. The teleconferenced meeting or proceeding shall comply with all otherwise applicable requirements of this chapter and all otherwise applicable provisions of law relating to a specific type of meeting or proceeding.

(2) Teleconferencing, as authorized by this section, may be used for all purposes in connection with any meeting within the subject matter jurisdiction of the legislative body. All votes taken during a teleconferenced meeting shall be by rollcall.

(3) If the legislative body of a local agency elects to use teleconferencing, it shall post agendas at all teleconference locations and conduct teleconference meetings in a manner that protects the statutory and constitutional rights of the parties or the public appearing before the legislative body of a local agency. Each teleconference location shall be identified in the notice and agenda of the meeting or proceeding, and each teleconference location shall be accessible to the public. During the teleconference, at least a quorum of the members of the legislative body shall participate from locations within the boundaries of the territory over which the local agency exercises jurisdiction, except as provided in subdivisions (d) and (e). The agenda shall provide an opportunity for members of the public to address the legislative body directly pursuant to Section 54954.3 at each teleconference location.

(4) For the purposes of this section, “teleconference” means a meeting of a legislative body, the members of which are in different locations, connected by electronic means, through either audio or video, or both. Nothing in this section shall prohibit a local agency from providing the public with additional teleconference locations.

(c) (1) No legislative body shall take action by secret ballot, whether preliminary or final.

(2) The legislative body of a local agency shall publicly report any action taken and the vote or abstention on that action of each member present for the action.

(3) Prior to taking final action, the legislative body shall orally report a summary of a recommendation for a final action on the salaries, salary schedules, or compensation paid in the form of fringe benefits of a local agency executive, as defined in subdivision (d) of Section 3511.1, during the open meeting in which the final action is to be taken. This paragraph shall not affect the public’s right under the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1) to inspect or copy records created or received in the process of developing the recommendation.

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(d) (1) Notwithstanding the provisions relating to a quorum in paragraph (3) of subdivision (b), if a health authority conducts a teleconference meeting, members who are outside the jurisdiction of the authority may be counted toward the establishment of a quorum when participating in the teleconference if at least 50 percent of the number of members that would establish a quorum are present within the boundaries of the territory over which the authority exercises jurisdiction, and the health authority provides a teleconference number, and associated access codes, if any, that allows any person to call in to participate in the meeting and the number and access codes are identified in the notice and agenda of the meeting.

(2) Nothing in this subdivision shall be construed as discouraging health authority members from regularly meeting at a common physical site within the jurisdiction of the authority or from using teleconference locations within or near the jurisdiction of the authority. A teleconference meeting for which a quorum is established pursuant to this subdivision shall be subject to all other requirements of this section.

(3) For purposes of this subdivision, a health authority means any entity created pursuant to Sections 14018.7, 14087.31, 14087.35, 14087.36, 14087.38, and 14087.9605 of the Welfare and Institutions Code, any joint powers authority created pursuant to Article 1 (commencing with Section 6500) of Chapter 5 of Division 7 for the purpose of contracting pursuant to Section 14087.3 of the Welfare and Institutions Code, and any advisory committee to a county-sponsored health plan licensed pursuant to Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code if the advisory committee has 12 or more members.

(e) (1) A local agency may use teleconferencing without complying with the requirements of paragraph (3) of subdivision (b) if the legislative body complies with the requirements of paragraph (2) of this subdivision in any of the following circumstances:

(A) The legislative body holds a meeting during a proclaimed state of emergency, and state or local officials have imposed or recommended measures to promote social distancing.

(B) The legislative body holds a meeting during a proclaimed state of emergency for the purpose of determining, by majority vote, whether as a result of the emergency, meeting in person would present imminent risks to the health or safety of attendees.

(C) The legislative body holds a meeting during a proclaimed state of emergency and has determined, by majority vote, pursuant to subparagraph (B), that, as a result of the emergency, meeting in person would present imminent risks to the health or safety of attendees.

(2) A legislative body that holds a meeting pursuant to this subdivision shall do all of the following:

(A) The legislative body shall give notice of the meeting and post agendas as otherwise required by this chapter.

(B) The legislative body shall allow members of the public to access the meeting and the agenda shall provide an opportunity for members of the public to address the legislative body directly pursuant to Section 54954.3. In each instance in which notice of the time of the teleconferenced meeting is otherwise given or the agenda for the meeting is otherwise posted, the legislative body shall also give notice of the means by which members of the public may access the meeting and offer public comment. The agenda shall identify and include an opportunity for all persons to attend via a call-in option or an internet-based service option. This subparagraph shall not be construed to require the legislative body to provide a physical location from which the public may attend or comment.

(C) The legislative body shall conduct teleconference meetings in a manner that protects the statutory and constitutional rights of the parties and the public appearing before the legislative body of a local agency.

(D) In the event of a disruption which prevents the public agency from broadcasting the meeting to members of the public using the call-in option or internet-based service option, or in the event of a disruption within the local agency's control which prevents members of the public from offering public comments using the call-in option or internet-based

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service option is restored. Actions taken on agenda items during a disruption which prevents the public agency from broadcasting the meeting may be challenged pursuant to Section 54960.1.

(E) The legislative body shall not require public comments to be submitted in advance of the meeting and must provide an opportunity for the public to address the legislative body and offer comment in real time. This subparagraph shall not be construed to require the legislative body to provide a physical location from which the public may attend or comment.

(F) Notwithstanding Section 54953.3, an individual desiring to provide public comment through the use of an internet website, or other online platform, not under the control of the local legislative body, that requires registration to log in to a teleconference may be required to register as required by the third-party internet website or online platform to participate.

(G) (i) A legislative body that provides a timed public comment period for each agenda item shall not close the public comment period for the agenda item, or the opportunity to register, pursuant to subparagraph (F), to provide public comment until that timed public comment period has elapsed.

(ii) A legislative body that does not provide a timed public comment period, but takes public comment separately on each agenda item, shall allow a reasonable amount of time per agenda item to allow public members the opportunity to provide public comment, including time for members of the public to register pursuant to subparagraph (F), or otherwise be recognized for the purpose of providing public comment.

(iii) A legislative body that provides a timed general public comment period that does not correspond to a specific agenda item shall not close the public comment period or the opportunity to register, pursuant to subparagraph (F), until the timed general public comment period has elapsed.

(3) If a state of emergency remains active, or state or local officials have imposed or recommended measures to promote social distancing, in order to continue to teleconference without compliance with paragraph (3) of subdivision (b), the legislative body shall, not later than 30 days after teleconferencing for the first time pursuant to subparagraph (A), (B), or (C) of paragraph (1), and every 30 days thereafter, make the following findings by majority vote:

(A) The legislative body has reconsidered the circumstances of the state of emergency.

(B) Any of the following circumstances exist:

(i) The state of emergency continues to directly impact the ability of the members to meet safely in person.

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

(4) For the purposes of this subdivision, “state of emergency” means a state of emergency proclaimed pursuant to Section 8625 of the California Emergency Services Act (Article 1 (commencing with Section 8550) of Chapter 7 of Division 1 of Title 2).

(f) This section shall remain in effect only until January 1, 2024, and as of that date is repealed.

(Amended by Stats. 2021, Ch. 165, Sec. 3. (AB 361) Effective September 16, 2021. Repealed as of January 1, 2024, by its own provisions. See later operative version added by Sec. 4 of Stats. 2021, Ch. 165.)

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 4, 2022
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

4. Ratify Amendment to the Ancillary Services Contract with Infomedia Group Inc., dba Carenet Healthcare Services

Contacts

Richard Pitts, D.O., Ph.D., Chief Medical Officer, (714) 246-8491
Marie Jeannis, R.N., Executive Director, Quality & Population Health Management, (714) 246-8591

Recommended Actions

Ratify Amendment to CalOptima's Medi-Cal, OneCare, and OneCare Connect Ancillary Services Contract with Infomedia Group Inc., dba Carenet Healthcare Services (Carenet), to reflect additional support services, revise the payment terms, and exercise the first one-year option to extend the contract term through June 30, 2023.

Background

Staff requests the CalOptima Board of Directors (Board) ratify an amendment to CalOptima's Ancillary Services Contract with Carenet, reflecting additional support services, revised payment terms, and a one-year extension of the contract through June 30, 2023.

Nurse Advice Line and after-hours support for customer service and behavioral health are regulatory requirements. In 2019, CalOptima delegated these services and issued a request for proposal (RFP) for an outside vendor to manage the 24/7 Nurse Advice Line and after-hours calls for CalOptima's Customer Service and Behavioral Health Integration departments. Carenet was selected through the RFP process, and CalOptima entered into a three-year (3) contract with Carenet, effective July 1, 2019, through June 30, 2022.

In July 2021, CalOptima and Carenet amended the contract to add member engagement outreach for COVID-19 Vaccine appointment scheduling, quality measures and gaps in care initiatives, welcome/onboarding calls, and telephonic health assessments. The amendment also contained language reflecting the provision of two (2) additional one-year (1) extension options, until June 30, 2024.

In March 2022, CalOptima's Board approved the CalFresh Outreach Strategy to address food insecurity by streamlining the process for CalOptima members to enroll in CalFresh. Carenet's member engagement services have expanded to support member outreach for CalFresh enrollment.

Discussion

CalOptima would like to exercise the first of the two one (1)-year renewal options to extend the current agreement through June 30, 2023. The amendment includes continuation of Nurse Advice Line and after-hours support for customer service and behavioral health, expanded member engagement, and interactive voice response messaging. The Carenet Contract agreement is included in the Fiscal Year 2022-2023 operating budget.

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To maintain the support services Carenet provides CalOptima's members, the contract amendment was executed on July 1, 2022. Staff requests that the Board ratify the amendment to CalOptima's Medi-Cal, OneCare, and OneCare Connect Ancillary Services contract with Carenet. Staff will evaluate the need to perform an RFP for these services prior to the end of the current contract term on June 30, 2023.

Fiscal Impact

The recommended action is a budgeted item under the Fiscal Year 2022-23 Operating Budget approved by the Board of June 2, 2022. Management will include medical expenses related to the rate increase in future operating budgets.

Rationale for Recommendation

The recommended action will allow CalOptima to continue to meet regulatory requirements for Nurse Advice Line Services and after-hours call support and to support timely member engagement activities.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Entities Covered by this Recommended Action
2. July 1, 2022_Carenet Healthcare Services- Amendment 2
3. June 25, 2021_Carenet Healthcare Services- Amendment 1 (Adds Member Engagement)
4. Infomedia Contract 190701 - Original Contract

Board Action

Board Meeting Dates	Action	Term	Not to Exceed Amount
June 3, 2021	Consider Authorizing Amendment to Contract with Infomedia Group, Inc., dba Carenet Healthcare Services to Support Member Outreach Calls	July 1, 2019 – June 30, 2022	

/s/ Michael Hunn *07/28/2022*
Authorized Signature **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Infomedia Group Inc., dba Carenet Healthcare Services	11845 IH-10 West, Suite 400	San Antonio	TX	78230

AMENDMENT 2 TO
ANCILLARY SERVICES CONTRACT
NON-MEDICAL PROVIDER

THIS AMENDMENT 2 TO THE ANCILLARY SERVICES CONTRACT ("Amendment 2") is effective **July 1, 2022** ("Amendment Effective Date") by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and Infomedia Group, Inc., dba **Carenet Healthcare Services** ("Provider"), with respect to the following facts:

RECITALS

A. CalOptima and Provider entered into an Ancillary Services Contract, effective July 1, 2019, ("**Contract**") under which Provider provides or arranges for the provision of Covered Services to Members.

B. CalOptima and Provider desire to amend this Contract on the terms and conditions set forth herein.

NOW, THEREFORE, the parties agree as follows:

1. Section 7.1 "Term" shall be deleted in its entirety and replaced with the following new Section 7.1:

"7.1 Term. The term of this Contract shall become effective as of the Effective Date and continue for a three (3)-year period, ending on June 30, 2022 ("**Initial Term**"). Upon written notice to Provider prior to the completion of the Initial Term, CalOptima may exercise the option to renew the Contract for an additional one-year extension, in which case the Contract will remain in effect until June 30, 2023. CalOptima may then, at its sole discretion, extend this Contract for additional one (1)-year terms, upon approval by the CalOptima Board of Directors, unless earlier terminated by either Party as provided for in this Contract."

2. Section 7.6 "Termination Without Cause" shall be deleted in its entirety and replaced with the following new Section 7.6:

"7.6 Termination Without Cause. Either party may terminate this Contract, without cause, upon one hundred eighty (180) days' prior written notice to the other party."

3. Section 9.13 shall be added to the Contract as follows:

"9.13 Dispute Resolution.

9.13.1 Meet and Confer. For any dispute not subject to or resolved by the provider appeals process, or if either party to this Contract has a dispute it seeks to address informally, the parties shall use reasonable efforts to informally meet and confer to try and resolve the dispute. The parties shall meet and confer within thirty (30) days of a written request submitted by either party in an effort to settle any dispute. At each meet-and-confer meeting, each party shall be represented by persons with final authority to settle the dispute. If either party fails to meet within the thirty (30)-day period, that party shall be deemed to have waived the meet-and-confer requirement, and at the other party's option, the dispute may proceed immediately to arbitration under Section 9.13.2.

9.13.2 Arbitration. If the parties are unable to resolve any dispute arising out of or relating to this Contract under Section 9.13.1, either party may submit the dispute for resolution exclusively through confidential, binding arbitration, instead of through trial by court or jury, in Orange County, California. The parties may agree in writing prior to commencing the arbitration on the dispute resolution rules and arbitration service that will be used to resolve the dispute. If the parties cannot reach such an agreement, the arbitration will be conducted by Judicial Arbitration and Mediation Services ("JAMS") in accordance with the commercial dispute rules then in effect for JAMS; provided, however, that this

Contract shall control in instances where it conflicts with JAMS's (or the applicable arbitration service's) rules. The arbitration shall be conducted on an expedited basis by a single arbitrator. The parties prefer that the arbitrator be a retired judge of the California Superior, Appellate, or Supreme Court or of a United States court sitting in California. If no such retired judge is available, the arbitrator may be an attorney with at least fifteen (15) years of experience, including at least five (5) years in managed health care. If the parties are unable to agree on the arbitrator within thirty (30) days of the date that the arbitration service accepts the arbitration, the arbitrator shall be selected by the arbitration service from a list of four potential arbitrators (all of whom shall be on arbitration services' panel of arbitrators) submitted by the parties, two from each side; provided, however, that nothing stated in this section shall prevent a party from disqualifying an arbitrator based on a conflict of interest. In making decisions about discovery and case management, it is the parties' express agreement and intent that the arbitrator at all times promote efficiency without denying either party the ability to present relevant evidence. In reaching and issuing decisions, the arbitrator shall have no jurisdiction to make errors of law and/or legal reasoning. The parties shall share the costs of arbitration equally, and each party shall bear its own attorneys' fees and costs.

9.13.3 Exclusive Remedy. With the exception of any dispute that under applicable laws may not be settled through arbitration, arbitration under Section 9.13.2 is the exclusive method to resolve a dispute between the Parties arising out of or relating to this Contract that is not resolved through the provider appeals or meet-and-confer processes

9.13.4 Waiver. By agreeing to binding arbitration as set forth in Section 9.13.2, the parties acknowledge that they are waiving certain substantial rights and protections which otherwise may be available if a dispute between them was determined by litigation in a court, including the right to a jury trial, attorneys' fees, and certain rights of appeal."

4. ATTACHMENT A – AMENDMENT I, COVERED SERVICES shall be deleted in its entirety and replaced with the new ATTACHMENT A - COVERED SERVICES, which is attached to this Amendment II and incorporated into the Agreement by this reference.

5. ATTACHMENT C – AMENDMENT I, COMPENSATION shall be deleted in its entirety and replaced with the new ATTACHMENT C – COMPENSATION, which is attached to this Amendment II and incorporated into the Agreement by this reference.

6. CONTRACT REMAINS IN FULL FORCE AND EFFECT – Except as specifically amended by this Amendment 2, all other conditions contained in the Contract shall continue in full force and effect. After the effective date of this Amendment, any reference to the Contract shall mean the Contract as amended and supplemented by this Amendment. Notwithstanding anything to the contrary in the Contract, in the event of a conflict between the terms and conditions of this Amendment and those contained within the Contract, the terms and conditions of this Amendment shall prevail. Capitalized terms not otherwise defined in this Amendment shall have the meanings ascribed to them in the Contract.

[signature page follows]

IN WITNESS WHEREOF, CalOptima and Provider have executed this Amendment 2.

FOR PROVIDER:	FOR CALOPTIMA:
VIKIE SPULAK Signed: 7/1/2022	Yunkyung Kim Yunkyung Kim (Jul 1, 2022 14:52 PDT)
Signature	Signature
Vikie Spulak	Yunkyung Kim
Print Name	Print Name
EVP Client Success	Chief Operating Officer
Title	Title
7/1/2022	Jul 1, 2022
Date	Date

ATTACHMENT A

COVERED SERVICES

ARTICLE 1
CALOPTIMA PROGRAMS

1.1 CalOptima Programs. Provider shall furnish Covered Services to eligible Members in the following CalOptima Programs:

___X___ Medi-Cal Program

___X___ Medicare Advantage Program (OneCare)

_____ PACE Program

___X___ Cal MediConnect Program/OneCare Connect (Members Dually Eligible for Medicare and Medi-Cal)

ARTICLE 2
SERVICES

SCOPE OF WORK

1. NURSE ADVICE LINE

Provider shall provide the following services:

- Customer service support for call center for Members and providers
- Customer service and clinical support for behavioral health line to Members and providers
- Customer service and clinical support for nurse advice line to Members
- Engagement strategies to support welcome calls, program reminders, and notifications for Members

Provider shall uphold requirements identified in the RFP at the same level of professional customer service as CalOptima staff provides, including the following service levels:

- Answer eighty percent (80%) of calls within thirty (30) seconds
- Maintain an abandoned call ("ABD") rate of five percent (5%) or less
- Maintain an Average Speed of Answer ("ASA") of thirty (30) seconds or less
- Provider will measure and report results for 80/30 and 30 second ASA; however, performance will only be measured against 80/30

All calls shall be answered by an actual individual employed by Provider, and Provider shall be transparent to the callers. The service level guarantees standard shall be maintained throughout the term of the Contract. Provider's staffing levels shall be adequate to handle the volume of calls received from CalOptima's Members and providers.

For each month in which any or all of the performance standards are not met, Provider will give CalOptima a fee credit of four percent (4%) for the calendar month. The parties agree that Force Majeure conditions as defined in the ANCILLARY SERVICES CONTRACT (i.e. Covid-19 pandemic that result in a non-compliance with the service levels will not result in damages, penalties, or withholding or offset of fees.

2. MEMBER ENGAGEMENT

2.1 Program Services Overview.

The Member engagement program shall consist of outbound telephonic and other engagement activities for Members. This will include, but will not be limited to,

COVID-19 outreach, welcome/onboarding calls, telephonic health assessments, appointment facilitation to address HEDIS measures, Public Health Emergency (PHE) Redetermination IVR campaign, risk adjustment, CalFresh or other gaps in care, post-discharge, or other outreach initiatives.

2.1.1 Provider shall perform 2,000 live outreach calls to the identified CalOptima Members per CalOptima's fiscal year. (July 1 – June 30)

2.1.2 Provider shall attempt to reach each Member a maximum of three (3) times.

2.1.3 Hours of operation for Member engagement will be 8 a.m. to 9 p.m. Pacific Standard Time, Monday through Saturday.

2.1.4 CalOptima shall send Provider eligible Member demographic information.

2.1.5 Provider shall provide CalOptima with standard reports and a data extract with all call details.

2.1.6 Provider shall provide complimentary allotment of 375,000 Interactive Voice Recording Calls as described in Attachment C - Compensation

For COVID-19 outreach, Provider shall make warm transfers to CalOptima to schedule vaccination with the Member.

2.2 **CalOptima Direction.** These services will only be provided by Provider at the direction of CalOptima, using approved CalOptima scripts and only to numbers that CalOptima has certified as meeting the requirements of the Telephone Consumer Protection ACT ("TCPA"), 42 U.S.C., Section 227.

ATTACHMENT C

COMPENSATION

CalOptima shall reimburse Provider, and Provider shall accept as payment in full from CalOptima for all services rendered under the Contract, the lesser of Provider's billed charges or the following amounts:

I. Nurse Advise Line:

CalOptima shall reimburse Provider for Covered Services as follows:

The monthly fees based on a per call model

Per Call Fee:	$28.75 per clinician call answered $5.60 per non-clinician call answered
Total call volume:	Pricing is based on a minimum 700 clinician calls answered per month, and 3,000 non-clinician calls answered per month
Language Services: Interpretation Services	$1.50 per minute

II. Member Engagement:

Live Outbound Calls: Live Outbound calls include complementary allotment of up to 2,000 calls per CalOptima's fiscal year (July – June). Any modifications to the outbound program set-up, to include script changes, reporting or file format, development, will be at the Professional Services Rate. Prior to work commencing, a time and cost effort will be provided to CalOptima for approval.

Additional CalOptima requests over the complementary 2,000 live outbound calls, , CalOptima shall reimburse Provider for Covered Services as follows:

$3.75 per call

Provider shall not charge, and CalOptima will not reimburse Provider, for the first 2,000 live outbound calls to the identified CalOptima Members per CalOptima's fiscal year (July – June).

Provider shall not charge, and CalOptima will not reimburse Provider, for invalid dialer detected numbers (disconnected, bad number or fax).

Any invalid numbers shall not count as part of the 2,000 calls per fiscal year, for which there is no separate charge, and for which CalOptima will not reimburse Provider.

Provider shall attempt to reach each Member a maximum of three (3) times. Average call length will not exceed three (3) minutes.

Program Support – Any standard maintenance and support services requested by CalOptima related to Member Engagement is included in this pricing unless additional campaigns are requested as identified in any modifications to the outbound program set-up, to include script changes, reporting or file format, development, will be at the Professional Services Rate. Prior to work commencing, a time and cost effort will be provided to CalOptima for approval.

Member Engagement Strategies – Interactive Voice Recording described below.

Member Engagement Strategies – Interactive Voice Recording (IVR). IVR/Automated messaging technologies include complementary allotment of up to 375,000 IVR calls per CalOptima's fiscal year (July – June). Provider will provide individual quote for CalOptima IVR campaign requests over the 375,000 allotments. These 375,000 IVR calls shall be limited to two (2) unique scripts per year. Additional unique scripts will be billed in accordance with the Professional Services Rates in Section III of this Attachment C.

III. Professional Services Rates:

Professional Services	Hourly Rate
Application Development/Programming/IT Professional Services and launching/delivery of a new campaign or modification to an existing campaign.	$150.00
Marketing and Creative Services	$125.00
Client Relationship Manager	$85.00
Program Support – Any maintenance and support services requested by CalOptima that are outside Provider's standard service described in this SOW	$65.00
Curriculum and Training Materials Development	$85.00
Training Delivery (Hours required by the trainer to train each class)	$85.00
Clinical Employee Program Training	$75.00/per person
Non-Clinical Employee Program Training	$32.00/per person
Any audit, compliance, including delegation oversight audit requests, quality inspections, or any general inspections requests (> 5 hours per/annual contract)	$85.00
CalOptima-Requested Travel	At Cost, as Prior Approved by CalOptima

IV. Payment Procedures:

Provider shall bill CalOptima with the assigned purchased order, and the invoice shall include a Unique Member Engagement Outreach Monthly Totals.

CalOptima agrees to make a payment to Provider of undisputed amounts within thirty (30) business days from receipt of an invoice services provided by Provider under this Contract.

Record of Signing

For

Name VIKIE SPULAK

Title EVP Client Success

Signed on 2022-07-01 13:09:05 GMT

Secured by Concord™
DocumentID: ZWExZTVkZDEtZj
SigningID: YTY5NTllODQtMD
Signing date: 7/1/2022
IP Address: 96.8.132.84
Email: vspulak@carenethealthcare.com

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AMENDMENT 1 TO
ANCILLARY SERVICES CONTRACT

THIS AMENDMENT 1 TO THE ANCILLARY SERVICES CONTRACT ("Amendment 1") is effective as of **June 3, 2021**, by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and Infomedia Group, Inc., dba **Carenet Healthcare Services** ("Provider"), with respect to the following facts:

RECITALS

A. CalOptima and Provider entered into an Ancillary Services Contract, by which Provider has agreed to provide or arrange for the provision of Covered Services to Members.

B. CalOptima and Provider desire to amend this Contract to replace the Term section of the Contract and include Member Engagement Services

NOW, THEREFORE, the parties agree as follows:

1. Section 7.1 "Term" shall be deleted in its entirety and replaced with the following:

   "7.1 Term. This Contract will commence on July 1, 2019 ("Effective Date") and will remain in effect until June 30, 2022. This Contract may be renewed at CalOptima's option for two additional one-year periods."

2. ATTACHMENT A, COVERED SERVICES shall be deleted in its entirety and replaced with the new ATTACHMENT A, COVERED SERVICES attached herein.

3. ATTACHMENT C, COMPENSATION shall be deleted in its entirety and replaced with the new ATTACHMENT C, COMPENSATION attached herein.

4. CONTRACT REMAINS IN FULL FORCE AND EFFECT – Except as specifically amended by this Amendment I, all other conditions contained in the Contract as previously amended shall continue in full force and effect.

IN WITNESS WHEREOF, CalOptima and Provider have executed this Amendment 1.

FOR PROVIDER:	FOR CALOPTIMA:
VIKIE SPULAK VIKIE SPULAK (Jun 25, 2021 10:48 CDT)	Ladan Khamseh Ladan Khamseh (Jun 25, 2021 09:04 PDT)
Signature	Signature
VIKIE SPULAK	Ladan Khamseh
Print Name	Print Name
CCO	Chief Operating Officer
Title	Title
Jun 25, 2021	Jun 25, 2021
Date	Date

ATTACHMENT A

COVERED SERVICES

ARTICLE 1
CALOPTIMA PROGRAMS

1.1 CalOptima Programs. Provider shall furnish Covered Services to eligible Members in the following CalOptima Programs:

__X__ Medi-Cal Program

__X__ Medicare Advantage Program (OneCare)

_____ PACE Program

__X__ Cal MediConnect Program/OneCare Connect (Members Dually Eligible for Medicare and Medi-Cal)

ARTICLE 2
SERVICES

SCOPE OF WORK

1. NURSE ADVICE LINE

Provider shall provide the following services:

- Customer service support for Call Center to CalOptima's Members and providers
- Customer service and clinical support for Behavioral Health Line to CalOptima Members and providers
- Customer service and clinical support for Nurse Advice Line to CalOptima's Members
- Engagement Strategies to support welcome calls, program reminders, notifications

Provider shall perform all service level guarantees and requirements per the RFP.

2. MEMBER ENGAGEMENT

The services will only be provided at the direction of CalOptima, using approved CalOptima scripts, and only to numbers that CalOptima has certified as meeting the requirements of the Telephone Consumer Protection Act (TCPA), 42 U.S.C., Section 227.

2.1 PROGRAM OVERVIEW

The program shall consist of outbound telephonic and other engagement activities for CalOptima Members. This will include, but will not be limited to, COVID-19 outreach, welcome/onboarding calls, telephonic health assessments, appointment facilitation to address HEDIS measures, Risk Adjustment, or other gaps in care, post-discharge, or other outreach initiatives.

2.1.1 Provider shall perform 2,000 live outreach calls to the identified CalOptima Members per fiscal year.

2.1.2 Provider shall attempt to reach each Member a maximum of three times.

2.1.3 Hours of Operation will be 8 am to 9 pm Pacific Standard Time, Monday through Saturday.

2.1.4 CalOptima shall send Provider eligible Member demographic information.

2.1.5 Provider shall provide CalOptima with standard reports and a data extract with all call details.

2.1.6 For COVID-19 outreach, Provider shall make warm transfers to CalOptima to schedule vaccination with the Member.

ATTACHMENT C

COMPENSATION

CalOptima shall reimburse Provider, and Provider shall accept as payment in full from CalOptima, the lesser of billed charges or the following amounts:

I. Nurse Advice Line:

CalOptima shall reimburse for Covered Services as follows:

$0.0575 PMPM

II. Member Engagement:

If CalOptima requests over 2,000 live outbound calls per fiscal year, CalOptima shall reimburse for Covered Services as follows:

$3.75 per call

Provider shall not charge and CalOptima will not reimburse for the first 2,000 live outbound calls to the identified CalOptima Members per fiscal year.

Provider shall not charge and CalOptima shall not reimburse for invalid numbers (disconnected, bad, fax, etc.)

Any invalid numbers shall not count as part of the 2,000 calls per fiscal year, for which there is no separate charge, and for which CalOptima shall not reimburse.

III. Payment Procedures:

Provider shall bill with the assigned purchased order, and invoice shall include a Unique Member Engagement Outreach Monthly Totals.

CalOptima agrees to make a payment within thirty (30) business days from receipt of an invoice services provided by Provider under this contract.

Infomedia Group, Inc., dba Carenet Healthcare Services - Ancillary Services [MCal; OC; OCC], Amendment 1

Final Audit Report 2021-06-25

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Agreement completed.

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Contract Summary Transmittal Form

Provider(s):	**Infomedia Group, Inc. dba Carenet Healthcare Services** 11845 IH 10 West, Suite 400 San Antonio, TX 78230 Contacts & Amendments: David Dreggors, Business Development ddreggors@carenethealthcare.com
TIN:	71-0879286
NPI:	N/A
Type of provider:	Ancillary
Specialty:	Call Center Support & Nurse Triage Services
Line of Business:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☐ PACE ☐ MSSP
Type of Document:	☒ Contract ☐ BAA Agreement ☐ Amendment ☐ Delegation Agreement ☐ Rate Amendment ☐ Certified Extension Letter for Renewal
FDR packet notification (for delegated or non-healthcare provider)	☐ Yes ☒ No
Credentialing completed by QI - (for new contracts only):	☐ Yes Date: _____ ☒ N/A Comments: _____
NetworX Agreement Pricing Code	N/A
Effective date of Initial Agreement:	07/01/2019
Effective date of Amendment:	N/A
Termination date of Agreement:	☐ _____ ☒ Renew for additional one-year term with Board Approval
Contract justification: New Carenet contract as a result of RFP. This contract will replace the existing Carenet contract.	
Financial justification: N/A	
Negotiator:	Ryan Aleshire
Date:	06/12/2019
File path for scanned contract/ amendment: R:\Contracts Read Only\ANCILLARY CAPITATED CONTRACTS\Nurse Advice Line	
File path for credentialing documentation (new contracts only): N/A	

ANCILLARY SERVICES CONTRACT

NON-MEDICAL PROVIDER

This Ancillary Services Contract (the "Contract") is entered into by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and **Infomedia Group, Inc. dba Carenet Healthcare Services** ("Provider"), with respect to the following:

RECITALS

A. CalOptima was formed pursuant to California Welfare and Institutions Code Section 14087.54 and Orange County Ordinance No. 3896, as amended by Ordinance Nos. 00-8 and 05-008, as a result of the efforts of the Orange County health care community.

B. CalOptima has entered into a contract with the State of California, Department of Health Care Services ("DHCS") ("DHCS Contract"), pursuant to which it is obligated to arrange and pay for the provision of health care services to certain Medi-Cal eligible beneficiaries in Orange County (referred to herein as the "Medi-Cal Program").

C. CalOptima has entered into a contract with the Department of Health and Human Services ("DHHS"), Centers for Medicare and Medicaid Services ("CMS"), to operate a Medicare Advantage ("MA") plan pursuant to Title II of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub. L. 108-73) ("MMA"), and to offer Medicare covered items and services to eligible individuals (referred to herein as the "OneCare Program"). CalOptima, as a dual-eligible Special Needs Plan (dual SNP), may only enroll those dual eligible individuals who meet all applicable Medicare Advantage eligibility requirements, and who are eligible to be enrolled in CalOptima's Medi-Cal Managed Care plan, as described in the contract between CalOptima and the California Department of Health Care Services (DHCS).

D. CalOptima has entered into a participation contract with the State of California, acting by and through the Department of Health Care Services ("DHCS" or "State"), and the Department of Health and Human Services ("HHS"), acting by and through the Centers for Medicare & Medicaid Services ("CMS"), to furnish health care services to Medicare/Medi-Cal enrollees who are enrolled in CalOptima's Cal MediConnect program ("DHCS/CMS Cal MediConnect Contract").

E. CalOptima has entered into a contract with the Centers for Medicare and Medicaid Services ("CMS") to operate a Program of All-Inclusive Care for the Elderly ("PACE") as a PACE Organization for the purposes set forth in sections 1894 and 1934 of the Social Security Act, and to offer eligible individuals services through PACE.

F. Provider is a provider of the items and services described in this Contract and has all certifications, licenses and permits necessary to furnish such items and services.

G. CalOptima has entered into an agreement with the California Department of Aging to operate as a program site under the Multipurpose Senior Services Program, a case management program with the goal of avoiding or delaying inappropriate placement of persons in nursing facilities, while fostering independent living in the community, as provided by Welfare and Institutions Code section 9560 et seq. As a program site, CalOptima is responsible for arranging for MSSP services for certain CalOptima members.

H. CalOptima desires to engage Provider to furnish, and Provider desires to furnish, certain items and services to CalOptima Members as described herein. CalOptima and Provider desire to enter into this Contract on the terms and conditions set forth herein below.

NOW, THEREFORE, the parties agree as follows:

ARTICLE 1
DEFINITIONS

The following definitions, and any additional definitions set forth in Attachments and Schedules attached hereto, apply to the terms set forth in this Contract

1.1 "Cal MediConnect" means a program to furnish health care services to Medicare/Medi-Cal members who are enrolled in CalOptima's Cal MediConnect Program. Cal MediConnect is also referred to as OneCare Connect.

1.2 "California Children Services Program" or "CCS" means a public health program, which assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of twenty-one (2l) years who have CCS eligible conditions, as defined in Title 22, California Code of Regulations (CCR), and Section 41800.

1.3 "CDA" means the California Department of Aging.

1.4 "CalOptima Direct" or "COD" means a program CalOptima administers for CalOptima beneficiaries not enrolled in a Health Network. COD consists of two components:

1.4.1 CalOptima Direct Members who are assigned to CalOptima's Community Network in accordance with CalOptima policy. Members are assigned to Primary Care Physicians (PCP) as their medical home, and their care is coordinated through their PCP in the Community Network.

1.4.2 "CalOptima Direct-Administrative" or "COD-Administrative" provides services to Members who reside outside of CalOptima's service area, are transitioning into a Heath Network, have a Medi-Cal Share of Cost, or are eligible for both Medicare and Medi-Cal. These Members are free to select any registered Practitioner for Physician services.

1.5 "CalOptima Policies" means CalOptima policies and procedures relevant to this Contract, as amended from time to time at the sole discretion of CalOptima.

1.6 "CalOptima Programs" means the Medi-Cal, OneCare, Multipurpose Senior Service Program (MSSP), Program of All-Inclusive Care for the Elderly (PACE) and Cal MediConnect (OneCare Connect) programs administered by CalOptima. Provider participates in the specific CalOptima Program(s) identified on Attachment A.

1.7 "CalOptima's Regulators" means those government agencies that regulate and oversee CalOptima's and its first tier downstream and/or related entity's ("FDR's") activities and obligations under this Contract including, without limitation, the Department of Health and Human Services, the Centers for Medicare and Medicaid Services, the California Department of Health Care Services, and the California Department of Managed Health Care and other government agencies that have authority to set standards and oversee the performance of the parties to this Contract.

1.8 "Claim" means a request for payment submitted by Provider in accordance with this Contract and CalOptima Policies.

1.9 "Clean Claim" means a Claim or invoice that has no defects or improprieties, contains all required supporting documentation, passes all system edits, and does not require any additional reviews by medical staff to determine appropriateness of services provided as defined in the CalOptima Program(s).

1.10 "Community Network" means CalOptima's direct health network that serves members who are enrolled in it pursuant to CalOptima Policies. Community Network Members are assigned to Primary Care Providers as their medical home, and their care is coordinated through the PCP.

1.11 "Compliance Program" means the program (including, without limitation, the compliance manual, code of conduct and CalOptima Policies) developed and adopted by CalOptima to promote, monitor and ensure that CalOptima's operations and practices and the practices of the members of

its Board of Directors, employees, contractors and providers comply with applicable law and ethical standards. The Compliance Program includes CalOptima's Fraud, Waste and Abuse ("FWA") plan.

1.12 "Covered Services" means those items and services available to Members set forth in Attachment A of this Contract.

1.13 "Effective Date" means the effective date of commencement of the Contract as provided in Article 10.

1.14 "Encounter Data" means the record of a Member receiving any items(s) or service(s) provided through Medicaid or Medicare under a prepaid, capitated or any other risk basis payment methodology submitted to CMS. The Encounter Data record shall incorporate HIPAA security, privacy, and transaction standards and be submitted in ASCX12N 837 or any successor format required by CalOptima's Regulators."

1.15 "Government Agencies" means Federal and State agencies that are parties to the Government Contracts including, HHS/CMS, DHCS, DMHC, and their respective agents and contractors, including quality improvement organizations (QIOs).

1.16 "Government Contract(s)" means the written contract(s) between CalOptima and the Federal and/or State government pursuant to which CalOptima administers and pays for covered items and services under a CalOptima Program.

1.17 "Government Guidance" means Federal and State operational and other instructions related to the coverage, payment and/or administration of CalOptima Program(s).

1.18 "Health Network" means a physician group, physician-hospital consortium or health care service plan, such as an HMO, which is contracted with CalOptima to provide items and services to non-COD Members on a capitated basis.

1.19 "Licenses" means all licenses and permits that Provider is required to have in order to participate in the CalOptima Programs and/or furnish the items and/or services described under this Contract.

1.20 "Medi-Cal" is the name of the Medicaid program for the State of California (*i.e.,* the program authorized by Title XIX of the Federal Social Security Act and the regulations promulgated thereunder).

1.21 "Medicare" means the Federal health insurance program defined in Title XVIII of the Federal Social Security Act and regulations promulgated thereunder.

1.22 "Member" means any person who has been determined to be eligible to receive benefits from, and is enrolled in, one or more CalOptima Program. Member may also be referred to as Enrollee or Participant depending on the CalOptima Program.

1.23 "Memorandum/Memoranda of Understanding" or "MOU" means an agreement(s) between CalOptima and an external agency(ies), which delineates responsibilities for coordinating care to CalOptima Members.

1.24 "MSSP" means Multipurpose Senior Services Program, as provided by W&I section 9560 et seq.

1.25 "Participation Status" means whether or not a person or entity is or has been suspended or excluded from participation in Federal and/or State health care programs and/or has a felony conviction (if applicable) as specified in CalOptima's Compliance Program and CalOptima Policies.

1.26 "Program of All-Inclusive Care for the Elderly" or "PACE" means a program that features a comprehensive medical and social services delivery system using an Interdisciplinary Team (IDT) approach in an adult day health center that is supplemented by in-home and referral services, in accordance with the enrollee's needs. The IDT is the group of individuals to which a PACE participant is assigned who are knowledgeable clinical and non-clinical PACE center staff responsible for the holistic needs of the PACE participant and who work in an interactive and collaborative manner to manage the delivery, quality, and continuity of participants' care. All PACE program requirements and services will be managed directly through CalOptima.

PACE Services shall include the following:

a. All Medicare-covered items and services
b. All Medi-Cal covered items and services; and
c. Other services determined necessary by the IDT to improve and maintain the participant's overall health status.

1.27 "Subcontract" means a contract entered into by Provider with a party that agrees to furnish items and/or services to CalOptima Members, or administrative functions or services related to Provider fulfilling its obligation to CalOptima under the terms of this Contract if, and to the extent, permitted under this Contract.

1.28 "Subcontractor" means a person or entity who has entered into a Subcontract with Provider for the purposes of filling Provider's obligations to CalOptima under the terms of this Contract. Subcontractors may also be referred to as Downstream Entities.

ARTICLE 2
FUNCTIONS AND DUTIES OF PROVIDER

2.1 Provision of Covered Services.

2.1.1 Provider shall furnish Covered Services identified in Attachment A to eligible Members in the applicable CalOptima Programs. Provider shall furnish such items and services in a manner satisfactory to CalOptima.

2.1.2 Throughout the term of this Contract, and subject to the conditions of the Contract, Provider shall maintain the quantity and quality of its services and personnel in accordance with the requirements of this Contract, to meet Provider's obligation to provide Covered Services hereunder.

2.1.3 Provider shall furnish Covered Services to Members under this Contract in the same manner as those services are provided to other patients.

2.2 Licensure. Provider represents and warrants that it has, and shall maintain during the term of this Contract, valid and active Licenses applicable to the Covered Services and for the State in which the Covered Services are rendered.

2.3 Regulatory Approvals. Provider represents and warrants that it has, and shall maintain during the term of this Contract, applicable Medi-Cal and Medicare provider and/or supplier numbers.

2.4 Good Standing. Provider represents it is in good standing with State licensing boards applicable to its business, DHCS, CMS and the DHHS Officer of Inspector General ("OIG"). Provider agrees to furnish CalOptima with any and all correspondence with, and notices from, these agencies of investigations and/or the issuance of criminal, civil and/or administrative sanctions (threatened or imposed) related to licensure, fraud and or abuse (execution of grand jury subpoena, search and seizure warrants, etc.), and/or Participation Status.

2.5 Geographic Coverage Area. Provider shall serve Members in all areas of Orange County, California.

2.6 Eligibility Verification. Provider shall verify a Member's eligibility for the applicable CalOptima Program benefits upon receiving request for Covered Services. For Members in the Medi-Cal Program with share of cost (SOC) obligations, Provider shall collect SOC in accordance with CalOptima Policies.

2.7 Marketing Requirements. Provider shall comply with CalOptima's marketing guidelines relevant to the pertinent CalOptima Program(s) and applicable laws and regulations.

2.8 Disclosure of Provider Ownership. Provider shall complete Attachment D and provide CalOptima with the following information, as applicable: (a) names of all officers of Provider's governing board; (b) names of all owners of Provider; (c) names of stockholders owning more than five percent (5%) of the stock issued by Provider; and (d) names of major creditors holding more than five percent (5%) of the debt of Provider. Provider shall complete any disclosure forms required under the CalOptima Programs as requested by CalOptima. Provider shall notify CalOptima immediately of any changes to the information included by Provider in the disclosure forms submitted to CalOptima.

2.9 Quality Improvement Program. Provider acknowledges and agrees that CalOptima is accountable for the quality of care furnished to its Members in all settings including services furnished by its ancillary health services providers and suppliers. Provider agrees that it is subject to the requirements of CalOptima's Quality Improvement Program ("QI Program") and that it shall participate in QI Program activities as required by CalOptima. Such activities may include, but are not limited to, the provision of requested data and the participation in assessment and performance audits and projects (including those required by CalOptima's Regulators) that support CalOptima's efforts to measure, continuously monitor, and evaluate the quality of items and services furnished to Members. Provider shall participate in CalOptima's QI Program development and implementation for the purpose of collecting and studying data reflecting clinical status and quality of life outcomes for CalOptima Members. Provider shall cooperate with CalOptima's Quality Improvement Organization ("QIO") including, without limitation, to resolve Member complaints.

Provider shall also allow CalOptima to use performance data for purposes including, but not limited to, quality improvement activities and public reporting to consumers, as identified in CalOptima policy GG.1638

2.10 Utilization & Resource Management Program. Provider acknowledges and agrees that CalOptima has implemented and maintains a Utilization & Resource Management Program ("UM Program") that addresses evaluations of medical necessity and processes to review and approve the provision of items and services, including Covered Services, to Members. Provider shall comply with the requirements of the UM Program including, without limitation, those criteria applicable to the Covered Services as described in this Contract.

2.11 CalOptima Oversight. Provider understands and agrees that CalOptima is responsible for the monitoring and oversight of all duties of Provider under this Contract, and that CalOptima has the authority and responsibility to: (i) implement, maintain and enforce CalOptima Policies governing Provider's duties under this Contract and/or governing CalOptima's oversight role; (ii) conduct audits, inspections and/or investigations in order to oversee Provider's performance of duties described in this Contract; (iii) require Provider to take corrective action if CalOptima or a Government Agency determines that corrective action is needed with regard to any duty under this Contract; and/or (iv) revoke the delegation of any duty, if Provider fails to meet CalOptima standards in the performance of that duty. Provider shall cooperate with CalOptima in its oversight efforts and shall take corrective action as CalOptima determines necessary to comply with the laws, accreditation agency standards, and/or CalOptima Policies governing the duties of Provider or the oversight of those duties.

2.12 Linguistic and Cultural Sensitivity Services. Provider shall comply with CalOptima Policies including, without limitation, the requirements set forth herein related to linguistic and cultural sensitivity. Provider shall address the special health needs of Members who are members of specific ethnic and cultural populations, such as, but not limited to, Vietnamese and Hispanic persons. Provider shall in its policies, administration, and services practice the values of (i) honoring the Members' beliefs, traditions and customs; (ii) recognizing individual differences within a culture; (iii) creating an open, supportive and responsive organization in which differences are valued, respected and managed; and (iv) through cultural diversity training, foster in staff and Subcontractors attitudes and interpersonal communication styles which respect Members' cultural backgrounds. Provider shall provide translation of written materials in the threshold languages identified by CalOptima at no higher than the sixth (6^{th}) grade reading level.

2.13 Provision of Interpreters. Provider shall ensure that CalOptima Members are provided with linguistic interpreter services and interpreter services for Members who are deaf and hard of hearing as necessary to ensure effective communication regarding arranging for the provision of non-medical services treatment, diagnosis, and medical history or health education pursuant to the requirements in this Contract, CalOptima Policies and Attachment B to this Contract.

Interpreters shall be used where needed and when technical or treatment information is to be discussed. Provider shall not require a Member to use friends or family as interpreters. However, a family member may be used when the use of the family member or friend: (a) is requested by a Member; (b) will not compromise the effectiveness of service; (c) will not violate a Member's confidentiality; and (d) Member is advised that an interpreter is available at no cost to the Member.

2.14 CalOptima's Compliance Program and Other Guidance. Provider and its employees, board members, owners, Participating Providers and/or Subcontractors furnishing medical and/or administrative services under this Contract ("Provider's Agents") shall comply with the requirements of CalOptima's Compliance Program, including CalOptima Policies, as may be amended from time to time. CalOptima shall make its Compliance Plan and Code of Conduct available to Provider and Provider shall make them available to Provider's Agents. Provider agrees to comply with, and be bound by, any and all MOUs.

2.15 Equal Opportunity. Provider and its Subcontractors will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Provider and its Subcontractors will take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Such action shall include, but not be limited to the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. Provider and its Subcontractors agree to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the Federal Government or DHCS, setting forth the provisions of the Equal Opportunity clause, Section 503 of the Rehabilitation Act of 1973, and the affirmative action clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212). Such notices shall state Provider and its Subcontractors' obligation under the law to take affirmative action to employ and advance in employment qualified applicants without discrimination based on their race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era and the rights of applicants and employees.

Provider and its Subcontractors will, in all solicitations or advancements for employees placed by or on behalf of Provider and its Subcontractors, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era.

Provider and its Subcontractors will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the Federal Government or the State, advising the labor union or workers' representative of Provider and its Subcontractors' commitments under the provisions herein and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

Provider and its Subcontractors will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212) and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity', and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and of the rules, regulations, and relevant orders of the Secretary of Labor.

Provider and its Subcontractors will furnish all information and reports required by Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity', and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and the Rehabilitation Act of 1973, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to its books, records, and accounts by the State and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

In the event of Provider and its Subcontractors' noncompliance with the requirements of the provisions herein or with any federal rules, regulations, or orders which are referenced herein, this Contract may be cancelled, terminated, or suspended in whole or in part, and Provider and its Subcontractors may be declared ineligible for further federal and state contracts, in accordance with procedures authorized in Federal Executive Order No. 11246 as amended, and such other sanctions may be imposed and remedies invoked as provided in Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity', and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

Provider and its Subcontractors will include the provisions of this section in every subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor, issued pursuant to Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity', and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or Section 503 of the Rehabilitation Act of 1973 or (38 U.S.C. 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each Subcontractor or Provider. Provider and its Subcontractors will take such action with respect to any subcontract or purchase order as the Director of the Office of Federal Contract Compliance Programs or DHCS may direct as a means of enforcing such provisions, including sanctions for noncompliance, provided, however, that in the event Provider and its Subcontractors become involved in, or are threatened with litigation by a Subcontractor or Provider as a result of such direction by DHCS, Provider and its Subcontractors may request in writing to DHCS, who, in turn, may request the United States to enter into such litigation to protect the interests of the State and of the United States.

2.16 Compliance with Applicable Laws. Provider shall observe and comply with all Federal and State laws and regulations, and requirements established in Federal and/or State programs in effect when the Contract is signed, or which may come into effect during the term of the Contract, which in any manner affects the Provider's performance under this Contract. Provider understands and agrees that payments made by CalOptima are, in whole or in part, derived from Federal funds, and therefore Provider and any Subcontractor are subject to certain laws that are applicable to individuals and entities receiving Federal funds. Provider agrees to comply with all applicable Federal laws, regulations, reporting requirements and CMS instructions including Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, and to require any Subcontractor to comply accordingly. Provider agrees to include the requirements of this section in its contracts with any Subcontractor.

2.17 No Discrimination/Harassment (Employees). During the performance of this Contract, Provider and its Subcontractors shall not unlawfully discriminate, harass, or allow harassment against any employee or applicant for employment because of race, religion, creed, color, national origin, ancestry, physical disability (including Human Immunodeficiency Virus (HIV), and Acquired Immune Deficiency Syndrome (AIDS)), mental disability, medical condition, marital status, age (over 40), gender or the use of family and medical care leave and pregnancy disability leave. Provider and Subcontractors shall ensure that the evaluation and treatment of their employees and

applicants for employment are free of such discrimination and harassment. Provider and Subcontractors shall comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900 et seq.) and the applicable regulations promulgated thereunder, (Title 2, CCR, Section 7285.0 et seq.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code, Section 12990, set forth in Chapter 5 of Division 4 of Title 2 of the CCR are incorporated into this Contract by reference and made a part hereof as if set forth in full. Provider and its Subcontractors shall give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement.

2.18 No Discrimination (Member). Neither Provider nor its Subcontractors shall discriminate against Members because of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, heath status, physical or mental disability, or identification with any other persons or groups defined in Penal Code 422.56, in accordance with Title VI of the Civil Rights Act of 1964, 42 USC Section 2000d (race, color, national origin); Section 504 of the Rehabilitation Act of 1973 (29 USC §794) (nondiscrimination under Federal grants and programs); Title 45 CFR Part 84 (nondiscrimination on the basis of handicap in programs or activities receiving Federal financial assistance); Title 28 CFR Part 36 (nondiscrimination on the basis of disability by public accommodations and in commercial facilities); Title IX of the Education Amendments of 1973 (regarding education programs and activities); Title 45 CFR Part 91 and the Age Discrimination Act of 1975 (nondiscrimination based on age); as well as Government Code Section 11135 (ethnic group identification, religion, age, sex, color, physical or mental handicap); Civil Code Section 51 (all types of arbitrary discrimination); Section 1557 of the Patient Protection and Affordable Care Act; and all rules and regulations promulgated pursuant thereto, and all other laws regarding privacy and confidentiality.

For the purpose of this Contract, if based on any of the foregoing criteria, the following constitute prohibited discrimination: (a) denying any Member any Covered Services or availability of a Provider, (b) providing to a Member any Covered Service which is different or is provided in a different name or at a different time from that provided to other similarly situated Members under this Contract, except where medically indicated, (c) subjecting a Member to segregation or separate treatment in any manner related to the receipt of any Covered Service, (d) restricting a Member in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any Covered Service, (e) treating a Member differently than others similarly situated in determining compliance with admission, enrollment, quota, eligibility, or other requirements or conditions that individuals must meet in order to be provided any Covered Service, or in assigning the times or places for the provision of such services. Provider and its Subcontractors agree to render Covered Services to Members in the same manner, in accordance with the same standards, and within the same time availability as offered to non-CalOptima patients. Provider and its Subcontractors shall take affirmative action to ensure that all Members are provided Covered Services without discrimination. For the purposes of this section, physical handicap 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 genetic handicap shall include, but not be limited to, Tay-Sachs trait, sickle cell trait, thalassemia trait, and X-linked hemophilia. Provider and its Subcontractors shall act upon all complaints alleging discrimination against Members in accordance with CalOptima's Policies

2.19 Reporting Obligations. Provider shall submit such reports and data required by CalOptima for the CalOptima Programs.

2.20 Subcontracting of Covered Services. Provider shall not subcontract for any Covered Services without the prior approval of CalOptima. Any subcontracting approved by CalOptima is subject to the requirements of this Contract. Subcontracts shall not terminate the legal liability of Provider under this Contract. Provider must ensure that all Subcontracts are in writing and include any and all provisions required by this Contract or applicable Government Programs to be incorporated into Subcontracts. Provider shall make all Subcontracts available to CalOptima or its regulators upon request. Provider is required to inform CalOptima of the name and business addresses of all

Subcontractors. Additionally, Provider shall require that all Subcontracts relating to the provision of Covered Services include, without limitation, the following provisions:

2.20.1 An agreement to make all books and records relative to the provision of and reimbursement for Covered Services furnished by Subcontractor to Provider available at all reasonable times for inspection, examination or copying by CalOptima or duly authorized representatives of the Government Agencies in accordance with Government Contract requirements.

2.20.2 An agreement to maintain such books and records in accordance with the general standards applicable to such books and records and any record requirements in this Contract and CalOptima Policies.

2.20.3 An agreement for the establishment and maintenance of and access to records as set forth in this Contract.

2.20.4 An agreement requiring Subcontractors to provide Covered Services to CalOptima Members in the same manner as those services are provided to other customers.

2.20.5 An agreement to comply with CalOptima's Compliance Program.

2.20.6 An agreement to comply with Member financial and hold harmless protections as set forth in this Contract.

2.21 Fraud and Abuse Reporting. Provider shall report to CalOptima all cases of suspected fraud and/or abuse, as defined in 42 Code of Federal Regulations, Section 455.2, relating to the rendering of Covered Services by Provider, whether by Provider, Provider's employees, Subcontractors, and/or Members within five (5) working days of the date when Provider first becomes aware of or is on notice of such activity.

2.22 Participation Status. Provider shall have policies and procedures to verify the Participation Status of Provider's Agents. In addition, Provider warrants and agrees as follows:

2.22.1 Provider and Provider's Agents shall meet CalOptima's Participation Status requirements during the term of this Contract.

2.22.2 Provider shall immediately disclose to CalOptima any pending investigation involving, or any determination of, suspension, exclusion or debarment by Provider or Provider's Agents occurring and/or discovered during the term of this Contract.

2.22.4 Provider shall take immediate action to remove any Provider Agent that does not meet Participation Status requirements from furnishing items or services related to this Contract (whether medical or administrative) to CalOptima Members.

2.22.5 Provider shall include the obligations of this Section in its Subcontracts.

2.23 Credentialing and Recredentialing. Prior to providing any Covered Services under, and throughout the duration of, this Contract, Provider, and all Subcontractors, shall be reviewed to confirm that required Licenses and other applicable qualifications are met. to the extent required by CalOptima Policy.

2.24 Physical Access for Members. Provider's and its Subcontractor's facilities shall comply with the requirements of Title III of the Americans with Disabilities Act of 1990, and shall ensure access for the disabled, which includes, but is not limited to, ramps, elevators, restrooms, designated parking spaces, and drinking water provision.

2.25 Smoke Free Workplace. 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. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible party. By signing this Contract, Provider 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. Provider further agrees that it will insert this certification into any subcontracts entered into that provide for children's services as described in the Act.

2.26 Member Rights. Provider shall ensure that each Member's rights, as set forth in state and federal law and CalOptima Policy, are fully respected and observed.

2.27 Electronic Transactions. Provider shall use best efforts to participate in the exchange of electronic transactions with CalOptima, including but not limited to electronic claims submission (EDI), verification of eligibility and enrollment through electronic means and submission of electronic prior authorization transactions in accordance with CalOptima Policy and Procedure.

2.28 Facility Construction or Repair. When applicable for purposes of construction or repair of facilities, Provider shall comply with the provisions in the following acts and/or will include such provisions in any applicable Subcontracts:

- Copeland "Anti-Kickback" Act (18 USC 874, 40 USC 2760) (29 CFR, Part 3)
- Davis-Bacon Act (40 USC 276a-7) (29 CFR, Part 5)
- Contract Work Hours and Safety Standards Act (40 USC 327-330) (29 CFR, Part 5)
- Executive Order 1126 of September 14, 1965 entitled, "Equal Employment Opportunity" as amended by Executive Order 11375 of October 13, 1967, as supplemented in Department of Labor Regulations (41 CFR, Part 60).

When Provider's agreement provides funding for both construction and non-construction activities, Provider shall obtain prior written approval from CalOptima before making any fund or budget transfers between construction and non-construction.

2.29 Debarment Certification. By signing this Contract, the Provider agrees to comply with applicable Federal suspension and debarment regulations including, but not limited to 7 CFR 3017, 45 CFR 76, 40 CFR 32, or 34 CFR 85.

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

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

2.29.1.2 Have not within a three-year period preceding this Contract have been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

2.29.1.3 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 Sub provision 13.1.2 herein; and

2.29.1.4 Have not within a three-year period preceding this Contract had one or more public transactions (Federal, State or local) terminated for cause or default.

2.29.1.5 Shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under Federal regulations (i.e., 48 CFR 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State.

2.29.1.6 Will include a clause entitled, "Debarment and Suspension Certification'' that essentially sets forth the provisions herein, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

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

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

2.29.4 If the Provider knowingly violates this certification, in addition to other remedies available to the Federal Government, CalOptima may terminate this Contract for cause or default.

2.30 Lobbying Restrictions and Disclosure Certification. Provider shall complete and submit the lobbying disclosure form required by federal law, when applicable, as set forth in this Addendum 1.

2.30.1 (Applicable to federally funded contracts in excess of $100,000 per Section 1352 of the 31, U.S.C.)

2.30.2 Certification and Disclosure Requirements

2.30.2.1 Each person (or recipient) who requests or receives a contract, subcontract, grant, or subgrant, which is subject to Section 1352 of the 31, U.S.C., and which exceeds $100,000 at any tier, shall file a certification (in the form set forth in Attachment E, consisting of one page, entitled "Certification Regarding Lobbying") that the recipient has not made, and will not make, any payment prohibited by Paragraph 2.29.3 of this provision.

2.30.2.2 Each recipient shall file a disclosure (in the form set forth in Attachment E-1 to this Addendum 1, entitled "Standard Form-LLL 'disclosure of Lobbying Activities'") if such recipient has made or has agreed to make any payment using non-appropriated funds (to include profits from any covered federal action) in connection with a contract or grant or any extension or amendment of that contract or grant, which would be prohibited under Paragraph 2.29.3 of this provision if paid for with appropriated funds.

2.30.2.3 Each recipient shall file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affect the accuracy of the information contained in any disclosure form previously filed by such person under Paragraph 2.29.2.2 herein. An event that materially affects the accuracy of the information reported includes:

2.30.2.3.1 A cumulative increase of $25,000 or more in the amount paid or expected to be paid for influencing or attempting to influence a covered federal action;

2.30.2.3.2 A change in the person(s) or individuals(s) influencing or attempting to influence a covered federal action; or

2.30.2.3.3 A change in the officer(s), employee(s), or member(s) contacted

for the purpose of influencing or attempting to influence a covered federal action.

2.30.2.4 Each person (or recipient) who requests or receives from a person referred to in Paragraph 2.28.2.1 of this provision a contract, subcontract, grant or subgrant exceeding $100,000 at any tier under a contract or grant shall file a certification, and a disclosure form, if required, to the next tier above.

2.30.2.5 All disclosure forms (but not certifications) shall be forwarded from tier to tier until received by the person referred to in Paragraph 2.28.2.1 of this provision. That person shall forward all disclosure forms to DHCS program contract manager.

2.30.3 Prohibition—Section 1352 of Title 31, U.S.C., provides in part that no appropriated funds may be expended by the recipient of a federal contract, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any of the following covered federal actions: the awarding of any federal contract, the making of any federal grant, the making of any federal loan, entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

2.31 Provider's Agent's Qualifications. Provider shall verify the qualifications of all Provider's Agents providing services under this Contract consistent with the services to be provided, as further described in the attached "scope of Work." In addition, for Provider's Agents that enter into Members' homes or have face-to-face contact with Members, Provider shall also conduct background investigations, including, but not be limited to, County, State and Federal criminal history and abuse registry screening. Provider shall comply with all applicable laws in conducting background investigations, and shall exclude unqualified Agents from providing services under this Contract.

2.32 Provider Agreement to Extend Terms and Rates. Provider agrees to extend to CalOptima Health Networks the same terms regarding Provider performance, duties and obligations and rates for Ancillary Services provided to CalOptima Members enrolled in Health Networks as are set forth in this Contract.

ARTICLE 3
FUNCTIONS AND DUTIES OF CALOPTIMA

3.1 Payment. CalOptima shall pay Provider for Covered Services provided to CalOptima Members. Provider agrees to accept the compensation set forth in Attachment C as payment in full from CalOptima for such Covered Services. Upon submission of a Clean Claim or invoice, CalOptima shall pay Provider pursuant to CalOptima Policies and Attachment C.

3.2 Service Authorization. CalOptima shall provide a written authorization process for Covered Services pursuant to CalOptima Policies Procedures as may be amended from time to time. .

3.3 Limitations of CalOptima's Payment Obligations. Notwithstanding anything to the contrary contained in this Contract, CalOptima's obligation to pay Provider any amounts shall be subject to CalOptima's receipt of the funding from the Federal and/or State governments.

ARTICLE 4
PAYMENT PROCEDURES

4.1 Billing and Claims Submission. Provider shall submit Claims or invoices for Covered Services in accordance with CalOptima Policies applicable to the Claims submission process.

4.2 Prompt Payment. CalOptima shall make payments to Provider in the time and manner set forth in CalOptima Policies related to the CalOptima Programs and/or this Contract. Additional procedures related to claims processing and payment are set forth in the attached CalOptima Program Addenda.

4.3 Claim Completion and Accuracy. Provider shall be responsible for the completion and accuracy of all Claims submitted whether on paper forms or electronically including claims submitted for the Provider by other parties. Use of a billing agent does not abrogate Provider's responsibility for the truth and accuracy of the submitted information. A Claim may not be submitted before the delivery of service. Provider acknowledges that Provider remains responsible for all Claims and that anyone who misrepresents, falsifies, or causes to be misrepresented or falsified, any records or other information relating to that Claim may be subject to legal action.

4.4 Claims Deficiencies. Any Claim that fails to meet CalOptima requirements for claims processing shall be denied and Provider notified of denial pursuant to CalOptima Policies and applicable Federal and/or State laws and regulations.

4.5 Member Financial Protections. Provider shall comply with Member financial protections as follows:

4.5.1 Provider agrees to indemnify and hold Members harmless from all efforts to seek compensation and any claims for compensation from Members for Covered Services under this Contract. In no event shall a Member be liable to Provider for any amounts which are owed by, or are the obligation of, CalOptima.

4.5.2 In no event, including, but not limited to, non-payment by CalOptima, CalOptima's or Provider's insolvency, or breach of this contract by CalOptima, shall Provider, or any of its Subcontractors, bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against the State of California or any Member or person acting on behalf of a Member for Covered Services pursuant to this Contract.

4.5.3 This provision does not prohibit Provider or its Subcontractors from billing and collecting payment for non-Covered Services if the CalOptima Member agrees to the payment in writing prior to the actual delivery of non-Covered Services and a copy of such agreement is given to the Member and placed in the Member's medical record prior to rendering such services.

4.5.4 Upon receiving notice of Provider invoicing or balance billing a Member for Covered Services, CalOptima may sanction the Provider or take other action as provided in this Contract.

4.5.5 This section shall survive the termination of this Contract for Covered Services furnished to CalOptima Members prior to the termination of this Contract, regardless of the cause giving rise to termination, and shall be construed to be for the benefit of Members. This section shall supersede any oral or written contrary agreement now existing or hereafter entered into between the Provider and its Subcontractors. Language to ensure the foregoing shall be included in all of Provider's Subcontracts related to provision of Covered Services to CalOptima Members.

4.6 Overpayments and CalOptima Right to Recover. Provider has an obligation to report any overpayment identified by Provider, and to repay such overpayment to CalOptima within sixty (60) days of such

identification by Provider, or of receipt of notice of an overpayment identified by CalOptima. Provider acknowledges and agrees that, in the event that CalOptima determines that an amount has been overpaid or paid in duplicate, or that funds were paid which were not due under this Contract to Provider, CalOptima shall have the right to recover such amounts from Provider by recoupment or offset from current or future amounts due from CalOptima to Provider, after giving Provider notice and an opportunity to return/pay such amounts. This right to recoupment or offset shall extend to any amounts due from Provider to CalOptima, including, but not limited to, amounts due because of:

4.6.1 Payments made under this Contract that are subsequently determined to have been paid at a rate that exceeds the payment required under this contract.

4.6.2 Payments made for services provided to a Member that is subsequently determined to have not be eligible on the date of service.

ARTICLE 5
INSURANCE AND INDEMNIFICATION

5.1 Indemnification. Each party to this Contract agrees to defend, indemnify and hold each other and the State harmless, with respect to any and all Claims, costs, damages and expenses, including reasonable attorney's fees, which are related to or arise out of the negligent or willful performance or non-performance by the indemnifying party, of any functions, duties or obligations of such party under this Contract. Neither termination of this Contract nor completion of the acts to be performed under this Contract shall release any party from its obligation to indemnify as to any claims or cause of action asserted so long as the event(s) upon which such claims or cause of action is predicated shall have occurred prior to the effective date of termination or completion.

5.2 Insurance Requirements

5.2.1 Professional Liability:

If providing Professional Services under this contract, the Vendor at its sole cost and expense, shall maintain a Professional Liability Insurance policy covering itself and any Subcontractors with minimum limits as follows:

Professional Liability providing Covered Services: $1,000,000 per incident/$2,000,000 aggregate

5.2.2 Commercial General Liability/Commercial Automobile Liability:

Vendor, at its sole cost and expense shall maintain a Commercial General Liability and a Commercial Automobile Liability Insurance policy with minimum limits as follows:

Commercial General Liability: (Including Personal Injury) $1,000,000 per occurrence/$2,000,000 aggregate

Commercial Automobile Liability: * $1,000,000 Combined Single Limit

Additional insured wording is required on both policies as well as primary and non-contributory wording and Waiver of Subrogation. Additional Insured wording to include: Orange County Health Authority, a public agency; DBA: Orange Prevention and Treatment Integrated Medical Assistance; DBA: CalOptima, CalOptima Foundation, including its officers, officials, directors, employees, agents, and volunteers.

*(Charter-party carriers of passengers:)

If applicable, vendor shall comply with the Public Utilities Commission (PUC) General Order No. 115-G, which requires higher levels of insurance for charter-party carriers of passengers and is based on seating capacity as follows:

$ 1,500,000 if seating capacity is 8-15

$ 5,000,000 if seating capacity is over 15 unless otherwise amended by future regulations.

In the case of a charter-party carrier with seating capacity of 7 or less, CalOptima will require $1,000,000 Combined Single Limit.

5.2.3 Workers' Compensation:

Vendor, at its sole cost and expense shall maintain a Workers' Compensation Insurance policy as required by the State of California with minimum limits as follows:

Employers' Liability Insurance:	$1,000,000 Bodily injury each accident
	$1,000,000 Bodily injury policy limit
	$1,000,000 Bodily injury each employee

Waiver of Subrogation wording is required and to include:

Orange County Health Authority, a public agency; DBA: Orange Prevention and Treatment Integrated Medical Assistance; DBA: CalOptima, CalOptima Foundation, including its officers, officials, directors, employees, agents, and volunteers.

5.2.4 Commercial Crime:

If applicable, Vendor, at its sole cost and expense shall maintain a commercial crime policy covering theft and dishonesty, forgery and alterations, money orders and counterfeit currency, credit card fraud, wire transfer fraud, and theft of client property as follows:

Commercial Crime Insurance:	$1,000,000 per occurrence

5.2.5 Cyber and Privacy Liability Insurance:

If applicable, Vendor shall maintain the following minimum coverages for such length of time as necessary to cover any and all claims:

Cyber and Privacy Liability Insurance: (including Privacy and Network Liability; Internet Media Liability; Business Interruption and Expense; Data Extortion; Regulatory Proceeding; and Data Breach Notification & Credit Monitoring)	$1,000,000 each coverage

5.2.6 Bonding:

If providing services which require bonding, Vendor shall be bonded at amounts usual or customary in Vendor's industry and type of service.

5.3 Insurer Ratings.

Such insurance shall be provided by an insurer:

(a) Rated by A.M. Best with rating of A- VII or better; and

(b) "admitted" to do business in California or an insurer approved to do business in California by the California Department of Insurance and listed on the Surplus Lines Association of California List of Eligible Surplus Lines Insurers (LESLI); or

(c) An Unincorporated Interindemnity Trust Arrangement as authorized by the California Insurance Code 12180.7.

5.4 Captive Risk Retention Group/Self Insured:

Where any of the insurances mentioned by Section 5.2 above are provided by a Captive Risk Retention Group or self-insured, Section 5.3 above may be waived at the sole discretion of CalOptima, but only after review of the Captive Risk Retention Group's or self-insured's audited financial statements.

5.5 Cancellation or Material Change:

The vendor shall not of its own initiative cause such insurances as addressed in this Article to be canceled or materially changed during the term of this Contract. Thirty (30) days prior written notice be given to CalOptima in the event of cancellation.

5.6 Certificates of Insurance:

Certificates of Insurance of the above insurance policies and/or evidence of self-insurance shall be provided to CalOptima prior to execution of the Contract and annually thereafter.

5.7 Subcontractors:

Vendor shall require each of its Subcontractors who perform services related to this Contract, if any, to maintain insurance coverage that meets all of the requirements set forth herein.

5.8 Failure or refusal to maintain or produce proof of Insurance:

If Vendor fails or refuses to maintain or produce proof of the insurance required by Section 5.2, CalOptima shall have the right, at its election, to terminate forthwith this Contract. Such termination shall not affect Vendor's right to be paid for its time and materials expended prior to notification of termination. Vendor waives the right to receive compensation and agrees to indemnity CalOptima for any work performed prior to approval of Insurance by CalOptima.

5.9 Other Liability:

Neither party shall be liable to the other for any indirect, exemplary, special, punitive, consequential or incidental damages or loss of goodwill, data or profits, or cost of cover.

ARTICLE 6
RECORDS, AUDITS AND REPORTS

6.1 Access to and Audit of Contract Records. For the purpose of review of items and services furnished under the terms of this Contract and duplication of any books and records, Provider and its Subcontractors shall allow CalOptima, its regulators and/or their duly authorized agents and representatives access to said books and records, including medical records, contracts, documents, electronic systems for the purpose of direct physical examination of the records by CalOptima or its regulators and/or their duly authorized agents and representatives at the Provider's premises. Provider shall be given advance notice of such visit in accordance with CalOptima Policies. Such access shall include the right to directly observe all aspects of Provider's operations and to inspect, audit and reproduce all records and materials and to verify Claims and reports required according to the provisions of this Contract. Provider shall maintain records in chronological sequence, and in an immediately retrievable form in accordance with the laws and regulations applicable to such record keeping. If DHCS, CMS, CDA or the DHHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, CDA or the DHHS Inspector General may inspect, evaluate, and audit the Provider at any time. Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate the Provider and its Subcontractors from participation in the Medi-Cal program; seek recovery of payments made to the Provider; impose other sanctions provided under the State Plan, and Provider's contract may be terminated due to fraud.

6.2 Records Retention. The Provider shall maintain books and records in accordance with the time and manner requirements set forth in Federal and State laws and CalOptima Programs as identified in the CalOptima Program Addenda to this Contract. Where the Provider furnishes Covered Services to a Member in more than one CalOptima Program with different record retention periods, then the greater of the record retention requirements shall apply.

6.3 Audit, Review and/or Duplication. Audit, review and/or duplication of data or records shall occur within regular business hours and shall be subject to Federal and State laws concerning confidentially and ownership of records. Provider shall pay all duplication and mailing costs associated with such audits.

6.4. Confidentiality of Member Information. Provider agrees to comply with applicable Federal and State laws and regulations governing the confidentiality of Member medical and other information. Provider further agrees:

6.4.1 Health Insurance Portability and Accountability Act (HIPAA). Provider shall comply with HIPAA statutory and regulatory requirements ("HIPAA requirements"), whether existing now or in the future within a reasonable time prior to the effective date of such requirements. Provider shall comply with HIPAA requirements as currently established in CalOptima Policies. Provider shall also take actions and develop capabilities as required to support CalOptima compliance with HIPAA requirements, including acceptance and generation of applicable electronic files in HIPAA compliant standards formats.

6.4.2 Members Receiving State Assistance. Notwithstanding any other provision of this Contract, names and identification numbers of Members receiving public assistance are confidential and are to be protected from unauthorized disclosure in accordance with applicable State and Federal laws and regulations. For the purpose of this Contract, Provider shall protect from unauthorized disclosure all information, records, data and data elements collected and maintained for the operation of the Contract and pertaining to Members.

6.4.3 Declaration of Confidentiality. If Provider has access to computer files or any data confidential by statute, including identification of eligible members, Provider agrees to sign a declaration of confidentiality in accordance with the applicable Government Contract and in a form acceptable to CalOptima and DHCS, DMHC (MRMIB) and/or CMS, as applicable.

ARTICLE 7
TERM AND TERMINATION

7.1 Term. The term of this Contract shall become effective on the Effective Date through June 30th, 2020. This Contract shall then automatically extend for additional one-year terms (July 1st through June 30th) upon formal approval by the CalOptima Board of Directors, unless earlier terminated by either party as provided for in this Contract.

7.2 Termination for Default. CalOptima may, in its sole discretion, terminate this Contract whenever CalOptima determines that the Provider or any Subcontractor (a) has repeatedly and inappropriately withheld Covered Services to a CalOptima Member(s), (b) has failed to perform its contracted duties and responsibilities in a timely and proper manner including, without limitation, service procedures and standards identified in this Contract, (c) has committed acts that discriminate against CalOptima Members on the basis of their health status or requirements for health care services; (d) has not provided Covered Services in the scope or manner required under the

provisions of this Contract; (e) has engaged in prohibited marketing activities; (f) has failed to comply with CalOptima's Compliance Program, including Participation Status requirements; (g) has committed fraud or abuse relating to Covered Services or any and all obligations, duties and responsibilities under this Contract; or (h) has materially breached any covenant, condition, or term of this Contract. A termination as described above shall be referred to herein as "Termination for Default." In the event of a Termination for Default, CalOptima shall give Provider prior written notice of its intent to terminate with a thirty (30)-day cure period if the Termination for Default is curable, in the sole discretion of CalOptima. In the event the default is not cured within the thirty (30)-day period, CalOptima may terminate the Contract immediately following such thirty (30)-day period. The rights and remedies of CalOptima provided in this clause are not exclusive and are in addition to any other rights and remedies provided by law or under the Contract. The Provider shall not be relieved of its liability to CalOptima for damages sustained by virtue of breach of the Contract by the Provider or any Subcontractor.

7.3 Immediate Termination. CalOptima may terminate this Contract immediately upon the occurrence of any of the following events and delivery of written notice: (i) the suspension or revocation of any license, permits and certification or accreditation required by Provider and/or Provider Agents; (ii) the determination by CalOptima that the health, safety, or welfare of Members is jeopardized by continuation of this Contract; (iii) the imposition of sanctions or disciplinary action against Provider or against Provider Agents in their capacities with the Provider by any Federal or State licensing agency; (iv) termination or non-renewal of any Government Contract; (v) the withdrawal of DHHS's approval of the waiver granted to the CalOptima under Section 1915(b) of the Social Security Act. If CalOptima receives notice of termination from any of the Government Agencies or termination of the Section 1915(b) waiver, CalOptima shall immediately transmit such notice to Provider.

7.4 Termination for Provider Insolvency. If the Provider and/or any of its Subcontractors becomes insolvent, the Provider shall immediately so advise CalOptima, and CalOptima shall have, at its sole option, the right to terminate the Contract immediately. In the event of the filing of a petition for bankruptcy by or against the Provider or a principal Subcontractor, the Provider shall assure that all tasks related to the Contract or the Subcontract are performed in accordance with the terms of the Contract.

7.5 Modifications or Termination to Comply with Law. CalOptima reserves the right to modify or terminate the Contract at any time when modifications or terminations are (a) mandated by changes in Federal or State laws, (b) required by Government Contracts, or (c) required by changes in any requirements and conditions with which CalOptima must comply pursuant to its Federally-approved Section 1915(b) waiver. CalOptima shall notify Provider in writing of such modification or termination immediately and in accordance with applicable Federal and/or State requirements, and Provider shall comply with the new requirements within 30 days of the effective date, unless otherwise instructed by DHCS and to the extent possible.

7.6 Termination Without Cause. Either party may terminate this Contract, without cause, upon ninety (90) days prior written notice to the other party as provided herein.

7.7 Rate Adjustments. The payment rates may be adjusted by CalOptima during the Contract period to reflect implementation of Federal or State laws or regulations, changes in the State budget, the Government Contract(s) or the Government Agencies' policies, and/or changes in Covered Services. If the Government Agency(ies) has provided CalOptima with advance notice of adjustment, CalOptima shall provide notice thereof to Provider as soon as practicable.

7.8 Approval By and Notice to Government Agencies. Provider acknowledges that this Contract and any modifications and/or amendments thereto are subject to the approval of applicable Federal and/or State agencies. CalOptima and Provider shall notify the Federal and/or State agencies of amendments to, or termination of, this Contract. Notice shall be given by first-class mail, postage prepaid to the attention of the State or Federal contracting officer for the pertinent CalOptima Program. Provider acknowledges and agrees that any amendments or modifications shall be consistent with requirements relating to submission to such Federal and/or State agency for

approval.

ARTICLE 8
GRIEVANCES AND APPEALS

8.1 Provider Grievances. Provider and/or Subcontractor complaints, concerns or differences shall be resolved through the mechanisms set forth in CalOptima Policies related to the applicable CalOptima Program(s).

8.2 Member Grievances and Appeals. Member grievances, complaints, and/or appeals shall be resolved in accordance with Federal and/or State laws, regulations and Government Guidance and as set forth in CalOptima Policies relating to the applicable CalOptima Program. Provider agrees to cooperate in the investigation of the issues and be bound by CalOptima's grievance decisions and, if applicable, State and/or Federal hearing decisions or any subsequent appeals.

ARTICLE 9
GENERAL PROVISIONS

9.1 Assignment and Assumption. Provider acknowledges and agrees that a primary goal of CalOptima is to ensure the provision of quality healthcare services to CalOptima Members and that CalOptima and Provider have entered into this Contract for the benefit of CalOptima Members. Accordingly, CalOptima retains the rights set forth in this Section. Except as specifically permitted hereunder, this Contract is not assignable by the Provider, either in whole or in part, without the prior written consent of CalOptima, provided that CalOptima's consent may be withheld in its sole and absolute discretion. For purposes of this Section and this Contract, assignment includes, without limitation, (a) the change of more than twenty-five percent (25%) of the ownership or equity interest in Provider (whether in a single transaction or in a series of transactions), (b) the change of more than twenty-five percent (25%) of the directors or trustees of Provider, (c) the merger, reorganization, or consolidation of Provider with another entity with respect to which Provider is not the surviving entity, and/or (d) a change in the management of Provider from management by persons appointed, elected or otherwise selected by the governing body of Provider (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

9.2 Documents Constituting Contract. This Contract and its attachments, schedules, addenda and exhibits, as well as Provider's response to the CalOptima's Request for Proposal (RFP) and any further information or clarification submitted as part of the RFP process, and all CalOptima Policies applicable to Covered Services and CalOptima Members (and any amendments thereto) shall constitute the entire agreement between the parties. It is the express intention of Provider and CalOptima that any and all prior or contemporaneous agreements, promises, negotiations or representations, either oral or written, relating to the subject matter and period governed by this Contract which are not expressly set forth herein shall be of no further force, effect or legal consequence after the effective date hereunder. In the event of any inconsistency between the RFP and this Contract, the terms and provisions of this Contract shall govern and control.

9.3 Force Majeure. Both parties shall be excused from performance hereunder for any period that they are prevented from meeting the terms of this Contract as a result of a catastrophic occurrence or natural disaster including but not limited to an act of war, and excluding labor disputes.

9.4 Governing Law and Venue. This Contract shall be governed by and construed in accordance with all laws of the State of California and Federal laws and regulations applicable to the CalOptima Programs and all contractual obligations of CalOptima. Provider shall bring any and all legal proceedings against CalOptima under this Contract in California State courts located in Orange County, California.

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

9.6 Independent Contractor Relationship. CalOptima and Provider agree that the Provider and any agents or employees of the Provider in performance of this Contract shall act in an independent capacity and not as officers or employees of CalOptima. Provider's relationship with CalOptima in the performance of this Contract is that of an independent contractor. Provider's personnel performing services under this Contract shall be at all times under Provider's exclusive direction and control and shall be employees of Provider and not employees of CalOptima. Provider shall pay all wages, salaries and other amounts due its employees in connection with this Contract and shall be responsible for all reports and obligations respecting them, such as social security, income tax withholding, unemployment compensation, workers' compensation, and similar matters.

9.7 No Liability of County of Orange. As required under Ordinance No. 3896 of the County of Orange, State of California, as amended, CalOptima and the Provider hereby acknowledge and agree that the obligations of CalOptima under this Contract are solely the obligations of CalOptima, and the County of Orange, State of California, shall have no obligation or liability therefor.

9.8 No Waiver. No delay or failure by either party hereto to exercise any right or power accruing upon noncompliance or default by the other party with respect to any of the terms of this Contract shall impair such right or power or be construed to be a waiver thereof. A waiver by either of the parties hereto of a breach of any of the covenants, conditions, or agreements to be performed by the other shall not be construed to be a waiver of any succeeding breach thereof or of any other covenant, condition, or agreement herein contained. Any information delivered, exchanged or otherwise provided hereunder shall be delivered, exchanged or otherwise provided in a manner which does not constitute a waiver of immunity or privilege under applicable law.

9.9 Notices. Any notice required to be given pursuant to the terms and provisions of this Contract, unless otherwise indicated herein, shall be in writing and shall be sent by Certified or Registered mail, return receipt requested, postage prepaid to the address set out below. Notice shall be deemed given seventy-two (72) hours after mailing.

If to CalOptima:

CalOptima
Director of Contracting
505 City Parkway West
Orange, CA 92868

If to Provider:
Carenet Healthcare Services
Attn: Stacie Stoner, VP Client Services
11845 IH-10 West, Suite 400
San Antonio, TX 78230

9.10 Omissions. In the event that either party hereto discovers any material omission in the provisions of this Contract which such party believes is essential to the successful performance of this Contract, said party may so inform the other party in writing, and the parties hereto shall thereafter promptly negotiate in good faith with respect to such matters for the purpose of making such reasonable adjustments as may be necessary to perform the objectives of this Contract.

9.11 Prohibited Interests. Provider covenants that, for the term of this Contract, no director, member, officer, or employee of CalOptima during his/her tenure has any interest, direct or indirect, in this Contract or the proceeds thereof.

9.12 Regulatory Approval. Notwithstanding any other provision of this Contract, the effectiveness of this Contract, amendments thereto, and assignments thereof, is subject to the approval of applicable Governmental Agencies and the conditions imposed by such agencies.

United States or the State of California in accordance with law or is declared null and void by any court of competent jurisdiction, the remainder of the provisions hereof shall remain in full force and effect.

ARTICLE 10
EXECUTION

10.1 Subject to the State of California and United States providing funding for the term of this Contract and for the purposes with respect to which it is entered into, and execution of the Government Contracts and the approval of the Contract by the Government Agencies, this Contract shall become effective on July 1st, 2019 (the "Effective Date").

IN WITNESS WHEREOF, the parties have executed this Contract as follows:

Provider	**CalOptima**
Signature	Signature
Vikie Spulak	Ladan Khamseh
Print Name	Print Name
Chief Client Officer	Chief Operating Officer
Title	Title
June 4, 2019	6/19/2019
Date	Date

ATTACHMENT A

COVERED SERVICES

ARTICLE 1
CALOPTIMA PROGRAMS

1.1 CalOptima Programs. Provider shall furnish Covered Services to eligible Members in the following CalOptima Programs:

___X___Medi-Cal Program

___X___Medicare Advantage Program (OneCare)

_____PACE Program

___X___Cal MediConnect Program/OneCare Connect (Members Dually Eligible for Medicare and Medi-Cal)

_____Multipurpose Senior Services Program (MSSP)

ARTICLE 2
SERVICES

2.1 Scope of Work. "Covered Services" as referred to in this Contract means those items and services as defined under applicable CalOptima Programs and CalOptima Policies and required to be furnished under this Contract, and provided to Members who are authorized to receive such items and services including:

Call Center Support and Nurse Triage Services

ATTACHMENT B

PROCEDURES FOR REQUESTING INTERPRETATION SERVICE

1. CALOPTIMA DIRECT MEMBERS AND PACE PARTICIPANTS

1.1 Cal Optima Responsibilities. CalOptima shall provide Members enrolled in CalOptima Direct (COD) and PACE with face-to-face language and sign language interpretation services to ensure effective communication with Providers. Upon notification from Provider pursuant to the provisions of this Contract that interpreter services are required, CalOptima shall arrange for and make payment for interpreter services for COD and PACE Members in accordance with the procedures set forth herein.

1.2 Request for Interpretation Services. To request these interpretation services Provider shall, at least one week before the scheduled appointment with the Member, contact CalOptima Customer Service Department at (714) 246-8500 to be connected with the Cultural and Linguistic (C&L) Coordinator. The following information will be needed at the time of the request:

a. Member name and ID, date of birth and telephone number;
b. Name and phone number of the care taker, if applicable;
c. Language or sign language needed;
d. Date and time of the appointment;
e. Address and telephone number of the facility where the appointment is to take place;
f. Estimated amount of time the interpretation service will be needed; and
g. Type of appointment: assessment, fitting/delivery or other.

1.3 Provider's Responsibilities.

1.3.1 C&L Coordinator. Provider shall make the request at least one week before the scheduled appointment. Provider shall communicate with the CalOptima C&L Coordinator. CalOptima C&L Coordinator will make the best effort to secure an interpreter within 72 hours of a request and will confirm to the Provider and Member of the result of this effort.

1.3.2 Appointment Changes. If there is any change with the appointment, Provider shall contact CalOptima C&L Coordinator, at least 72 hours before the scheduled appointment.

1.3.3 Provider Obligation For Cost. If Provider fails to communicate with CalOptima C&L Coordinator in a timely manner (less than 72 hours before the appointment), Provider will have to incur the cost of an urgent interpretation service request.

2. HEALTH NETWORK MEMBERS

2.1 Health Network Contact. Provider shall contact Member's Health Network customer service department to request the needed interpretation services and shall follow the Health Network policy and procedures for those services.

ATTACHMENT C

COMPENSATION

CalOptima shall reimburse Provider, and Provider shall accept as payment in full from CalOptima, the lesser of billed charges or the following amounts:

I. Medi-Cal Program Reimbursement

For Medi-Cal Members, CalOptima shall reimburse for Covered Services as follows:

$0.0575 PMPM

II. Medicare Advantage (OneCare) Program Reimbursement

For Medicare Advantage (OneCare) Members, CalOptima shall reimburse for Covered Services as follows:

$0.0575 PMPM

III. PACE Program Reimbursement

For PACE Members, CalOptima shall reimburse for Covered Services as follows:

N/A

IV. Cal MediConnect (OneCare Connect) Program Reimbursement

For Cal MediConnect (OneCare Connect) Members, CalOptima shall reimburse for Covered Services as follows:

$0.0575 PMPM

V. MSSP Program Reimbursement

Invoicing and Rates. Upon receipt of Clean Claim or invoice, CalOptima shall pay Provider, within 30 days, for services authorized the previous month. CalOptima shall pay Provider at rates in Attachment C, pursuant to CalOptima Policies and Procedures, as may be amended from time to time. Provider will not be paid for time required for Provider to travel to or from the Member's home, unless travel is included as part of the Authorized Services provided, e.g. shopping or transportation/escort. In such instances, Provider may also request reimbursement for mileage at the current CalOptima reimbursement rate. Provider shall submit to CalOptima each month an invoice referencing a Service Authorization Form (SAF) number for Authorized Services provided the prior month. Invoices are due within 15 days after the end of the month in which Authorized Services were provided. Invoices not submitted within 90 days of the month of service will not be paid. Invoices shall be sent to: CalOptima, Senior Select Program/MSSP, 505 City Parkway West, Orange, CA, 92868.

N/A

ATTACHMENT D

DISCLOSURE FORM

Infomedia Group, Inc. dba Carenet Healthcare Services

Name of Provider

The undersigned hereby certifies that the following information regarding

Infomedia Group, Inc. dba Carenet Healthcare Services (the "Provider") is true and correct as of the date set forth below:

Officer(s)/Director(s)/General Partner(s):
John Erwin, Director
John Erwin, Scott Schawe, Mick Mazour and Vikie Spulak Officers.

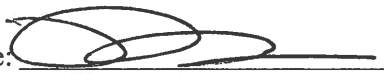
Co-Owner(s):
John Erwin

Stockholder(s) owning more than five percent (5%) of the Provider's stock:
Not Applicable

Major creditor(s) holding more than five percent (5%) of the Provider's debt:
Not Applicable

Form of Provider (Corporation, Partnership, Sole Proprietorship, Individual, etc.):
Corporation

Dated: June 6, 2019

Signature: 

Name: Vikie Spulak
(Please type or print)

Title: CCO
(Please type or print)

ATTACHMENT E

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES

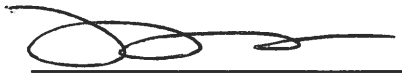
CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the making, awarding or entering into of this Federal contract, Federal grant, or cooperative agreement, and the extension, continuation, renewal, amendment, or modification of this Federal contract, grant, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency of the United States Government, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, or cooperative agreement, the undersigned shall complete and submit Standard Form LLL, "Disclosure of Lobbying Activities" in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontractors, subgrants, and contracts under grants and cooperative agreements) of $100,000 or more, and that all subrecipients shall certify and disclose accordingly.
This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S.C., any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Infomedia Group, Inc. dba Carenet Healthcare Services	Vikie Spulak
Name of Contractor	Printed Name of Person Signing for Contractor
	
Contract / Grant Number	Signature of Person Signing for Contractor
June 6, 2019	CCO
Date	Title

After execution by or on behalf of Contractor, please return to:

Department of Health Care Services
Medi-Cal Managed Care Division
MS 4415, 1501 Capitol Avenue, Suite 71.4001 P.O.
Box 997413
Sacramento, CA 95899-7413

ATTACHMENT E-1 N/A

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: contract grant cooperative agreement loan loan guarantee loan insurance	2. Status of Federal Action: bid/offer/application initial award post-award	3. Report Type: initial filing material change For Material Change Only: Year _____ quarter_____ date of last report

4. Name and Address of Reporting Entity: Prime Subawardee Tier, if known: Congressional District, If known:	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime: Congressional District, If known:
6. Federal Department/Agency:	Federal Program Name/Description: CDFA Number, if applicable:
8. Federal Action Number, if known:	9. Award Amount, if known:
10. a. Name and Address of Lobbying Entity (If individual, last name, first name, MI): (attach Continuation Sheets(s)	b. Name and Address of Lobbying Entity (If individual, last name, first name, MI): SF-LLL-A, If necessary)
Amount of Payment (check all that apply): $ actual planned Form of Payment (check all that apply): a. cash b. in-kind, specify: Nature Value	13. Type of Payment (check all that apply): a. retainer b. one-time fee c. commission d. contingent fee e. deferred f. other, specify:
14. Brief Description of Services Performed or to be Performed and Dates(s) of Service, including Officer(s), Employee(s), or Member(s) Contracted for Payment indicated in item 11:	
15. Continuation Sheet(s) SF-LLL-A Attached: Yes No	
16. Information requested through this form is authorized by Title 31, U.S.C., Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to Title 31, U.S.C., Section 1352. This information will be reported to the Congress semiannually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $19,000 and not more than $100,000 for each such failure.	Signature: Print Name: Title: Telephone No.: Date:
Federal Use Only	Authorized for Local Reproduction Standard Form-LLL

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime federal recipients at the initiation or receipt of a covered federal action, or a material change to a previous filing, pursuant to Title 31, U.S.C., Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered federal action. Use the SF - LLL- A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

Identify the type of covered federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered federal action.

Identify the status of the covered federal action.

Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered federal action.

Enter the full name, address, city, state, and ZIP code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants, and contract awards under grants.

If the organization filing the report in Item 4 checks "Subawardee," then enter the full name, address, city, state, and ZIP code of the prime federal recipient. Include Congressional District, if known.

Enter the name of the federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation United States Coast Guard.

Enter the federal program name or description for the covered federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CDFA) number for grants, cooperative agreements, loans, and loan commitments.

Enter the most appropriate federal identifying number available for the federal action identified in Item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract grant, or loan award number; the application/proposal control number assigned by the federal agency). Include prefixes, e.g., "RFP-DE-90401."

For a covered federal action where there has been an award or loan commitment by the federal agency, enter the federal amount of the award/loan commitment for the prime entity identified in Item 4 or 5.

10. (a) Enter the full name, address, city, state, and ZIP code of the lobbying entity engaged by the reporting entity identified in Item 4 to influence the covered federal action.
10. (b) Enter the full names of the Individual(s) performing services and include full address if different from 10.(a). Enter last name, first name, and middle initial (MI).

Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (Item 4) to the lobbying entity (Item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

Check the appropriate box(es). Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.

Check the appropriate box(es). Check all boxes that apply. If other, specify nature.

Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with federal officials, identify the federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.
Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.

The certifying official shall sign and date the form, print his/her name, title, and telephone number.

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time for reviewing instruction, searching existing data sources, gathering and maintaining the data needed, and completing and renewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to the Office of Management and Budget, Paperwork Reduction Project, (0348-0046), Washington, DC 20503.

ADDENDUM 1
MEDI-CAL PROGRAM

The following additional terms and conditions apply to items and services furnished to Members under the CalOptima Medi-Cal Program (COD and Health Network Members): These terms and conditions are additive to those contained in the main Contract. In the event that these terms and conditions conflict with those in the main Contract, these terms and conditions shall prevail.

1. Records Retention. Provider and its Subcontractors shall maintain and retain all records of all items and services provided Members for ten (10) years from the final date of the contract between CalOptima and DHCS, or the date of completion of any audit, whichever is later, unless a longer period is required by law. Records involving matters which are the subject of litigation shall be retained for a period of not less than ten (10) years following the termination of litigation. Provider's and its Subcontractors' books and records shall be maintained within, or be otherwise accessible within the State of California and pursuant to Section 1381(b) of the Health and Safety Code. Such records shall be maintained and retained on Provider's State licensed premises for such period as may be required by applicable laws and regulations related to the particular records. Such records shall be maintained in chronological sequence and in an immediately retrievable form that allows CalOptima, and/or representatives of any regulatory or law enforcement agencies, immediate and direct access and inspection of all such records at the time of any onsite audit or review.

   Microfilm copies of the documents contemplated herein may be substituted for the originals with the prior written consent of CalOptima, provided that the microfilming procedures are approved by CalOptima as reliable and are supported by an effective retrieval system. If CalOptima is concerned about the availability of such records in connection with the continuity of care to a Member, Provider shall, upon request, transfer copies of such records to CalOptima's possession.

   This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise.

2. Access to Books and Records.

   2.1 Provider agrees to make all of its premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining to the goods and services furnished under the terms of the Contract, available for the purpose of an audit, inspection, evaluation, examination or copying by CalOptima, DHCS, CMS, Department of Health and Human Services (DHHS) Inspector General, the Comptroller General, Department of Justice (DOJ), or their designees, at all reasonable times at Provider's place of business or at such other mutually agreeable location in California, in a form maintained in accordance with the general standards applicable to such book or record keeping for a term of at least ten (10) years from the final date of the Contract between CalOptima and DHCS, or from the date of completion of any audit, whichever is later. If DHCS, CMS, or the DHHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit Provider at any time. Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate the Provider from participation in the Medi-Cal program; seek recovery of payments made to the Subcontractor; impose other sanctions provided under the State Plan, and direct CalOptima to terminate this Contract due to fraud.

   2.2 Through the end of the records retention period specified in Section 2.1, above, Provider shall allow CalOptima, DHCS, the DHHS Office of the Inspector General, the

Comptroller General of the United States, CDA, Bureau of Medi-Cal Fraud, DMHC, and other authorized State agencies, or their duly authorized representatives or designees, including DHCS' External Quality Review organization contractor, to audit, inspect, monitor or otherwise evaluate the quality, appropriateness, and timeliness of services performed under this Contract, and to inspect, evaluate, and audit any and all premises, books, records, equipment, facilities, contracts, computers, or other electronic systems maintained by Provider pertaining to these services at any time pursuant to 42 CFR 438.3(h). Records and documents include, but are not limited to, all physical records originated or prepared pursuant to the performance under this Contract, including working papers, reports, financial records, and books of account, medical records, prescription files, laboratory results, subcontracts, information systems and procedures, and any other documentation pertaining to medical and non-medical services rendered to Members. Upon request, through the end of the records retention period specified in Section 2.1, above, Provider shall furnish any record, or copy of it, to CalOptima, DHCS, or any other entity listed in this section, at Provider's sole expense.

2.3 Authorized State and Federal agencies will have the right to monitor all aspects of Provider's operation for compliance with the provisions of this Contract and applicable Federal and State laws and regulations. Such monitoring activities will include, but are not limited to, inspection and auditing of Provider's facilities, management systems and procedures, and books and records, at any time, pursuant to 42 CFR 438.3(h). The monitoring activities will be either announced or unannounced. To assure compliance with the Contract and for any other reasonable purpose, CalOptima, the State of California, and their authorized representatives and designees, will have the right to premises access, with or without notice to Provider. This will include the MIS operations site or such other place where duties under the Contract are being performed. Staff designated by CalOptima or authorized State agencies will have access to all security areas and Provider will provide and will require any and all of its Subcontractors to provide, reasonable facilities, cooperation and assistance to CalOptima or State representative(s) in the performance of their duties. Access will be undertaken in such a manner as to not unduly delay the work of Provider or its Subcontractor(s).

2.4 Provider and its Subcontractors shall cooperate in the audit process by signing any consent forms or documents required to effectuate the release of any records or documentation Provider may possess in order to verify Provider's records when requested by regulatory or oversight organizations, including, but not limited to; DHCS, DMHC, Department of Justice, Attorney General, Federal Bureau of Investigation and Bureau of Medi-Cal Fraud and/or CalOptima.

2.5 This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise.

3. Form of Records. Provider's and its Subcontractors' books and records shall be maintained in accordance with the general standards applicable to such book or record-keeping.

4. Downstream Contracts. In the event that Provider is allowed to subcontract for services under this Contract, and does so subcontract, then Provider shall, upon request, provide copies of such subcontracts to CalOptima or DHCS.

5. Assignment and Delegation. Except as specifically permitted hereunder, this Contract is not assignable, nor are the duties hereunder delegable, by the Provider, either in whole or in part, without the prior written consent of CalOptima and DHCS, provided that consent may be withheld in their sole and absolute discretion. Any assignment or delegation shall be void unless prior

written approval is obtained from both DHCS and CalOptima. For purposes of this Section and this Contract, an assignment constitutes any of the following: (i) the change of more than twenty-five percent (25%) of the ownership or equity interest in Provider (whether in a single transaction or in a series of transactions); (ii) the change of more than twenty-five percent (25%) of the directors or trustees of Provider; (iii) the merger, reorganization, or consolidation of Provider with another entity with respect to which Provider is not the surviving entity; and/or (iv) a change in the management of Provider from management by persons appointed, elected or otherwise selected by the governing body of Provider (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

6. Third Party Tort Liability/Estate Recovery. Provider shall make no claim for the recovery of the value of Covered Services rendered to a Member when such recovery would result from an action involving tort liability of a third party, recovery from the estate of deceased Member, Workers' Compensation, or casualty liability insurance awards and uninsured motorist coverage. Provider shall inform CalOptima of potential third party liability claims, and provide information relative to potential third party liability claims, in accordance with CalOptima Policy.

7. Records Related to Recovery for Litigation. Upon request by CalOptima, Provider shall timely gather, preserve and provide to CalOptima, in the form and manner specified by CalOptima, any information specified by CalOptima, subject to any lawful privileges, in Provider's or its Subcontractors' possession, relating to threatened or pending litigation by or against CalOptima or DHCS. If Provider asserts that any requested documents are covered by a privilege, Provider shall: 1) identify such privileged documents with sufficient particularity to reasonably identify the document while retaining the privilege; and 2) state the privilege being claimed that supports withholding production of the document. Such request shall include, but is not limited to, a response to a request for documents submitted by any party in any litigation by or against CalOptima or DHCS. Provider acknowledges that time may be of the essence in responding to such request. Provider shall use all reasonable efforts to immediately notify CalOptima of any subpoenas, document production requests, or requests for records, received by Provider or its Subcontractors related to this Contract or subcontracts entered into under this Contract.

8. Medi-Cal Policies. Covered Services provided under this Contract shall comply with all applicable Medi-Cal Managed Care Division (MMCD) Policy Letters.

9. Medi-Cal Credentialing. If Provider is of a provider type that is not able to enroll in Medi-Cal through DHCS, Provider shall provide an accurate, current, signed copy of the DHCS Medi-Cal Disclosure Form, DHCS-6216, or such other disclosure form as DHCS may otherwise specify to meet the requirements of Section 51000.35 of Title 22 of the California Code of Regulations.

10. Changes in Availability or Location of Services. Any substantial change in the availability or location of services to be provided under this Contract requires the prior written approval of DHCS. Provider's or a Subcontractor's proposal to reduce or change the hours, days, or location at which the services are available shall be given to CalOptima at least 75 days prior to the proposed effective date. DHCS' denial of the proposal shall prohibit implementation of the proposed changes.

11. Confidentiality of Medi-Cal Members. Provider and its employees, agents, or Subcontractors shall protect from unauthorized disclosure the names and other identifying information concerning persons either receiving services pursuant to this Contract, or persons whose names or identifying information become available or are disclosed to Provider, its employees, agents, or Subcontractors as a result of services performed under this Contract, except for statistical information not identifying any such person. Provider and its employees, agents, or Subcontractors shall not use such identifying information for any purpose other than carrying out Provider's obligations under this Contract. Provider and its employees, agents, or Subcontractors shall promptly transmit to the

CalOptima all requests for disclosure of such identifying information not emanating from the Member. Provider shall not disclose, except as otherwise specifically permitted by this Contract or authorized by the Member, any such identifying information to anyone other than DHCS or CalOptima without prior written authorization from CalOptima. For purposes of this provision, identity shall include, but not be limited to, name, identifying number, symbol, or other identifying particular assigned to the individual, such as finger or voice print or a photograph.

Names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted thereunder. For the purpose of this Contract, all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to Members shall be protected by Provider from unauthorized disclosure. Provider may release Medical Records in accordance with applicable law pertaining to the release of this type of information. Provider is not required to report requests for Medical Records made in accordance with applicable law. With respect to any identifiable information concerning a Member under this Contract that is obtained by Provider or its Subcontractors, Provider:

11.1 will not use any such information for any purpose other than carrying out the express terms of this Contract,

11.2 will promptly transmit to CalOptima all requests for disclosure of such information, except requests for Medical Records in accordance with applicable law,

11.3 will not disclose, except as otherwise specifically permitted by this Contract, any such information to any party other than DHCS or CalOptima without CalOptima's prior written authorization specifying that the information is releasable under Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted there under, and

11.4 will, at the termination of this Contract, return all such information to CalOptima or maintain such information according to written procedures sent to the Provider by CalOptima for this purpose.

12. DHCS Directions. If required by DHCS, Provider and its Subcontractors shall cease specified activities, which may include, but are not limited to, referrals, assignment of beneficiaries, and reporting, until further notice from DHCS.

13. Air or Water Pollution Requirements. Any federally funded agreement and/or subcontract in excess of $100,000 must comply with the following provisions unless said agreement is exempt under 40 CFR 15.5. Provider agrees to comply with all applicable standards, orders, or requirements issued under the Clean Air Act (42 USC 7401 et seq.), as amended, and the Federal Water Pollution Control Act (33 USC 1251 et seq.), as amended.

ADDENDUM 2
MEDICARE ADVANTAGE PROGRAM
(ONECARE)

The following additional terms and conditions apply to items and services furnished to Members under the CalOptima Medicare Advantage Program (OneCare):

1. Record Retention. Provider agrees to retain books, records, Member medical, Subcontractor and other records for at least ten (10) years from the final date of the contract between CalOptima and DHCS, or the date of completion of any audit, whichever is later, unless a longer period is required by law.

2. Right of Inspection, Evaluation, Audit of Records. Provider and its Subcontractors agree to maintain and make available contracts, books, documents, and records involving transactions related to the Contract to CalOptima, DMHC, DHHS, the Comptroller General, the U.S. General Accounting Office ("GAO"), any Quality Improvement Organization ("QIO") or accrediting organizations, including NCQA, and other representatives of regulatory or accrediting organizations or their designees to inspect, evaluate, and audit for ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later. For purposes of utilization management, quality improvement and other CalOptima administrative purposes, CalOptima and officials referred to above, shall have access to, and copies of, at reasonable time upon request, the medical records, books, charts, and papers relating to the Provider's provision of health care services to Members, the cost of such services, and payments received by Provider from Members (or from others on their behalf). Medical records shall be provided at no charge to Members or CalOptima.

3. Accountability Acknowledgement. Provider further agrees and acknowledges that CalOptima oversees and is accountable to CMS for functions or responsibilities described in MA regulations; that CalOptima may only delegate activities or functions in a manner consistent with the MA program delegation requirements; and that any services or other activities performed by Provider pursuant to the Contract are consistent and comply with CalOptima's contractual obligations with CMS and adhere to delegation requirements set forth by MA statutes, regulations and/or other guidance. Where delegated responsibilities are identified in this Contract, the following shall apply:

   (a) Delegation by CalOptima. To the extent that responsibilities are delegated to Provider under this Contract, Provider warrants that it meets CalOptima delegation criteria set forth in the Attachment to this Contract and agrees to accept delegated responsibility for those listed activities. Provider agrees to perform the delegated activities in a manner consistent with the delegation criteria. Provider agrees to notify CalOptima of any change in its eligibility under the delegation criteria within twenty-four (24) hours from the date it fails to meet such delegation criteria. Provider acknowledges that delegation to another entity does not alter Provider's ultimate obligations and responsibilities set forth in this Contract. Provider acknowledges and agrees that CalOptima retains final authority and responsibility for activities delegated under this Contract. Activities not expressly delegated herein by CalOptima or for which delegation is terminated are the responsibility of CalOptima.

   (b) Reports on Delegated Activities. Provider agrees to provide CalOptima with periodic reports on delegated activities performed by Provider as provided in the delegation criteria. The report shall be in a form and contain such information as shall be agreed upon between the parties. Provider agrees to take those corrective actions identified by CalOptima through the audit review process.

(c) CalOptima Oversight of Delegation. The delegation of the functions and responsibilities stated herein does not relieve CalOptima of any of its accountability to CMS and obligations to its Members under applicable law. CalOptima is authorized to perform and remains liable for the performance of such obligations, notwithstanding any delegation of some or all of those obligations by Provider, which will be monitored by CalOptima on an ongoing basis. In the event Provider breaches its obligation to perform any delegated duties, CalOptima shall have all remedies set forth in this Contract, including, but not limited to, penalties or termination of the delegation of such functions to Provider as set forth in this Contract. Moreover, CalOptima shall have the right to require Provider to terminate any Subcontracting provider for good cause, including but not limited to breach of its obligations to perform any delegated duties.

4. Reporting Requirements. Provider shall comply with CalOptima's reporting requirements in order that it may meet the requirements set forth in MA laws and regulations for submitting encounter and other data including, without limitation, 42 CFR § 422.516. Provider also agrees to furnish medical records that may be required to obtain any additional information or corroborate the Encounter Data.

ADDENDUM 3

PACE PROGRAM REQUIREMENTS

The terms and requirements of this Addendum 3 shall apply for services provided by Provider to Members who are enrolled in the CalOptima PACE program only.

1. State Approval and Termination.

   1.1 This Addendum to the Contract shall not become effective until approved in writing by the California Department of Health Care Services (DHCS) and Centers for Medicare and Medicaid Services, (CMS), or by operation of law where DHCS and CMS have acknowledged receipt, verbally or in writing, and has failed to approve or disapprove the proposed contract within sixty (60) days of receipt.

   1.2 Amendments to this Contract and amendments to any subcontract agreements between Provider and Subcontractor shall be submitted to DHCS for prior approval at least thirty (30) days before the effective date of any proposed changes governing compensation, services, or term. Proposed changes which are neither approved nor disapproved by DHCS shall become effective by operation of law within thirty (30) days after DHCS has acknowledged receipt, or upon the date specified in the amendment, whichever is later.

   1.3 CalOptima may terminate this Contract as it applies to providing services to CalOptima PACE participants if CalOptima's PACE Agreement or State Medi-Cal contract is terminated for any reason. CalOptima shall notify Provider of any such termination immediately upon its provision of notice of termination of the PACE Agreement or State Medi-Cal contract, or upon receipt of a notice of termination of the PACE Agreement from DHCS/CMS, or the State Medi-Cal Contract from DHCS.

2. Provider's Responsibilities applicable to providing services to CalOptima PACE enrollees. Provider shall be accountable to CalOptima in accordance with the terms of this Contract. For CalOptima PACE enrollees, Provider agrees to do the following:

   2.1 Provider shall make available a location that is accessible to PACE participants within the PACE service area of Orange County, California.

   2.2 Duties Related to Provider's Position. Provider shall perform all the duties related to its position, as specified in this Contract.

   2.3 Services Authorized. Provider shall furnish only those services authorized by the CalOptima PACE Interdisciplinary Team (IDT); PCP referral is deemed as an IDT authorization.

   2.4 Interdisciplinary Team Meeting Participation. If necessary for the benefit of a CalOptima PACE participant's care delivery or planning, Provider shall participate in CalOptima PACE Interdisciplinary Team meetings as required. Such participation may be by telephone, unless in-person attendance at such meetings is reasonably warranted under the circumstances.

   2.5 Payment in Full. Provider shall accept CalOptima's payment as payment in full, and shall not seek any reimbursement for services directly from the CalOptima PACE member, Medi-Cal, Medicare or other insurance carrier or provider. Provider shall not seek any type of copayment from PACE member for Covered Services. CalOptima PACE participants shall not be liable to Provider for any sum owed by CalOptima, and Provider agrees not to maintain any action at law or in equity against CalOptima PACE participants

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to collect sums that are owed by CalOptima. Surcharges to CalOptima PACE participants by Provider are prohibited. Whenever CalOptima receives notice of any such surcharge, CalOptima shall take appropriate action, and Contractor shall reimburse the participant as appropriate.

2.6 Hold Harmless. In accordance with the Medi-Cal Contract and the PACE Agreement, Provider will not bill the State of California, CMS or CalOptima PACE participants in the event CalOptima cannot or will not pay for services performed by Provider pursuant to this Contract.

2.7 Reporting. Provider shall provide such information and written reports to CalOptima, DHCS, and DHHS, as may be necessary for compliance by CalOptima with its statutory obligations, and to allow CalOptima to fulfill its contractual obligations to DHCS and CMS.

2.8 Coverage of Non-Network Providers. Provider agrees that should arrangements be made by Provider with another physician/provider who is not under contract with CalOptima to provide Covered Services required under this Contract, such physician/provider shall (a) accept Provider's fees from CalOptima as full payment for services delivered to CalOptima PACE participants, (b) bill services provided through Provider's office, unless Provider has made other billing arrangements with CalOptima, (c) not bill CalOptima PACE participants directly, under any circumstances, and (d) cooperate with and participate in CalOptima's quality assurance and improvement program.

2.9 Participant Bill of Rights. Provider shall cooperate and comply with the CalOptima PACE Participant Bill of Rights. A copy of the CalOptima PACE Participant Bill of Rights is attached. CalOptima may, at its sole discretion, make reasonable changes to this document from time to time, and a copy of the revised document will be sent to Provider.

2.10 The CalOptima PACE program director or his or her designee shall be designated as the liaison to coordinate activities between Provider and PACE.

3. Records Retention. Provider and its Subcontractors shall maintain and retain all records, including Encounter Data, of all items and services provided Members for ten (10) years from the final date of the contract between CalOptima and DHCS, or the date of completion of any audit, which ever is later, unless a longer period is required by law. Records involving matters which are the subject of litigation shall be retained for a period of not less than ten (10) years following the termination of litigation. Provider's and its Subcontractors' books and records shall be maintained within, or be otherwise accessible within the State of California and pursuant to Section 1381(b) of the Health and Safety Code. Such records shall be maintained and retained on Provider's State licensed premises for such period as may be required by applicable laws and regulations related to the particular records. Such records shall be maintained in chronological sequence and in an immediately retrievable form that allows CalOptima, and/or representatives of any regulatory or law enforcement agencies, immediate and direct access and inspection of all such records at the time of any onsite audit or review.

Microfilm copies of the documents contemplated herein may be substituted for the originals with the prior written consent of CalOptima, provided that the microfilming procedures are approved by CalOptima as reliable, and are supported by an effective retrieval system. If CalOptima is concerned about the availability of such records in connection with the continuity of care to a Member, Provider shall, upon request, transfer copies of such records to CalOptima's possession.

This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise.

4. Access to Books and Records. Provider and its Subcontractors agree to make all of its books and records pertaining to the goods and services furnished under, or in any way pertaining to, the terms of Contract and any Subcontract, available for inspection, examination and copying by the Government Agencies, including the DOJ, CDA, Bureau of Medi-Cal Fraud, Comptroller General and any other entity statutorily entitled to have oversight responsibilities of the COHS program, at all reasonable times at the Provider's or Subcontractor's place of business or such other mutually agreeable location in California, in a form maintained in accordance with general standards applicable to such book or record keeping. Provider shall provide access to all security areas and shall provide and require Subcontractors to provide reasonable facilities, cooperation and assistance to State representatives in the performance of their duties.

   Provider and its Subcontractors shall cooperate in the audit process by signing any consent forms or documents required to effectuate the release of any records or documentation Provider may possess in order to verify Provider's records when requested by regulatory or oversight organizations, including, but not limited to; DHCS, DMHC, Department of Justice, Attorney General, Federal Bureau of Investigation and Bureau of Medi-Cal Fraud and/or CalOptima.

   This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise.

5. Downstream Contracts. In the event that Provider is allowed to subcontract for services under this Contract, and does so subcontract, then Provider shall, upon request, provide copies of such subcontracts to CalOptima or DHCS.

6. Assignment and Delegation. This Contract is not assignable, nor are the duties hereunder delegable, by the Provider, either in whole or in part, without the prior written consent of CalOptima and DHCS, provided that consent may be withheld in their sole and absolute discretion. Any assignment or delegation shall be void unless prior written approval is obtained from both DHCS and CalOptima. For purposes of this Section and this Contract, an assignment constitutes any of the following: (i) the change of more than twenty-five percent (25%) of the ownership or equity interest in Provider (whether in a single transaction or in a series of transactions); (ii) the change of more than twenty-five percent (25%) of the directors or trustees of Provider; (iii) the merger, reorganization, or consolidation of Provider with another entity with respect to which Provider is not the surviving entity; and/or (iv) a change in the management of Provider from management by persons appointed, elected or otherwise selected by the governing body of Provider (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

7. Third Party Tort Liability/Estate Recovery. Provider shall make no claim for the recovery of the value of Covered Services rendered to a Member when such recovery would result from an action involving tort liability of a third party, recovery from the estate of a deceased Member, Workers' Compensation, or casualty liability insurance awards and uninsured motorist coverage. Provider shall inform CalOptima of potential third party liability claims, and provide information relative to potential third party liability claims, in accordance with CalOptima Policy.

8. Records Related to Recovery for Litigation. Upon request by CalOptima, Provider shall timely gather, preserve and provide to CalOptima, in the form and manner specified by CalOptima, any information specified by CalOptima, subject to any lawful privileges, in Provider's or its Subcontractors' possession, relating to threatened or pending litigation by or against CalOptima or DHCS. If Provider asserts that any requested documents are covered by a privilege, Provider shall: 1) identify such privileged documents with sufficient particularity to reasonably identify the document while retaining the privilege; and 2) state the privilege being claimed that supports withholding production of the document. Such request shall include, but is not limited to, a response to a request for documents submitted by any party in any litigation by or against

CalOptima or DHCS. Provider acknowledges that time may be of the essence in responding to such request. Provider shall use all reasonable efforts to immediately notify CalOptima of any subpoenas, document production requests, or requests for records, received by Provider or its Subcontractors related to this Contract or subcontracts entered into under this Contract.

9. DHCS Policies. Covered Services provided under this Contract shall comply with all applicable requirements of the DHCS Medi-Cal Managed Care Program and the DHCS Long-Term Care Division (LTCD).

10. Changes in Availability or Location of Services. Any substantial change in the availability or location of services to be provided under this Contract requires the prior written approval of DHCS. Provider's or a Subcontractor's proposal to reduce or change the hours, days, or location at which the services are available shall be given to CalOptima at least 75 days prior to the proposed effective date. DHCS' denial of the proposal shall prohibit implementation of the proposed changes.

11. Confidentiality of Medi-Cal Members. Provider and its employees, agents, or Subcontractors shall protect from unauthorized disclosure the names and other identifying information concerning persons either receiving services pursuant to this Contract, or persons whose names or identifying information become available or are disclosed to Provider, its employees, agents, or Subcontractors as a result of services performed under this Contract, except for statistical information not identifying any such person. Provider and its employees, agents, or Subcontractors shall not use such identifying information for any purpose other than carrying out Provider's obligations under this Contract. Provider and its employees, agents, or Subcontractors shall promptly transmit to CalOptima all requests for disclosure of such identifying information not emanating from the Member. Provider shall not disclose, except as otherwise specifically permitted by this Contract or authorized by the Member, any such identifying information to anyone other than DHCS or CalOptima without prior written authorization from CalOptima. For purposes of this provision, identity shall include, but not be limited to, name, identifying number, symbol, or other identifying particular assigned to the individual, such as finger or voice print or a photograph.

    11.1 Names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted thereunder. For the purpose of this Contract, all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to Members shall be protected by Provider from unauthorized disclosure. Provider may release Medical Records in accordance with applicable law pertaining to the release of this type of information. Provider is not required to report requests for Medical Records made in accordance with applicable law. With respect to any identifiable information concerning a Member under this Contract that is obtained by Provider or its Subcontractors, Provider:

        11.1.1 will not use any such information for any purpose other than carrying out the express terms of this Contract,

        11.1.2 will promptly transmit to CalOptima all requests for disclosure of such information, except requests for Medical Records in accordance with applicable law,

        11.1.3 will not disclose, except as otherwise specifically permitted by this Contract, any such information to any party other than DHCS or CalOptima without CalOptima's prior written authorization specifying that the information is releasable under Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted there under, and

11.1.4 will, at the termination of this Contract, return all such information to CalOptima or maintain such information according to written procedures sent to the Provider by CalOptima for this purpose.

12. DHCS Directions. If required by DHCS, Provider and its Subcontractors shall cease specified activities, which may include, but are not limited to, referrals, assignment of beneficiaries, and reporting, until further notice from DHCS.

13. Air or Water Pollution Requirements. Any federally funded agreement and/or subcontract in excess of $100,000 must comply with the following provisions, unless said agreement is exempt under 40 CFR 15.5. Provider agrees to comply with all applicable standards, orders, or requirements issued under the Clean Air Act (42 USC 7401 et seq.), as amended, and the Federal Water Pollution Control Act (33 USC 1251 et seq.), as amended.

14. Provider shall have a right to submit an Appeal through the mechanisms set forth in CalOptima Policies regarding Provider dispute resolution.

ADDENDUM 4
CAL MEDICONNECT PROGRAM REQUIREMENTS

The following additional terms and conditions apply to items and services furnished to Members under the CalOptima Cal MediConnect Program. These terms and conditions are additive to those contained in the main Contract. In the event that these terms and conditions conflict with those in the main Contract, these terms and conditions shall prevail.

1. Provider shall provide services in accordance with applicable DHCS and CMS laws, regulations, instructions, and contractual obligations with CalOptima.

2. Provider shall (1) comply with the confidentiality and laws regarding confidentiality and disclosure of medical records, or other health and enrollment information, (2) ensure that medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas, (3) maintain the records and information in an accurate and timely manner, and (4) ensure timely access by enrollees to the records and information that pertain to them, and (5) comply with all DHCS and CMS confidentiality requirements.

3. Provider shall comply with all CalOptima and DHCS monitoring of performance and any monitoring requests by CalOptima and DHCS.

4. Provider shall also allow CalOptima to use performance data for purposes including, but not limited to, quality improvement activities, monitoring, and, public reporting to consumers as identified in CalOptima policy.

5. Provider shall submit timely and accurate Encounter Data and other data and reports required by CalOptima and CalOptima's Regulators as provided in this Contract and in CalOptima's Policies.

6. Provider shall comply with CalOptima Policies including, without limitation, the requirements set forth herein related to linguistic and cultural sensitivity. Provider shall address the special health needs of Members who are members of specific ethnic and cultural populations, such as, but not limited to, Vietnamese and Hispanic persons. Provider shall, in its policies, administration, and services, practice the values of (i) honoring the Members' beliefs, traditions and customs; (ii) recognizing individual differences within a culture; (iii) creating an open, supportive and responsive organization in which differences are valued, respected and managed; and (iv) through cultural diversity training, fostering in staff and Subcontractors attitudes and interpersonal communication styles that respect Members' cultural backgrounds. Provider shall provide translation of written materials in the Threshold Languages and Concentration Languages identified by CalOptima at no higher than the sixth (6^{th}) grade reading level.

7. CMS Participation Requirements. Provider represents and warrants that: (i) neither Provider nor any of its employees or agents furnishing services under this Contract are excluded from participating in any federal or state healthcare program as defined in 42 U.S.C. Section 1320a-7b(f) ("Federal Health Care Program(s)"); (ii) Provider has not arranged or contracted with (by employment or otherwise) with any employee, contractor or agent that Provider knows or should know are excluded from participation in Federal Health Care Programs; (iii) no action is pending against Provider or any of its employees or agents performing services under this Contract to suspend or exclude such persons or entities from participation in any Federal Health Care Program; and (iv) Provider agrees to immediately notify CalOptima in the event that it learns that it is or has employed or contacted with a person or entity that is excluded from participation in any Federal Health Care Program. In the event Provider fails to comply with the above, CalOptima reserves the right to require Provider to pay immediately to CalOptima, the amount of any sanctions or other penalties that may be imposed on CalOptima by DHCS and/or CMS for violation of this prohibition, and shall be responsible for any resulting overpayments.

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8. Downstream Entity Contracts. If any services under this Contract are to be provided by a Downstream Entity Contracts subcontracted by Provider, Provider shall ensure that such subcontracts are in compliance with 42 CFR Sections 422.504, 423.505 and 438.6(1). Such subcontracts shall include all language required by DHCS and CMS as provided in this Contract.

9 Air or Water Pollution Requirements. Any federally funded agreement and/or subcontract in excess of $100,000 must comply with the following provisions unless said agreement is exempt under 40 CFR 15.5. Provider agrees to comply with all applicable standards, orders, or requirements issued under the Clean Air Act (42 USC 7401 et seq.), as amended, and the Federal Water Pollution Control Act (33 USC 1251 et seq.), as amended.

ADDENDUM 5
MULTIPURPOSE SENIOR SERVICES PROGRAM (MSSP)

The terms and requirements of this Addendum 5 shall apply for services provided by Provider to Members who are enrolled in the CalOptima Multipurpose Senior Services Program.

1. MSSP Site Manual. is the Multipurpose Senior Services Program (MSSP) Site Manual, dated July 1, 1992, produced by the CDA, and all subsequent amendments and revisions. Provider shall abide by the MSSP Site Manual, training manuals, and other guidance issued by the CDA Medi-Cal Services Branch, including any subsequent changes to State and Federal Law.

2. Vendor Application Form. Provider shall complete a CDA-approved Vendor Application Form. Provider shall submit to CalOptima any changes to the information contained in the Vendor Application Form within 15 days of any change.

3. Training/Education. Provider agrees to provide ongoing education and training, at least annually, for all employees and Subcontractors who handle personal, sensitive or confidential information. Provider employees and Subcontractors will complete the Security Awareness Training module located on the Department of Aging's website, www.aging.ca.gov, within 30 days of the start date of this Contract, or within 30 days of the start date of any new employee or Subcontractor. Provider may substitute its own Security Training program for CDA's Security Awareness Training program, provided such training meets or exceeds CDA's training requirement. Provider shall maintain documentation of training and education provided to their staff and/or Subcontractors. All employees, volunteers and Subcontractors who handle personal, sensitive or confidential information relating to CDA's programs must participate in Security Awareness Training.

4. Provider Confidentiality Statement. The Provider shall sign and return a Contractor/Vendor Confidentiality Statement (CDA 1024 Form) with this Contract. This is to ensure that Contractor/Vendors are aware of, and agree to comply with, their obligations to protect CDA information assets from unauthorized access and disclosure.

5. Travel Reimbursement Limits. In the event that this Contract provides for the reimbursement of authorized travel, any reimbursement for such authorized travel shall be at a rate not to exceed those amounts paid by the State in accordance with the Department of Personnel Administration's rules and regulations, which may be found at http://www.dpa.ca.gov/textdocs/freepmls/PML2008019.pdf (generally), http://www.dpa.ca.gov/personnel-policies/travel/meals-and-incidentals.htm (per diem), and http://www.dpa.ca.gov/personnel-policies/travel/short-term-travel.htm (lodging). This is not to be construed as limiting Provider from paying any differences in costs, from funds not derived from MSSP, between the Department of Personnel Administration rates and any rates Provider is obligated to pay under other contractual agreements. No travel outside of the State of California shall be reimbursed, unless prior written authorization from the State is obtained (CCR, Title 2, Section 599.615 et seq.).

6. The Provider shall maintain complete records (which shall include, but not be limited to, accounting records, contracts, agreements, letters of agreement, insurance documentation in accordance with Article XII., Memoranda and/or Letters of Understanding, and patient records) of its activities and expenditures hereunder in a form satisfactory to CDA, and shall make all records pertaining to this Contract available for inspection and audit by CalOptima and the State, or either's duly authorized agents, at any time during normal business hours. All such records must be maintained and made available by the Provider; (a) until an audit has occurred and an audit resolution has been issued, or unless otherwise authorized in writing by CDA or DHCS' Audit Branch, (b) for such longer period, if any, as is required by applicable statue, by any other clause of this Contract, or (c) for such longer period as CDA deems necessary.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 4, 2022
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

5. Ratify Amendment to Contract with Newmark Knight Frank

Contacts

Michael Hunn, Chief Executive Officer, (657) 900-1481
Nancy Huang, Chief Financial Officer, (657) 235-6935

Recommended Actions

1. Ratify amendment to contract with Newmark Knight Frank for real estate services as follows:
    a. Amend the contract term to add two (2) additional one-year extension options, each exercisable at CalOptima's sole discretion, and exercise the first of these two (2) one-year options to extend the contract term through February 28, 2024; and
    b. Expand the scope of work.

2. Authorize unbudgeted expenditures in an amount not to exceed $75,000 from existing reserves for additional real estate-related services.

Background/Discussion

At its February 6, 2020, meeting, the CalOptima Board of Directors (Board) authorized entering into an agreement with Newmark Knight Frank for real estate-related services. These services addressed the following: status of the office space and parking capacity at the 505 Building, the PACE lease renewal, and the potential value and uses of the Development Agreement. The original contract included two consecutive one-year extensions, with the last extension expiring on February 28, 2023.

At this time, Staff requests that the Board ratify the contract amendment with Newmark Knight Frank. The amendment modifies the term of the contract from two (2) additional consecutive one (1)-year terms to four (4) and exercises the third option, extending the contract through February 28, 2024. In addition, the amendment includes language to expand the scope of work to include general commercial real estate advisory and brokerage services and to represent CalOptima on any future real estate transactions, at CalOptima's discretion.

Staff also requests Board authority to amend the current agreement with Newmark Knight Frank for unbudgeted expenditures estimated up to $75,000 to complete the third-party due diligence reports that are associated with a potential acquisition for the Board's consideration.

Fiscal Impact

The recommended action is unbudgeted. An allocation of up to $75,000 from existing reserves will fund the third-party due diligence reports.

The contract with Newmark Knight Frank is an "at risk" contract. The contracted vendor will be compensated through possible future commissions only, therefore there is no additional fiscal impact to CalOptima's Operating Budget related to extending the contract term.

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Rationale for Recommendation
The recommendation will allow CalOptima continued support in furtherance of the mission and vision.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Entities Covered by this Recommended Board Action
2. Contract Amendment No. 4 with Newmark Knight Frank

Board Action(s)

Board Meeting Dates	Action	Term	Not to Exceed Amount
February 6, 2020	Authorize contract with Newmark Knight Frank	Through February 28, 2023	Per contracted commissions schedule
April 7, 2022	Ratify amendments to contract with Newmark Knight Frank	N/A	$50,000
August 4, 2022	Ratify amendments to contract with Newmark Knight Frank	Through February 28, 2025	$75,000

/s/ Michael Hunn *07/28/2022*
Authorized Signature **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

CalOptima Medi-Cal Health Networks				
Name	**Address**	**City**	**State**	**Zip Code**
Newmark Knight Frank	700 South Flower Street, Suite 2500	Los Angeles	CA	90017

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AMENDMENT NO. 4 TO CONTRACT 20-10931
BETWEEN
ORANGE COUNTY HEALTH AUTHORITY, dba CALOPTIMA
AND
NEWMARK OF SOUTHERN CALIFORNIA, INC., A CALIFORNIA CORPORATION
DBA NEWMARK KNIGHT FRANK (CONTRACTOR)

AMENDMENT NO. 4 TO THIS CONTRACT is entered into as of the date last executed below, with respect to the following facts:

A. CalOptima and CONTRACTOR (hereinafter collectively referred to as "the Parties") entered into Contract 20-10931 on March 9th, 2020, Amendment No. 1 on June 30, 2021, Amendment No. 2 on December 28, 2021, and Amendment No. 3 on January 19, 2022, under which agreed to provide Real Estate Advisory & Brokerage Services (hereinafter, "Contract").

B. Pursuant to Article 17 of the Contract, the Contract may be amended only in writing and executed by the parties.

C. The Parties now desire to amend the Contract to add additional extensions, extend the Contract, broaden the Scope of Work of the Contract, and add additional reports for immediate use.

NOW, THEREFORE, THE PARTIES AGREE AS FOLLOWS:

1. Section 15 of the Contract is hereby modified to change "two (2) additional consecutive one (1) year terms" to "four (4) additional consecutive one (1) year terms". Additionally, the 3rd option will be exercised to extend the term of the contract through February 28, 2024.

2. Exhibit A, Scope of Work, shall be modified to add Section A.4, as follows:
4.General Commercial Real Estate Advisory & Brokerage Services.
CONTRACTOR may assist and represent CalOptima, at CalOptima's option, in the purchase and lease of any buildings and properties that meet CalOptima's parameters. Payment to CONTRACTOR shall made Pursuant to Exhibit B-1 (C) of the contract. CalOptima hereby authorizes CONTRACTOR to order the following listed third-party reports for the due diligence associated potential acquisitions:

Property Condition Report *-Supplemental Reports: MEP-FLS, Roofing Inspection*
Phase I Environmental Site Assessment
ALTA Survey
Appraisal

3. Third Party Reports. CalOptima hereby authorizes CONTRACTOR to order the third-party reports listed below for the due diligence associated with the potential acquisition of 14851 Yorba St & 165 N Myrtle Ave, Tustin, CA. CONTRACTOR shall use commercially reasonable efforts to obtain industry standard reports from third party vendors that have been deemed reliable. Reports shall not exceed $75,000.00. Upon delivery of the reports to CalOptima, payment to CONTRACTOR shall be made pursuant to Exhibit B (C) of the contract.

Property Condition Report *-Supplemental Reports: MEP-FLS, Roofing Inspection*
Phase I Environmental Site Assessment
ALTA Survey
Appraisal

4. **No Other Changes.** This Amendment No. 4 is by this reference made part of said Contract. Except as otherwise provided in this Amendment, all of the terms, conditions, and provisions of the Contract and prior amendments shall continue in full force and effect. In the event of any conflict or inconsistency between the provisions of this Amendment and any provisions of the Contract and prior amendments, if any, the provisions of this Amendment No. 4 shall in all respect govern and control. Unless otherwise specifically defined herein, terms used in this Amendment shall have the same meaning as ascribed to them in the Contract. The execution and delivery of this Amendment shall have the same meaning as ascribed to them in the Contract. The execution and delivery of this Amendment shall not operate as a waiver of or, except as expressly set forth herein, an amendment of any right, power or remedy of either party in effect prior to the date hereof.

5. **Authority to Execute.** The persons executing this Amendment on behalf of the Parties warrant that they are duly authorized to execute this Amendment and that by executing this Amendment, the Parties are formally bound.

6. **Counterparts.** This Amendment may be executed in any number of counterparts, all of which taken together shall constitute one and the same instrument, and any of the Parties hereto may execute the Amendment by signing any such counterpart.

IN WITNESS THEREOF, these Parties have, by their duly authorized representatives, executed thisAmendment No. 4 to Contract 20-10931 on the day and year last shown below.

"CALOPTIMA"

Date: _____

_____

By: Nancy Huang

Its: CFO

Date: _____

_____

By: Michael Hunn

Its: CEO

Date: _____

"CONTRACTOR"

_____

By: Gregory P. May

Its: EVP, Regional Managing Director
CA #00946118
18401 Von Karman Ave., Suite 150
Irvine, CA 92612

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 4, 2022
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

6. Ratify a License Agreement with the County of Orange for Use of Space at the County Community Service Center

Contacts

Michael Hunn, Interim Chief Executive Officer, (657) 900-1481
Deanne Thompson, Executive Director, Marketing and Communications, (714) 954-2141

Recommended Action

Staff recommends ratifying a license agreement with the County of Orange (County) for a term of five years through June 12, 2027, for CalOptima's Customer Service satellite office at the County Community Service Center (CCSC) located at 15496 Magnolia Street, Westminster, CA 92683.

Background

Since 2008, CalOptima has utilized space at the main CCSC office as a Customer Service satellite office to offer monthly education seminars that aim to increase members' knowledge about CalOptima, Medi-Cal programs, and support services. The County subsequently opened a satellite office (CCSC Annex) in October 2016, where CalOptima established a CalOptima satellite office with one dedicated CalOptima staff. CalOptima utilizes shared space through a paid license agreement with the County with a term from August 5, 2016, through June 30, 2022. The County extended their lease agreement with their landlord, and CalOptima subsequently entered into a new license agreement with the County. The current license agreement fee between CalOptima and the County is $2,132.00 per month.

Since October 2016, CalOptima staff has provided on-site education about CalOptima's programs and services, customer service support, and bi-monthly educational seminars at the CCSC Annex. In January 2017, CalOptima started offering new member orientation for its Vietnamese-speaking members there. Starting in late May 2017, a full-time, bi-lingual Customer Service Representative was designated to the satellite office to serve CalOptima members and potential members. To increase CalOptima's visibility in the community, CalOptima collaborated with community partners to host additional health education seminars and mobile mammogram events in 2018 and 2019 at the CCSC Annex.

In addition to CalOptima's services, the CCSC offers a variety of health and human services, including application assistance and education workshops to assist with housing, mental and public health, and support services for older adults. Representatives from the Orange County Health Care Agency (a mental health specialist and public health nurse), Orange County Housing Authority, the Family Caregiver Resource Center, the Council on Aging, and the Office on Aging are on-site to assist members comprehensively with their needs. The CCSC was recently renovated and expanded their services to include Eligibility Technicians from the County of Orange Social Services Agency, three (3) Social Workers to provide community health and resource navigation service and the Orange County Workforce Development. These added services will streamline public assistance programs provided by the County and provide more comprehensive services to the community. The CCSC is also referred to as the CCSC Navigation Hub.

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In March 2020, the CCSC Annex closed due to COVID-19, with CalOptima's Customer Service Representative returned to the CCSC in August 2021. In 2022, CalOptima served 124 visitors.

Discussion

The license agreement, like the County's lease, expired on June 30, 2022. The County extended their lease agreement with the landlord and requested that CalOptima enter into a new license agreement to continue providing CalOptima services. Staff recommends ratification of this new license agreement with the County.

Staff recommends CalOptima continue the collaboration with the County and maintain CalOptima's presence in the community. Therefore, Staff requests that the Board ratify the new license agreement for a term of five years with an end date of June 12, 2027. Insurance requirements are included in the new License Agreement. The license fees and insurance expenses are included as part of CalOptima's Fiscal Year (FY) 2022-23 operating budget.

Fiscal Impact

Funding for the period of June 12, 2022, through June 30, 2023, is a budgeted item in the FY 2022-23 Operating Budget. Management will include funding for the period of July 1, 2023, through June 11, 2027, in future operating budgets.

Rationale for Recommendation

As part of CalOptima's mission, staff works toward providing direct Customer Service for members and potential members to access their health care services and provide health education to members and the community at large. By operating a licensed site in central Orange County, CalOptima is able to expand services to its members and maintain a presence in the community.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Covered Entities
2. CalOptima Board Action dated February 3, 2022, Consider Authorization to Enter into Negotiations with the County of Orange to Modify and Extend the Current License Agreement for Use of Space at the County Community Services Center Annex
3. New License Agreement between CalOptima and the County of Orange

/s/ Michael Hunn *07/28/2022*
Authorized Signature Date

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Attachment to the August 4, 2022 Board of Directors Meeting – Agenda Item 6

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip code
The County of Orange Social Services Agency	500 N. State College Blvd.	Orange	CA	92868

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 3, 2022
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

4. Authorization to Enter into Negotiations with the County of Orange to Modify and Extend the Current License Agreement for Use of Space at the County Community Service Center Annex

Contacts

Michael Hunn, Interim Chief Executive Officer, (657) 900-1481
Rachel Selleck, Executive Director, Public Affairs, (657) 900-1096

Recommended Action

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to negotiate and execute a modification and extension of the License Agreement with the County of Orange for up to an additional four years through June 30, 2026, which allows use of approximately 362 square feet of space at the County Community Service Center Annex (CCSC Annex), located at 15496 Magnolia Street, Suite 111, Westminster, CA 92683.

Background

Since 2008, CalOptima has utilized space at the main CCSC office to offer monthly education seminars that aim to increase members' knowledge about CalOptima, Medi-Cal programs, and support services. The County subsequently opened a satellite office (CCSC Annex) in October 2016 where CalOptima established a CalOptima satellite office. One dedicated CalOptima staff is located there and CalOptima utilizes shared space through a paid License Agreement with the County that has a term that runs from August 5, 2016, through June 30, 2022. The current License Agreement fee is $1,705.72 per month, approximately 24% of the County's monthly rent under the lease, which is justified through the amount of space CalOptima occupies and shared common spaces at the CCSC Annex.

Since October 2016, CalOptima staff has provided on-site education about CalOptima's programs and services, customer service support, and bi-monthly educational seminars at the CCSC Annex. In January 2017, CalOptima started offering New Member Orientation for our Vietnamese-speaking members there, and starting in late May 2017, a full-time, bi-lingual Customer Service Representative was designated to the satellite office to serve CalOptima members/potential members. To increase CalOptima's visibility in the community, CalOptima collaborated with community partners to host additional health education seminars and mobile mammogram events in 2018 and 2019 at the CCSC Annex.

In addition to CalOptima's services, the CCSC offers a variety of health and human services, including application assistance and education workshops to assist with housing, mental and public health and support services for older adults. Representatives from the Orange County Health Care Agency (a mental health specialist and public health nurse), Orange County Housing Authority, the Family Caregiver Resource Center, the Council on Aging and the Office

on Aging are on-site to assist members comprehensively with their needs.

In 2019, the total number of visitors assisted by CalOptima staff ranged from 38 to 73 individuals per month. In March 2020, the CCSC Annex closed due to COVID-19, with CalOptima's Customer Service Representative returning to the CCSC Annex in August 2021.

Discussion

The License Agreement, like the County's current lease, is due to expire on June 30, 2022. While the County's current Lease Agreement includes an option to extend the term beyond June 30, 2022, for an additional four (4) year term, the CalOptima License Agreement does not. If extended, the proposed termination date is June 30, 2026. The County has until the end of February to inform the landlord of its intent to exercise its option to extend; once exercised, the landlord and the County may begin negotiations. Due to a historically lengthy process between the landlord and County, CalOptima staff is seeking authority to enter into negotiations now to stay abreast of the latest negotiation efforts.

Subject to the County's extension of the Lease Agreement through June 30, 2026, CalOptima staff is seeking Board authority to negotiate an extension of the existing License Agreement for the same period, and Board authority to enter into a modification and extension of the license term under the same provisions. Any modifications to insurance requirements will be reviewed by the Director of Financial Compliance, and if needed, CalOptima's broker, to confirm that CalOptima can meet the requirements and for consistency with current market practices. In the event of unanticipated substantive changes to the Lease Agreement, CalOptima will return to the Board for further authorization. The license fees and insurance expenses for the extended years will be included as part of CalOptima's annual budgeting process.

Staff recommends continuing the collaboration with the County and maintaining CalOptima's presence in the community through authorizing the Chief Executive Officer to negotiate and execute an extension and modification to the License Agreement as set forth above.

Fiscal Impact

Management will include expenses related to the terms of the extended Lease Agreement in the Fiscal Year 2022-23 and future operating budgets.

Rationale for Recommendation

As part of CalOptima's mission, staff works toward providing access to health care services for our members. By operating a licensed site in central Orange County, CalOptima is able to expand services to our members and maintain a presence in the community.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Covered Entities
2. CalOptima Board Action dated February 2, 2021 Consider Authorizing Extension of License Agreement with the County of Orange for Use of Space at the County Community Services Center
3. Second Amendment to Fully Executed License Agreement between CalOptima and the County of Orange

/s/ Michael Hunn — *01/27/20222*

Authorized Signature — **Date**

Attachment to the February 3, 2022 Board of Directors Meeting – Agenda Item 4

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip code
The County of Orange Social Services Agency	500 N. State College Blvd.	Orange	CA	92868

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CalOptima Board Action Agenda Referral

Action To Be Taken February 4, 2021
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

6. Consider Authorizing Modification and Extension of License Agreement with the County of Orange for Use of Space at the Orange County Community Service Center Annex

Contacts

Richard Sanchez, Chief Executive Officer, (657) 900-1481
Rachel Selleck, Executive Director, Public Affairs, (657) 900-1096

Recommended Action

Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to negotiate and execute a modification of and extension to the License Agreement with the County of Orange, as amended by the First Amendment to License, for up to an additional four years through June 30, 2025 or other determined date, which allows use of approximately 362 square feet of space along with common areas at the Orange County Community Service Center Annex (OCCSCA), located at 15496 Magnolia Street, Suite 111, Westminster, CA 92683.

Background

As a public agency and community health plan that serves the Medi-Cal population in Orange County, CalOptima has been committed to member outreach, health education and engagement since its inception. By actively engaging CalOptima members in coordination with community-based organizations, we increase opportunities for our members to receive information regarding our programs, learn about their benefits and be more proactive participants in their own health care.

Beginning in 2008, CalOptima utilized space at the main County Community Service Center (CCSC) office at no cost to CalOptima to offer monthly health education seminars to increase members knowledge about CalOptima and provide information to support our members' health care needs. Due to growth in membership and programs, and increased interest in the health education seminars, the space at the main office was insufficient to meet CalOptima and member needs for services at the main CCSC office. In May 2016, Orange County Social Services Agency informed CalOptima of an opportunity to expand our capacity at the CCSC office by licensing space located across the parking lot from the main CCSC office (referred to as the OCCSCA).

Effective August 5, 2016, CalOptima entered into a License Agreement for one dedicated office and access to a shared conference room for 50 percent of the time at the OCCSCA. The License at OCCSA for CalOptima's use of this space as a satellite office was effective through June 30, 2017. On June 1, 2017, CalOptima's Board of Directors authorized the CEO to extend the License Agreement for an additional four years through June 30, 2021. We are informed that the County's lease rent for July 1, 2020 – June 30, 2021 is $7,129 per month ($3.36 per square foot) for the OCCSCA space. The total leased space for the OCCSCA is comprised of 2,080 square feet, with CalOptima's use of 109 square feet for the dedicated office, 253 square feet for the shared conference room, and estimated 21 percent use of the common area. CalOptima's current License fee for July 1, 2020 through June 30, 2021 is $1,705.72 per month. CalOptima's License fee includes the use of space, as well as utilities, information technology, janitorial and telephone services. These expenses

are equivalent to approximately 24% of the County's monthly rent under the lease. The OCCSCA is centrally located in the county and may be more convenient for certain CalOptima members who reside in the cities of Santa Ana, Garden Grove and Westminster. Since September 2016, CalOptima staff has been on-site to provide information and education about CalOptima's programs and services, enhanced customer service support, and additional monthly educational seminars.

Initially, staff from various CalOptima departments rotated on-site at OCCSCA to serve members, including staff from the Behavioral Health Integration, Program of All-Inclusive Care (PACE), OneCare Connect Sales and Marketing, Customer Service and Community Relations departments. Services offered on-site include information and referrals for our programs and services, information and enrollment in the PACE and OneCare Connect programs, assistance with navigating health care benefits and customer service-related issues including provider and health network selection, referrals, and replacement ID cards.

In January 2017, CalOptima started offering New Member Orientation for our Vietnamese-speaking members at this location. Starting late May 2017, a full-time, bi-lingual Customer Service Representative was designated to the satellite office at OCCSCA to serve CalOptima members and potential members. Services expanded to include addressing billing inquiries, assisting with Protected Health Information (PHI) forms, reviewing pharmacy/medication denials and cases, filing grievances and appeals, and opening coordination of care cases.

CalOptima has also collaborated with community partners and internal departments to increase awareness and utilization of our satellite office. Since opening, CalOptima has hosted health education seminars on a monthly basis. The Population Health Management Department hosted mobile mammogram events on March 10, 2018 and October 29, 2019 in collaboration with Susan G. Komen Orange County, Orange County Health Care Agency Every Woman Counts Program and Alinea Mobile Imaging. This event targeted CalOptima Direct and CalOptima Community Network members who lived within a 5-mile radius of the satellite office and who were due for their breast cancer screening.

In addition to CalOptima's services, the OCCSCA offers a variety of health and human services to local residents including resources and referrals, application assistance and education workshops to assist with housing, mental and public health and support services for older adults. Representatives from Orange County Health Care Agency mental health specialist and public health nurse, Orange County Housing Authority, the Family Caregiver Resource Center, the Council on Aging and the Office on Aging are available on-site to assist members.

In 2019, the total number of visitors assisted by CalOptima staff ranged from 38 to 73 individuals per month or an average of one to three per day. In March 2020, the satellite office closed due to COVID-19. To ensure the safety and well-being of our members and prevent the spread of COVID-19, health education seminars, new member orientations, workshops and events are currently on hold; however, since July 2020, CalOptima's Customer Service Representative has been able to serve our members visiting the satellite office via telephonic support. In discussions with the County regarding COVID impacts, the County has informally advised that CalOptima's use of the designated office space and

the shared space will not be impacted due to COVID-19. The County is taking steps to ensure the safety of the community and staff by implementing social distancing requirements and limiting the number of community members entering the building.

Discussion

The License Agreement, like the County's current Lease Agreement, is due to expire on June 30, 2021. While the County's current Lease Agreement includes an option to extend the term beyond June 30, 2021 for an additional four (4) year term, the CalOptima License Agreement does not. If the County extends its Lease Agreement, and CalOptima extends the License Agreement the new termination date for both agreements would be June 30, 2025. The County has until the end of February 2021 to inform the landlord of its intent to exercise its option to extend. Once exercised, the landlord and the County may begin negotiations. Due to the potential for a lengthy process for determining the rental rate, CalOptima may not know if the space will remain available, and, if so, what the monthly License fee will be until shortly before the end of the current term.

CalOptima staff is seeking Board authority to negotiate an extension of the existing License Agreement to coincide with the County's lease term, subject to the County's extension of the lease, through June 30, 2025. The Board's approval of this item would authorize CalOptima staff to have direct discussions with the County regarding its plans, if any, to extend the Lease Agreement and CalOptima's License Agreement and to begin discussions about the extensions without waiting for the County and the landlord to come to final agreement on the Lease terms. CalOptima staff is also seeking Board authority to enter into a modification and extension of the License Agreement to extend the term for up to four years under the same provisions, subject to the monthly License fee (including utility and other services currently provided) not exceeding the same proportional rate (24%) of the monthly rent negotiated between the landlord and County. Any modifications to insurance requirements will be reviewed by the Director of Financial Compliance, with the assistance of Legal Counsel, and if needed, CalOptima's broker, to confirm that CalOptima can meet the requirements and to ensure consistency with current market practices. In the event of any other material changes, CalOptima will return to the Board for further authorization. The monthly License fees and insurance expenses for the extended years are expected to be included as part of the annual budgeting process.

The licensed site establishes a valuable CalOptima presence in the community and is available to provide local access and information to members regarding CalOptima benefits and health education to support their health care needs. This office is centrally located in Orange County and provides CalOptima with an opportunity to serve our members in their community, while establishing CalOptima's presence in the community. Staff recommends authorization to negotiate with the County, and for the Chief Executive Officer, with assistance of legal counsel, authorization to execute an extension and modification to the License Agreement as set forth above. The Board's approval will allow time for staff to engage with the County and to complete any documentation necessary prior to the end of the existing term of the License Agreement.

Fiscal Impact

The current License Agreement with the County of Orange for CCSC is a budgeted item in the amount of $21,000 under the Fiscal Year (FY) 2020-21 Operating Budget approved by the Board on June 4, 2020. Funding for the recommended action to modify and extend the License Agreement through June 30, 2025, will be included in the CalOptima Fiscal Year (FY) 2021-22 Operating Budget and future operating budgets.

Rationale for Recommendation

As part of CalOptima's mission, staff works toward providing access to health care services for our members. By operating a satellite site in central Orange County, CalOptima is able to expand services to our members and maintain a local presence in the community.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Entities Covered by this Recommended Board Action
2. CalOptima Board Action dated August 4, 2016 Consider Authorization of License Agreement with the County of Orange for Usage of Space at the County Community Service Center.
3. CalOptima Board Action dated June 1, 2017 Consider Authorizing Extension of License Agreement with the County of Orange for Use of Space at the County Community Services Center.
4. First Amendment to Fully Executed License Agreement between CalOptima and the County of Orange.
5. County of Orange Board of Supervisors Agenda Item 17-00473 dated June 6, 2017 Lease Amendment for Multi-Agency Use at 15460 and 15496 Magnolia, Westminster Attachment F Redlined Lease 15496 Magnolia

/s/ Richard Sanchez — *01/27/2021*

Authorized Signature — **Date**

Attachment to the February 4, 2021 Board of Directors Meeting – Agenda Item 6

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip code
The County of Orange Social Services Agency	500 N. State College Blvd.	Orange	CA	92868

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 4, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item

36. Consider Authorization of License Agreement with the County of Orange for Usage of Space at the County Community Service Center

Contact

Phil Tsunoda, Executive Director Public Policy and Public Affairs, (714) 246-8400

Recommended Actions

1. Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to enter into a one year license agreement with the County of Orange for non-exclusive use of approximately 362 square feet of space at the County Community Service Center (CCSC), located at 15496 Magnolia Street, Westminster, CA 92683; and
2. Approve allocation of $22,538 from existing reserves to fund the license agreement through June 30, 2017.

Background

The current County Community Service Center (CCSC) facility provides a variety of health and human services to local residents, including referrals for mental and public health, resources for the homeless, legal assistance, marriage licenses and passport services. The current CCSC also offers residents help to apply for Medi-Cal and Medicare. Representatives from the Health Care Agency, Social Services Agency, Office on Aging, Department of Housing, and County Clerk-Recorder Department are available on designated days.

As a public and community health plan that serves the low-income Medi-Cal population in Orange County, CalOptima has been committed to member outreach, health education and engagement since its inception. By actively engaging our members in efforts with our community-based organization partners and through health education workshops, health fairs and seminars, we increase opportunities for our members to receive information regarding our programs, learn about their benefits and be more proactive participants in their own health care.

Since 2008, CalOptima has utilized available space at the current CCSC offer health education seminars. At the current CCSC location, CalOptima currently hosts one health education seminar per month to assist members about health care programs. Topics at some of the recent health education seminars have included:

- Program for All-Inclusive Care for the Elderly (PACE)
- OneCare Connect
- Medicare 2016: New Policy and Changes
- Memory Loss, Dementia, and Alzheimer's Disease
- Understanding Social Security Programs and Benefits
- Consult with Three Cardiologists: Learn about Stroke and Peripheral Arterial Disease

While CalOptima members reside throughout Orange County, a large percentage reside in the central portion of the county. Residents in the cities of Santa Ana, Garden Grove, and Westminster comprise over 30% of CalOptima's total membership.

The current CCSC, located in the City of Westminster, has proven to be a centrally-located space for CalOptima members to attend health education seminars, and obtain information about programs and services. In conjunction with services offered by various county departments, the County of Orange provided CalOptima with use of the CCSC at no cost as a service to community residents.

Due to CalOptima's growth in membership and programs, and the resulting increase in interest in CalOptima's health education seminars at CCSC, additional space would better accommodate the needs of CalOptima members. At recent seminars, members have been turned away due to lack of space. While staff has addressed this issue in the short term by hosting multiple seminar sessions on the same day, the current space presents logistical challenges.

Earlier this year, the County of Orange informed CalOptima of its decision to expand capacity at the CCSC by leasing additional space located across the parking lot from the existing facility effective July 1, 2016 for use by the Orange County Social Services Agency. The leased space would provide the County with expanded space for its programs and also provide CalOptima with the opportunity to enter into a license agreement with the County that would provide CalOptima with a dedicated office, as well as shared use of a conference room space in order to offer more health education seminars and other community events each month.

Discussion

Staff recommends authorization of the license agreement with the County of Orange, which would allow CalOptima to have one dedicated office, along with shared use of a conference room. The County's recently added CCSC space has a conference room (which is 253 square feet in size) that is adjacent to the entryway of the suite. Additionally, the County of Orange is proposing to remove the wall between the conference room and the entryway (at CalOptima's expense), which would create a larger space for community events, such as the health education seminars. While the original CCSC has a maximum capacity to hold events with 20 participants, the new CCSC space will have the capacity to hold events with approximately 50 participants.

The County's newly leased CCSC space is comprised of 2,080 square feet total. The County's primary lease agreement with the property owner is for $5,000 per month (approximately $2.40 per square foot) and includes seven offices as well as a conference room. As proposed, CalOptima would have access to the conference room for 50% of the time, one dedicated office, and the common area of the leased space.

Based on estimates provided by the County of Orange, the monthly expenses to CalOptima for its portion of the space is $1,453.02. This cost estimate is based on: 253 square footage of conference room space, 109 square foot dedicated CalOptima office, and prorated 21% of total common area. The County of Orange estimates the improvement costs to remove the wall between the conference room and the entryway at $7,646 in one-time costs to CalOptima.

Staff has conducted a review of the County of Orange's sub-lease agreement. Based on current commercial real estate trends, the proposed license is well within market pricing.

	Total Amount
License Fee (August 2016 - June 2017) • Fee includes leased space, IT services, telephone services, janitorial services, and electrical/utilities	$14,892
Improvement costs (Removal of wall)	$7,646
Total	**$22,538**

The County of Orange's primary lease agreement for the annexed CCSC is for the period of July 1, 2016 through June 30, 2017. Staff is proposing CalOptima's license for the CCSC annex to be for the period of August 5, 2016 through June 30, 2017.

Fiscal Impact
The recommended action to execute a license agreement with the County of Orange through June 30, 2017, for usage of space at the CCSC will be funded through an allocation of $22,538 from existing reserves.

Rationale for Recommendation
As part of CalOptima's mission, staff works towards providing access to health care services for our members. In the past eight years, CalOptima's participation at the CCSC has proved extremely valuable, as we have helped provide access to information about programs and benefits, as well as critical health education to members. Due to CalOptima's new programs and substantial increase in overall membership, the current CCSC location no longer meets the needs of our members. The opportunity to partner with the County of Orange and sub-lease additional space, provides a low-cost solution to not only meet the existing logistical challenges of the health education seminars, but also provides an opportunity for CalOptima to expand its services to members.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Draft County of Orange CCSC Annex Proposed License Agreement with CalOptima for new CCSC location
2. CCSC Cost Apply
3. County of Orange Primary Lease Agreement for new CCSC location
4. Quotation for Tenant Improvements

/s/ Michael Schrader — *07/29/2016*
Authorized Signature — **Date**

Back to Agenda Back to Item

LICENSE AGREEMENT

This LICENSE AGREEMENT (**"License"**) is made and entered into _____ , 2016 (**"Effective Date"**), by and between, CALOPTIMA, (hereinafter referred to as **"LICENSEE"**) and COUNTY OF ORANGE, a political subdivision of the State of California (hereinafter referred to as **"COUNTY"**) without regard to number and gender. LICENSEE and COUNTY may individually be referred to herein as a "**Party**," or collectively as the "**Parties**."

RECITALS

I. COUNTY leases that certain real property located at 15496 Magnolia in the City of Westminster, (**"County Property"**) pursuant to a lease dated July 1, 2016 for COUNTY's Social Services Agency's (**"SSA"**) Orange County Community Service Center Annex (**"OCCSCA"**).

II. The Services provided by LICENSEE will include a convenient on-site source while SSA clients are at the SSA Office.

III. COUNTY agrees to provide LICENSEE sufficient office space within the SSA Office for LICENSEE to provide the Services.

NOW THEREFORE, in consideration of the Recitals above, incorporated herein by reference, COUNTY and LICENSEE do hereby agree as follows:

1. DEFINITIONS (AMLC-2.1 S)

The following words in this License have the significance attached to them in this clause, unless otherwise apparent from context:

"Board of Supervisors" means the Board of Supervisors of the County of Orange, a political subdivision of the State of California.

"Chief Real Estate Officer" means the Chief Real Estate Officer, County Executive Office, County of Orange, or designee or upon written notice to LESSOR, such other person or entity as shall be designated by the County Executive Officer.

"County Counsel" means the County Counsel, County of Orange, or designee, or upon written notice to LICENSEE, such other person or entity as shall be designated by the Board of Supervisors.

"County Executive Officer" means the County Executive Officer, County Executive Office, County of Orange, or designee, or upon written notice to LICENSEE, such other person or entity as shall be designated by the Board of Supervisors.

"**Facilities Services Manager**" means the Manager of the Social Services Agency, Facilities Services, County of Orange, or designee, or upon written notice to LICENSEE, such other person or entity as shall be designated by the Director of Social Services Agency.

"Risk Manager" means the Manager of County Executive Office, Risk Management, for the County of Orange, or upon written notice to LICENSEE, such entity as shall be designated by the County Executive Officer.

"SSA Director" means the Director of Social Services Agency, County of Orange, or designee, or upon written notice to LICENSEE, such other person or entity as shall be designated by the County Executive Officer or the Board of Supervisors.

2. TERM (AMLC-3.1 N)

The term of this License shall commence on the Effective Date and terminate on June 30, 2017, unless terminated as provided in Clause 3 (TERMINATION) of this License.

3. TERMINATION (AMLC-3.3 S)

This License shall be revocable by either COUNTY's SSA Director or LICENSEE at any time; however, as a courtesy the Parties will attempt to give thirty (30) days written notice to the other Party upon revocation.

4. LICENSE AREA (AMLC-4.2 N)

COUNTY grants to LICENSEE the non-exclusive right to use that certain property hereinafter referred to as **"License Area,"** shown on Exhibit A, attached hereto and by reference made a part hereof, for the purposes set forth in Clause 6 (USE) of this License together with non-exclusive, in common use of COUNTY's elevators, stairways, washrooms, hallways, driveways for vehicle ingress and egress, pedestrian walkways, other facilities and common areas appurtenant to LICENSEE's License Area created by this License.

During the term of this License, the dates and times for use of the License Area will be determined by the Facilities Services Manager, and the location of the License Area is subject to relocation at the sole discretion of the Facilities Operations Manager.

5. PARKING (AMLC-4.4 S)

Throughout the term of this License COUNTY shall provide one (1) parking space for LICENSEE's free and non-exclusive use.

6. USE (AMLC-5.1 N)

LICENSEE's use of the License Area shall be limited to general office to provide clients with health related workshops and information regarding their Medi-Cal benefits.

LICENSEE agrees not to use the License Area for any other purpose nor to engage in or permit any other activity within or from the License Area without prior written permission from the Facilities Services Manager. LICENSEE further agrees not to conduct or permit to be conducted any public or private nuisance in, on, or from the License Area, not to commit or permit to be committed waste on the License Area, and to comply with all governmental laws and regulations in connection with its use of the License Area.

NO ALCOHOLIC BEVERAGES OR TOBACCO PRODUCTS SHALL BE SOLD OR CONSUMED WITHIN THE LICENSE AREA.

7. LICENSE FEE (AMLC-6.1 S)

LICENSEE agrees to pay COUNTY from and after the effective date of this License according to the following schedule:

MONTH	MONTHLY LICENSE FEE
1	$0.00
2	$361.73
3	$1,453.02
4	$1,453.02
5	$1,453.02
6	$1,453.02
7	$1,453.02
8	$1,453.02
9	$1,453.02
10	$1,453.02
11	$1,453.02
12	$1,453.02

The monthly License Fee shall be payable in advance, without prior notice or demand on the first day of each calendar month while this License is in effect without deduction or offset in lawful money of the United States.

In the event the obligation to pay the License Fee begins or terminates on some day other than the first day or last day of the month, the License Fee shall be prorated to reflect the actual period of use on the basis of a thirty (30) day month. The fee for any partial calendar month during which this License becomes effective will be payable on such effective date.

8. PAYMENT PROCEDURE (AMLC-7.1 N)

All payments shall be delivered to the County of Orange, Office of the Auditor-Controller, P. O. Box 567 (630 N. Broadway), Santa Ana, California 92702. The designated place of payment may be changed at any time by COUNTY upon ten (10) days written notice to LICENSEE. License Fee payments may be made by check payable to the County of Orange. Said License Fee payment shall include a payment voucher indicating that the payment is for the monthly License Fee for office space at the Orange County Community Service Center Annex in Westminster, California. A duplicate copy of the payment voucher shall be mailed to the County of Orange, Social Services Agency, 500 N. State College Boulevard, Orange, California,

92868, Attention: Facilities Services Manager. LICENSEE assumes all risk of loss if payments are made by mail.

No payment by LICENSEE or receipt by COUNTY of a lesser amount than the payment due shall be deemed to be other than on account of the payment due, nor shall any endorsement or statement on any check or any letter accompanying any check or payment as payment be deemed an accord and satisfaction, and COUNTY shall accept such check or payment without prejudice to COUNTY's right to recover the balance of said payment or pursue any other remedy in this License.

9. CHARGE FOR LATE PAYMENT (AMLC-7.2 S)

LICENSEE hereby acknowledges that late payment of sums due hereunder will cause COUNTY to incur costs not contemplated by this License, the exact amount of which will be extremely difficult to ascertain. Such costs include but are not limited to costs such as administrative processing of delinquent notices, increased accounting costs, etc.

Accordingly, if any payment pursuant to this license is not received by COUNTY by the due date, a late charge of one and one-half percent (1.5%) of the payment due and unpaid plus $100 shall be added to the payment, and the total sum shall become immediately due and payable to the COUNTY. An additional charge of one and one-half percent (1.5%) of said payment, excluding late charges, shall be added for each additional month that said payment remains unpaid.

LICENSEE and COUNTY hereby agree that such late charges represent a fair and reasonable estimate of the costs that COUNTY will incur by reason of LICENSEE's late payment.

Acceptance of such late charges (and/or any portion of the overdue payment) by COUNTY shall in no event constitute a waiver of LICENSEE's default with respect to such overdue payment, or prevent COUNTY from exercising any of the other rights and remedies granted hereunder.

10. UTILITIES, JANITORIAL, MAINTENANCE AND REPAIR (AMLC-9.3 N)

COUNTY shall be responsible for all charges for all utilities (water, gas and sewer),. County shall be responsible for all maintenance and repairs (including but not limited to: fire alarm, fire extinguisher, HVAC system, elevator maintenance, landscaping, pest control, and trash). COUNTY shall be responsible for telephone service, internet service and janitorial service. All charges for services provided by COUNTY pursuant to this Clause shall be included in LICENSEE's "MONTHLY LICENSE FEE" pursuant to Clause 7. (LICENSE FEE) of the License.

11. CONSTRUCTION AND/OR ALTERATION BY LICENSEE (AMD2.1 S)

COUNTY's Consent. No structures, improvements, or facilities shall be constructed, erected, altered, or made by LICENSEE within the License Area without prior written consent of the Facilities Services Manager. Any conditions relating to the manner, method, design, and construction of said structures, improvements, or facilities fixed by the Facilities Services Manager as a condition to granting such consent, shall be conditions hereof as though originally stated herein. LICENSEE may, at any time and at its sole expense, install and place business fixtures and equipment within License Area.

Strict Compliance with Plans and Specifications. All improvements constructed by LICENSEE within the

License Area shall be constructed in strict compliance with detailed plans and specifications approved by the Facilities Services Manager.

COUNTY shall contract with a licensed contractor to remove the existing wall between the "Reception Area" and "Room #1" as depicted in Exhibit B, to replace existing carpet, and repair any areas resulting from removing said wall. LICENSEE shall reimburse COUNTY in the amount not to exceed Seven Thousand six hundred forty-five dollars and fifty-five cents ($7,645.55) within twenty (20) business days of COUNTY's submittal to LICENSEE of an invoice from COUNTY.

12. MECHANICS LIENS OR STOP-NOTICES (AMD4.1 S)

LICENSEE shall at all times indemnify, defend with counsel approved in writing by COUNTY and save COUNTY harmless from all claims, losses, demands, damages, cost, expenses, or liability costs for labor or materials in connection with construction, repair, alteration, or installation of structures, improvements, equipment, or facilities within the License Area, and from the cost of defending against such claims, including attorney fees and costs.

In the event a lien or stop-notice is imposed upon the License Area as a result of such construction, repair, alteration, or installation, LICENSEE shall either:

A. Record a valid Release of Lien, or

B. Procure and record a bond in accordance with Section 3143 of the Civil Code, which frees the License Area from the claim of the lien or stop-notice and from any action brought to foreclose the lien.

Should LICENSEE fail to accomplish either of the two optional actions above within fifteen (15) days after the filing of such a lien or stop-notice, the License shall be in default and shall be subject to immediate termination.

13. OWNERSHIP OF IMPROVEMENTS (AMD6.1 N)

All improvements, exclusive of trade fixtures, constructed or placed within the License Area by LICENSEE must, upon completion, be free and clear all liens, claims, or liability for labor or material and at COUNTY's option shall be the property of COUNTY's at the expiration of this License or upon earlier termination hereof. COUNTY retains the right to require LICENSEE, at LICENSEE's cost, to remove all LICENSEE's improvements located on the License Area at the expiration or termination hereof.

14. INSURANCE (AML10.1 N)

LICENSEE agrees to purchase all required insurance at LICENSEE's expense and to deposit with COUNTY certificates of insurance, including all endorsements required herein, necessary to satisfy COUNTY that the insurance provisions of this License have been complied with and to keep such insurance coverage and the certificates and endorsements therefore on deposit with COUNTY during the entire term of this License. This License shall automatically terminate at the same time LICENSEE's insurance coverage is terminated. If within ten (10) business days after termination under this Clause LICENSEE obtains and provides evidence of the required insurance coverage acceptable to Facilities Services Manager, this License may be reinstated at the sole discretion of Facilities Services Manager.

LICENSEE agrees that LICENSEE shall not operate on the License Area at any time the required insurance is not in full force and effect as evidenced by a certificate of insurance and necessary endorsements or, in the interim, an official binder being in the possession of Facilities Services Manager. In no cases shall assurances by LICENSEE, its employees, agents, including any insurance agent, be construed as adequate evidence of insurance. Facilities Services Manager will only accept valid certificates of insurance and

endorsements, or in the interim, an insurance binder as adequate evidence of insurance. LICENSEE also agrees that upon cancellation, termination, or expiration of LICENSEE's insurance, COUNTY may take whatever steps are necessary to interrupt any operation from or on the License Area until such time as the Facilities Services Manager reinstates the License.

If LICENSEE fails to provide Facilities Services Manager with a valid certificate of insurance and endorsements, or binder at any time during the term of the License, COUNTY and LICENSEE agree that this shall constitute a material breach of the License. Whether or not a notice of default has or has not been sent to LICENSEE, said material breach shall permit COUNTY to take whatever steps necessary to interrupt any operation from or on the License Area, and to prevent any persons, including, but not limited to, members of the general public, and LICENSEE's employees and agents, from entering the License Area until such time as Facilities Services Manager is provided with adequate evidence of insurance required herein. LICENSEE further agrees to hold COUNTY harmless for any damages resulting from such interruption of business and possession, including, but not limited to, damages resulting from any loss of income or business resulting from the COUNTY's action.

All contractors performing work on behalf of LICENSEE pursuant to this License shall obtain insurance subject to the same terms and conditions as set forth herein for LICENSEE. LICENSEE shall not allow contractors or subcontractors to work if contractors have less than the level of coverage required by COUNTY from LICENSEE under this License. It is the obligation of LICENSEE to provide written notice of the insurance requirements to every contractor and to receive proof of insurance prior to allowing any contractor to begin work within the License Area. Such proof of insurance must be maintained by LICENSEE through the entirety of this License and be available for inspection by a COUNTY representative at any reasonable time.
All self-insured retentions (**"SIRs"**) and deductibles shall be clearly stated on the Certificate of Insurance. If no SIRs or deductibles apply, indicate this on the Certificate of Insurance with a "0" by the appropriate line of coverage. Any **SIR** or deductible in excess of $25,000 ($5,000 for automobile liability), shall specifically be approved by COUNTY's Risk Manager.

If LICENSEE fails to maintain insurance acceptable to COUNTY for the full term of this License, COUNTY may terminate this License.

Qualified Insurer

The policy or policies of insurance must be issued by an insurer licensed to do business in the state of California (California Admitted Carrier) or have a minimum rating of A- (Secure A.M. Best's Rating) and VIII (Financial Size Category) as determined by the most current edition of the **Best's key Rating Guide/Property-Casualty/United States or ambest.com**.

If the insurance carrier is not an admitted carrier in the state of California and does not have an A.M. Best rating of A-/VIII, COUNTY's Risk Manager retains the right to approve or reject a carrier after a review of the company's performance and financial ratings.

The policy or policies of insurance maintained by LICENSEE shall provide the minimum limits and coverage as set forth below:

Coverages	Minimum Limits

Coverages	Minimum Limits
Commercial General Liability	$1,000,000 per occurrence $2,000,000 aggregate
Automobile Liability including coverage for owned, non-owned and hired vehicles	$1,000,000 limit per occurrence
Workers' Compensation	Statutory
Employers' Liability Insurance	$1,000,000 per occurrence

Required Coverage Forms

The Commercial General Liability coverage shall be written on Insurance Services Office (**"ISO"**) form CG 00 01, or a substitute form providing liability coverage at least as broad.
The Business Auto Liability coverage shall be written on ISO form CA 00 01, CA 00 05, CA 00 12, CA 00 20, or a substitute form providing liability coverage as broad.

Required Endorsements

The following endorsements must be submitted with the Certificate of Insurance:

a) The Commercial General Liability policy shall contain an Additional Insured endorsement using ISO form CG 2010 or CG 2033 or a form at least as broad naming the COUNTY, its elected and appointed officials, officers, employees, and agents as Additional Insureds.

b) The Commercial General Liability policy shall contain a primary non-contributing endorsement evidencing that the LESSEE's insurance is primary and any insurance or self-insurance maintained by the COUNTY shall be excess and non-contributing.

c) The Workers' Compensation policy shall contain a waiver of subrogation endorsement waiving all rights of subrogation against the COUNTY, and members of the Board of Supervisors, its elected and appointed officials, officers, agents and employees.

d) The Commercial Property policy shall contain a Loss Payee endorsement naming the COUNTY as respects the COUNTY's financial interest when applicable.

All insurance policies required by this contract shall waive all rights of subrogation against the COUNTY and members of the Board of Supervisors, its elected and appointed officials, officers, agents and employees when acting within the scope of their appointment or employment.

All insurance policies required by this contract shall give COUNTY thirty (30) days notice in the event of cancellation and ten (10) days for non-payment of premium. This shall be evidenced by policy provisions or an endorsement separate from the Certificate of Insurance.

The Commercial General Liability policy shall contain a severability of interests' clause, also known as a "separation of insureds" clause (standard in the ISO CG 001 policy).

Insurance certificates should be forwarded to COUNTY's address provided in Clause 17 (NOTICES) below or to an address provided by SSA/Facilities Services Manager. LICENSEE has ten (10) business days to provide adequate evidence of insurance or this License may be cancelled.

COUNTY expressly retains the right to require LICENSEE to increase or decrease insurance of any of the above insurance types throughout the term of this License. Any increase or decrease in insurance will be as deemed by COUNTY's Risk Manager as appropriate to adequately protect COUNTY.

COUNTY shall notify LICENSEE in writing of changes in the insurance requirements. If LICENSEE does not deposit copies of acceptable certificates of insurance and endorsements with COUNTY incorporating such changes within thirty (30) days of receipt of such notice, this License may be in breach without further notice to LICENSEE, and COUNTY shall be entitled to all legal remedies.

The procuring of such required policy or policies of insurance shall not be construed to limit LICENSEE's liability hereunder nor to fulfill the indemnification provisions and requirements of this License, nor in any way to reduce the policy coverage and limits available from the insurer.

15. OPERATIONS (AMLC-11.1 N)

LICENSEE shall keep and maintain the License Area and all improvements of any kind in good condition and in substantial repair. COUNTY will, on LICENSEE's behalf, provide all maintenance and repairs to the License Area during the term of the License. LICENSEE is required to notify COUNTY of any and all necessary maintenance and repairs to the License Area on a timely basis.

LICENSEE expressly agrees to maintain the License Area in a safe, clean, wholesome, and sanitary condition, to the complete satisfaction of COUNTY and in compliance with all applicable laws. LICENSEE further agrees to keep the License Area free and clear of rubbish and litter. COUNTY shall have the right to enter upon and inspect the License Area at any time for cleanliness and safety.

LICENSEE shall designate in writing to COUNTY an on-site representative who shall be responsible for the day to day operation and level of maintenance, cleanliness, and general order.

16. LIMITATION OF THE LICENSE (AMLC-13.1 S)

This License and the rights and privileges granted LICENSEE in and to the License Area are subject to all covenants, conditions, restrictions, and exceptions of record or apparent from a physical inspection of the License Area. Nothing contained in this License or in any document related hereto shall be construed to imply the conveyance to LICENSEE of rights in the License Area, which exceed those owned by COUNTY.

17. HIPAA NOTICE (N)

LICENSEE acknowledges that the Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA) requires COUNTY to safeguard and maintain the confidentiality of any Protected Health Information (PHI). LICENSEE hereby agrees not to access, remove, destroy, or relocate any property used by COUNTY to safeguard and store PHI. LICENSEE further agrees to use appropriate safeguards and to

take all reasonable steps to prevent access to any PHI stored on the premises, including informing its workforce, contractors and vendors of the confidential nature of the records maintained by COUNTY. LICENSEE agrees to report to COUNTY within ten (10) calendar days any unauthorized use or any disclosure of PHI, which LICENSEE becomes aware. Upon COUNTY's knowledge of any breach, disclosure, or unauthorized use of PHI by LICENSEE, COUNTY shall:

a. Provide an opportunity for LICENSEE to cure the breach or end the violation. If LICENSEE does not cure the breach or end the violation within thirty (30) days or shorter period as required by COUNTY, COUNTY shall terminate this Agreement; or

b. Immediately terminate this Agreement if cure is not possible.

18. HAZARDOUS MATERIALS (AMLC-16.1 S)

A. Definition of Hazardous Materials. For purposes of this License, the term **"Hazardous Material"** or "Hazardous Materials" shall mean any hazardous or toxic substance, material, product, byproduct, or waste which is or shall become regulated by any governmental entity, including, without limitation, the COUNTY acting in its governmental capacity, the State of California or the United States government.

B. Use of Hazardous Materials. LICENSEE or LICENSEE's employees, agents, independent contractors or invitees (collectively **"LICENSEE Parties"**) shall not cause or permit any Hazardous Materials to be brought upon, stored, kept, used, generated, released into the environment or disposed of on, under, from or about the License Area (which for purposes of this clause shall include the subsurface soil and ground water). Notwithstanding the foregoing, LICENSEE may keep on or about the License Area small quantities of Hazardous Materials that are used in the ordinary, customary and lawful cleaning of and business operations on the License Area.

C. LICENSEE Obligations. If the presence of any Hazardous Materials on, under or about the License Area caused or permitted by LICENSEE or LICENSEE Parties results in (i) injury to any person, (ii) injury to or contamination of the License Area (or a portion thereof), or (iii) injury to or contamination or any real or personal property wherever situated, LICENSEE, at its sole cost and expense, shall promptly take all actions necessary or appropriate to return the License Area to the condition existing prior to the introduction of such Hazardous Materials to the License Area and to remedy or repair any such injury or contamination. Without limiting any other rights or remedies of COUNTY under this License, LICENSEE shall pay the cost of any cleanup or remedial work performed on, under, or about the License Area as required by this License or by applicable laws in connection with the removal, disposal, neutralization or other treatment of such Hazardous Materials caused or permitted by LICENSEE or LICENSEE Parties. Notwithstanding the foregoing, LICENSEE shall not take any remedial action in response to the presence, discharge or release, of any Hazardous Materials on, under or about the License Area caused or permitted by LICENSEE or LICENSEE Parties, or enter into any settlement agreement, consent decree or other compromise with any governmental or quasigovernmental entity without first obtaining the prior written consent of the COUNTY. All work performed or caused to be performed by LICENSEE as provided for above shall be done in good and workmanlike manner and in compliance with plans, specifications, permits and other requirements for such work approved by COUNTY.

D. Indemnification for Hazardous Materials. To the fullest extent permitted by law, LICENSEE hereby agrees to indemnify, hold harmless, protect and defend (with attorneys acceptable to COUNTY) COUNTY, its elected officials, officers, employees, agents and independent contractors and the

License Area, from and against any and all liabilities, losses, damages (including, but not limited, damages for the loss or restriction on use of rentable or usable space or any amenity of the License Area or damages arising from any adverse impact on marketing of the License Area), diminution in the value of the License Area, judgments, fines, demands, claims, recoveries, deficiencies, costs and expenses (including, but not limited to, reasonable attorneys' fees, disbursements and court costs and all other professional or consultant's expenses), whether foreseeable or unforeseeable, arising directly or indirectly out of the presence, use, generation, storage, treatment, on or off-site disposal or transportation of Hazardous Materials on, into, from, under or about the License Area by LICENSEE or LICENSEE's Parties. The foregoing indemnity shall also specifically include the cost of any required or necessary repair, restoration, clean-up or detoxification of the License Area and the preparation of any closure or other required plans.

19. NOTICES (AMLC-14.1 S)

All notices pursuant to this License shall be addressed as set forth below or as either Party may hereafter designate by written notice and shall be sent through the United States mail in the State of California duly registered or certified with postage prepaid. If any notice is sent by registered or certified mail, as aforesaid, the same shall be deemed served or delivered twenty-four (24) hours after mailing thereof as above provided. Notwithstanding the above, COUNTY may also provide notices to LICENSEE by personal delivery, by regular mail, or by electric mail and any such notice so given shall be deemed to have been given upon receipt.

TO: COUNTY

County of Orange
Social Services Agency
Facilities Services
500 N. State College Boulevard
Orange, CA 92868

With a copy to:

County Executive Office
Attention: Chief Real Estate Officer
333 W. Santa Ana Boulevard, 3rd Floor
Santa Ana, CA 92701

TO: LICENSEE

CalOptima
15496 Magnolia, #111
Westminster, CA 92806
Phil Tsunoda, Executive Director,
Public Policy & Public Affairs
ptsunoda@caloptima.org

20. ATTACHMENTS TO LICENSE (AMLC-15.1 S)

This License includes the following, which are attached hereto and made a part hereof:

I. GENERAL CONDITIONS
II. EXHIBITS
Exhibit A - License Description
Exhibit B – Floor Plan

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WITNESS WHEREOF, the parties have executed this License the day and year first above written.

APPROVED AS TO FORM:
OFFICE OF COUNTY COUNSEL
ORANGE COUNTY, CALIFORNIA

By_____
Deputy County Counsel

Date:_____

LICENSEE
CalOptima

By_____

Name:_____
Title:_____

RECOMMENDED FOR APPROVAL

Social Services Agency

By_____
Carol Wiseman, Chief Deputy Director

CEO Real Estate Services

By_____
John Beck, Administrative Manager

COUNTY

COUNTY OF ORANGE

By _____
Scott Mayer, Chief Real Estate Officer
County Executive Office
Per Resolution No. 14-014 of the Board of Supervisors and Minute Order dated January 28, 2014

Date:_____

GENERAL CONDITIONS (AMLC-GC l-17 S)

1. PERMITS AND LICENSES (AMLC - GC2 S)

LICENSEE shall be required to obtain any and all permits and/or licenses which may be required in connection with the operation of the License Area as set out herein. No permit, approval, or consent given hereunder by COUNTY, in its governmental capacity, shall affect or limit LICENSEE's obligations hereunder, nor shall any approvals or consents given by COUNTY, as a Party to this License, be deemed approval as to compliance or conformance with applicable governmental codes, laws, rules, or regulations.

2. SIGNS (AMLC-GC3 S)

LICENSEE agrees not to construct, maintain, or allow any signs, banners, flags, etc., upon License Area except as approved by Facilities Operations Manager unapproved signs, banners, flags, etc., may be removed.

3. LICENSE ORGANIZATION (AMLC-GC4 S)

The various headings and numbers herein, the grouping of provisions of this License into separate clauses and paragraphs, and the organization hereof, are for the purpose of convenience only and shall not be considered otherwise.

4. AMENDMENTS (AMLC-GC5 S)

This License is the sole and only agreement between the Parties regarding the subject matter hereof; other agreements, either oral or written, are void. Any changes to this License shall be in writing and shall be properly executed by both Parties.

5. UNLAWFUL USE (AMLC-GC6 S)

LICENSEE agrees no improvements shall be erected, placed upon, operated, nor maintained on the License Area, nor any business conducted or carried on therein or there from, in violation of the terms of this License, or of any regulation, order of law, statute, bylaw, or ordinance of a governmental agency having jurisdiction.

6. INSPECTION (AMLC-GC7 S)

COUNTY or its authorized representative shall have the right at all reasonable times to inspect the operation to determine if the provisions of this License are being complied with.

7. INDEMNIFICATION (AMLC-GC8 S)

LICENSEE hereby waives all claims and recourse against COUNTY including the right of contribution for loss or damage of persons or property arising from, growing out of, or in any way connected with or related to this License except claims arising from the concurrent active or sole negligence of COUNTY, its officers, agents, and employees. LICENSEE hereby agrees to indemnify, hold harmless, and defend with counsel acceptable to COUNTY, its officers, agents, and employees against any and all claims, loss, demands, damages, cost, expenses, or liability costs arising out of the operation, use, or maintenance of the property

described herein, and/or LICENSEE's exercise of the rights under this License, except for liability arising out of the concurrent active or sole negligence of COUNTY, its officers, agents, or employees, including the cost of defense of any lawsuit arising there from.

In the event COUNTY is named as co-defendant, LICENSEE shall notify COUNTY of such fact and shall represent COUNTY with counsel acceptable to COUNTY in such legal action unless COUNTY undertakes to represent itself as co-defendant in such legal action, in which event LICENSEE shall pay to COUNTY its litigation costs, expenses, and attorney's fees. In the event judgment is entered against COUNTY and LICENSEE because of the concurrent active negligence of COUNTY and LICENSEE, their officers, agents, or employees, an apportionment of liability to pay such judgment shall be made by a court of competent jurisdiction. Neither Party shall request a jury apportionment.

8. TAXES AND ASSESSMENTS (AMLC-GC9 S)

Although not anticipated, should this License create a possessory interest which is subject to the payment of taxes levied on such interest, it is understood and agreed that all taxes and assessments (including but not limited to said possessory interest tax) which become due and payable in connection with this License or upon fixtures, equipment, or other property used in connection with this License, shall be the full responsibility of LICENSEE, and LICENSEE shall cause said taxes and assessments to be paid promptly.

9. PARTIAL INVALIDITY (AMLC-GC10 S)

If any term, covenant, condition, or provision of this License is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remainder of the provisions hereof shall remain in full force and effect and shall in no way be affected, impaired, or invalidated thereby.

10. WAIVER OF RIGHTS (AMLC-GC11 S)

The failure of COUNTY to insist upon strict performance of any of the terms, covenants, or conditions of this License shall not be deemed a waiver of any right or remedy that COUNTY may have, and shall not be deemed a waiver of the right to require strict performance of all the terms, covenants, and conditions of the License thereafter, nor a waiver of any remedy for the subsequent breach or default of any term, covenant, or condition of the License. Any waiver, in order to be effective, must be signed by the Party whose right or remedy is being waived.

11. CONDITION OF LICENSE AREA UPON TERMINATION (AMLC-GC12 S)

Except as otherwise agreed to herein, upon termination of this License, LICENSEE shall redeliver possession of said License Area to COUNTY in substantially the same condition that existed immediately prior to LICENSEE’s entry thereon, reasonable wear and tear, flood, earthquakes, and any act of war excepted.

12. DISPOSITION OF ABANDONED PERSONAL PROPERTY (AMLC-GC13 S)

If LICENSEE abandons the License Area or is dispossessed thereof by process of law or otherwise, title to any personal property belonging to LICENSEE and left on the License Area ten (10) days after such event shall be deemed, at COUNTY’s option, to have been transferred to COUNTY. COUNTY shall have the

right to remove and to dispose of such property without liability there from to LICENSEE or to any person claiming under LICENSEE, and shall have no need to account therefore.

13. TIME OF ESSENCE (AMLC-GC14 S)

Time is of the essence of this License. Failure to comply with any time requirements of this License shall constitute a material breach of this License.

14. NO ASSIGNMENT (AMLC-G15 S)

The License granted hereby is personal to LICENSEE and any assignment of said license by LICENSEE, voluntarily or by operation of law, shall automatically terminate the License granted hereby.

15. CHILD SUPPORT ENFORCEMENT REQUIREMENTS (AMLC-GC16 S)

In order to comply with child support requirements of the County of Orange, LICENSEE hereby furnishes COUNTY's Facilities Operations Manager, COUNTY's standard form, Child Support Enforcement Certification Requirements. COUNTY acknowledges receipt of the aforementioned form, which contains the following information:

a) In the case where LICENSEE is doing business as an individual, LICENSEE's name, date of birth, Social Security number, and residence address;

b) In the case where LICENSEE is doing business in a form other than as an individual, the name, date of birth, Social Security number, and residence address of each individual who owns an interest of ten (10) percent or more in the contracting entity;

c) A certification that LICENSEE has fully complied with all applicable federal and state reporting requirements regarding its employees; and

d) A certification that LICENSEE has fully complied with all lawfully served Wage and Earnings Assignment Orders and Notices of Assignment and will continue to so comply.

Failure of LICENSEE to continuously comply with all federal and state reporting requirements for child support enforcement or to comply with all lawfully served Wage and Earnings Assignment Orders and Notices of Assignment shall constitute a material breach of this License. Failure to cure such breach within sixty (60) calendar days of notice from COUNTY's shall constitute grounds for termination of this License.

It is expressly understood that this data will be transmitted to governmental agencies charged with the establishment and enforcement of child support orders and will not be used for any other purpose.

16. RIGHT TO WORK AND MINIMUM WAGE LAWS (AMLC-GC17 S)

In accordance with the United States Immigration Reform and Control Act of 1986, LICENSEE shall require its employees that directly or indirectly service the License Area or terms and conditions of this License, in any manner whatsoever, to verify their identity and eligibility for employment in the United States. LICENSEE shall also require and verify that its contractors or any other persons servicing the License Area

or terms and conditions of this License, in any manner whatsoever, verify the identity of their employees and their eligibility for employment in the United States.

Pursuant to the United States of America Fair Labor Standard Act of 1938, as amended, and State of California Labor Code, Section 1178.5, LICENSEE shall pay no less than the greater of the Federal or California Minimum Wage to all its employees that directly or indirectly service the License Area, in any manner whatsoever. LICENSEE shall require and verify that all its contractors or other persons servicing the License Area on behalf of LICENSEE also pay their employees no less than the greater of the Federal or California Minimum Wage.

LICENSEE shall comply and verify that its contractors comply with all other Federal and State of California laws for minimum wage, overtime pay, record keeping, and child labor standards pursuant to the servicing of the License Area or terms and conditions of this License.

Notwithstanding the minimum wage requirements provided for in this clause, LICENSEE, where applicable, shall comply with the prevailing wage and related requirements pursuant to the provisions of Section 1773 of the Labor Code of the State of California.

17. BEST MANAGEMENT PRACTICES (AMLC 15.1 S)

LICENSEE and all of LICENSEE's, agents, employees and contractors shall conduct operations under this License so as to assure that pollutants do not enter municipal storm drain systems which systems are comprised of, but are not limited to curbs and gutters that are part of the street systems ("**Stormwater Drainage System**"), and to ensure that pollutants do not directly impact "**Receiving Waters**" (as used herein, Receiving Waters include, but are not limited to, rivers, creeks, streams, estuaries, lakes, harbors, bays and oceans).

The Santa Ana and San Diego Regional Water Quality Control Boards have issued National Pollutant Discharge Elimination System ("**NPDES**") permits ("**Stormwater Permits**") to the County of Orange, and to the Orange County Flood Control District and cities within Orange County, as co-permittees (hereinafter collectively referred to as "**County Parties**") which regulate the discharge of urban runoff from areas within the County of Orange, including the License Area. The County Parties have enacted water quality ordinances that prohibit conditions and activities that may result in polluted runoff being discharged into the Stormwater Drainage System.

To assure compliance with the Stormwater Permits and water quality ordinances, the County Parties have developed a Drainage Area Management Plan ("**DAMP**") which includes a Local Implementation Plan ("**LIP**") for each jurisdiction that contains Best Management Practices ("**BMP(s)**") that parties using properties within Orange County must adhere to. As used herein, a BMP is defined as a technique, measure, or structural control that is used for a given set of conditions to manage the quantity and improve the quality of stormwater runoff in a cost effective manner. These BMPs are found within the COUNTY's LIP in the form of Model Maintenance Procedures and BMP Fact Sheets (the Model Maintenance Procedures and BMP Fact Sheets contained in the DAMP/LIP shall be referred to hereinafter collectively as "**BMP Fact Sheets**") and contain pollution prevention and source control techniques to eliminate non-stormwater discharges and minimize the impact of pollutants on stormwater runoff.

The use under this License does not require BMP Fact Sheets.

18. PAYMENT CARD COMPLIANCE (AMLC-G15 S)

Should LICENSEE conduct credit/debit card transactions in conjunction with their business with the COUNTY, on behalf of the COUNTY, or as part of the business that they conduct, LICENSEE covenants and warrants that it is currently Payment Card Industry Data Security Standard (**"PCI DSS"**) and Payment Application Data Security Standards (**"PA DSS"**) compliant and will remain compliant during the entire duration of this License. LICENSEE agrees to immediately notify COUNTY in the event LICENSEE should ever become non-compliant, and will take all necessary steps to return to compliance and shall be compliant within ten (10) days of the commencement of any such interruption.

Upon demand by COUNTY, LICENSEE shall provide to COUNTY written certification of LICENSEE's PCI DSS and/or PA DSS compliance.

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LICENSE DESCRIPTION (10.1 S)

PROJECT NO: GA 1213-236 DATE: 6/29/16

PROJECT: CalOptima
15496 Magnolia, #111
Westminster, CA 92806

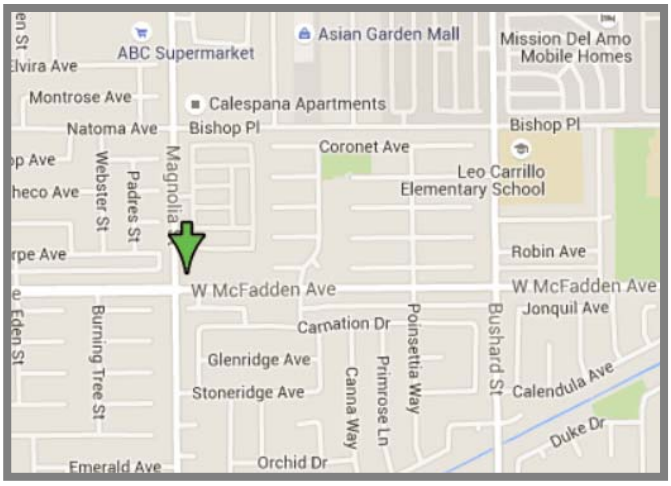
WRITTEN BY: EAS

All the License Area referenced on a Floor Plan marked Exhibit B, attached hereto and made a part hereof, being approximately Three Hundred Sixty Two (362) rentable square feet of COUNTY-designated space for LICENSEE's non-exclusive use, which space may vary from time-to-time based on COUNTY's pre-approval in writing, and being a portion of the Orange County Community Service Center Annex building located at 15496 Magnolia, Suite 111, Rooms 1 and 2 in the City of Westminster, County of Orange, State of California, together with appurtenant right to use common areas located thereon, and the non-exclusive use of one parking space in the adjacent parking lot.

NOT TO BE RECORDED

EXHIBIT A

GA 1213-237
SSA/CalOptima



Location Map

N

License Area:
Rooms 1 & 2

EXHIBIT B

Reception Area

ES: 7/28/2016 10:05:44 AM
15496 Magnolia, Westminster

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CCSC COST APPLY - 15496 Magnolia Street, Westminster

FY 2016-17 MONTHLY INVOICE CODING SUMMARY

Invoice Coding and Job Number Allocation.

	Fund/Dept/Budget Control Unit/Object/Job No.	July 2016	August 2016	September 2016	October 2016	November 2016	December 2016	January 2017	February 2017	March 2017	April 2017	May 2017	June 2017	Annual Total
Social Services Agency/Partners	100/063/063 2211/2200/ S34000	$ 656.94	$ 295.21	$ 1,116.57	$ 1,116.57	$ 1,116.57	$ 1,116.57	$ 1,116.57	$ 1,116.57	$ 1,116.57	$ 1,116.57	$ 1,116.57	$ 1,116.57	**$ 12,117.85**
Clerk-Recorder	100/063/063 2211/2200/ S34006	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Health Care Agency	100/063/063 2211/2200/ S34007	$ 1,278.26	$ 1,278.26	$ 4,365.61	$ 4,365.61	$ 4,365.61	$ 4,365.61	$ 4,365.61	$ 4,365.61	$ 4,365.61	$ 4,365.61	$ 4,365.61	$ 4,365.61	**$ 46,212.65**
OC Community Resources	100/063/063 2211/2200/ S34008	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
CalOptima	100/063/063 2211/2200/S34009	$ -	$ 361.73	$ 1,453.02	$ 1,453.02	$ 1,453.02	$ 1,453.02	$ 1,453.02	$ 1,453.02	$ 1,453.02	$ 1,453.02	$ 1,453.02	$ 1,453.02	**$ 14,891.90**
		$ 1,935.20	**$ 1,935.20**	**$ 6,935.20**	**$ 6,935.20**	**$ 6,935.20**	**$ 6,935.20**	**$ 6,935.20**	**$ 6,935.20**	**$ 6,935.20**	**$ 6,935.20**	**$ 6,935.20**	**$ 6,935.20**	**$ 73,222.40**

LEASED SPACE

	sq ft	Allocation %	July 2016	August 2016	September 2016	October 2016	November 2016	December 2016	January 2017	February 2017	March 2017	April 2017	May 2017	June 2017	Annual Total
Social Services Agency	**177.25**	**16.43%**	**$ 251.40**	**$ 107.96**	**$ 929.32**	**$ 929.32**	**$ 929.32**	**$ 929.32**	**$ 929.32**	**$ 929.32**	**$ 929.32**	**$ 929.32**	**$ 929.32**	**$ 929.32**	**$ 9,652.58**
Health Care Agency - Total	**666.25**	**61.75%**	**$ 405.80**	**$ 405.80**	**$ 3,493.15**	**$ 3,493.15**	**$ 3,493.15**	**$ 3,493.15**	**$ 3,493.15**	**$ 3,493.15**	**$ 3,493.15**	**$ 3,493.15**	**$ 3,493.15**	**$ 3,493.15**	**$ 35,743.11**
- Environmental Health	379.05	35.13%	$ 230.87	$ 230.87	$ 1,987.36	$ 1,987.36	$ 1,987.36	$ 1,987.36	$ 1,987.36	$ 1,987.36	$ 1,987.36	$ 1,987.36	$ 1,987.36	$ 1,987.36	20,335.35
- AMHS	232.7	21.57%	$ 141.73	$ 141.73	$ 1,220.05	$ 1,220.05	$ 1,220.05	$ 1,220.05	$ 1,220.05	$ 1,220.05	$ 1,220.05	$ 1,220.05	$ 1,220.05	$ 1,220.05	12,483.93
- Public Health Nursing	54.5	5.05%	$ 33.19	$ 33.19	$ 285.74	$ 285.74	$ 285.74	$ 285.74	$ 285.74	$ 285.74	$ 285.74	$ 285.74	$ 285.74	$ 285.74	2,923.83
Clerk-Recorder	**0**	**0.00%**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
OC Community Resources - Total	**0**	**0.00%**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
Cal Optima	**235.5**	**21.83%**	**$ -**	**$ 143.44**	**$ 1,234.73**	**$ 1,234.73**	**$ 1,234.73**	**$ 1,234.73**	**$ 1,234.73**	**$ 1,234.73**	**$ 1,234.73**	**$ 1,234.73**	**$ 1,234.73**	**$ 1,234.73**	**$ 12,490.71**
					$ -										
TOTAL	**1079**	**100%**	**$ 657.20**	**$ 657.20**	**$ 5,000.00**	**$ 5,657.20**	**$ 5,657.20**	**$ 5,657.20**	**$ 5,657.20**	**$ 5,657.20**	**$ 5,657.20**	**$ 5,657.20**	**$ 5,657.20**	**$ 5,657.20**	**$ 57,886.40**

Total leased space: 2080 sq. ft.

Lease rates:	Monthly	Fiscal Year total:
Rent: September 1, 2016 - September 30, 2017	$ 5,000.00	$ 50,000.00
Operating Expenses: July 1 2016- June 30, 2017	$ 657.20	$ 7,886.40

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IT SERVICES

	# computers	Allocation %	July 2016	August 2016	September 2016	October 2016	November 2016	December 2016	January 2017	February 2017	March 2017	April 2017	May 2017	June 2017	Annual Total
Social Services Agency	**1**	**12.50%**	**$ 96.25**	**$ 48.13**	**$ 48.13**	**$ 48.13**	**$ 48.13**	**$ 48.13**	**$ 48.13**	**$ 48.13**	**$ 48.13**	**$ 48.13**	**$ 48.13**	**$ 48.13**	**$ 625.63**
Health Care Agency - Total	**6**	**75.00%**	**$ 288.75**	**$ 288.75**	**$ 288.75**	**$ 288.75**	**$ 288.75**	**$ 288.75**	**$ 288.75**	**$ 288.75**	**$ 288.75**	**$ 288.75**	**$ 288.75**	**$ 288.75**	**$ 3,465.00**
- Environmental Health	5	$ 0.63	$ 240.63	$ 240.63	240.625	240.625	240.625	240.625	240.625	240.625	240.625	240.625	240.625	240.625	$ 2,887.50
- AMHS	0.5	$ 0.06	$ 24.06	$ 24.06	24.0625	24.0625	24.0625	24.0625	24.0625	24.0625	24.0625	24.0625	24.0625	24.0625	$ 288.75
- Public Health Nursing	0.5	$ 0.06	$ 24.06	$ 24.06	24.0625	24.0625	24.0625	24.0625	24.0625	24.0625	24.0625	24.0625	24.0625	24.0625	$ 288.75
Clerk-Recorder	**0**	**0.00%**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
OC Community Resources - Total	**0**	**0.00%**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
Cal Optima	**1**	**12.50%**	**$ -**	**$ 48.13**	**$ 48.13**	**$ 48.13**	**$ 48.13**	**$ 48.13**	**$ 48.13**	**$ 48.13**	**$ 48.13**	**$ 48.13**	**$ 48.13**	**$ 48.13**	**$ 529.38**
TOTAL	**8**	**100%**	**$ 385.00**	**$ 385.00**	**$ 385.00**	**$ 385.00**	**$ 385.00**	**$ 385.00**	**$ 385.00**	**$ 385.00**	**$ 385.00**	**$ 385.00**	**$ 385.00**	**$ 385.00**	**$ 4,620.00**

Monthly IT rates	$ 385.00
Annual Telephone Service Costs	$ 4,620.00

TELEPHONE SERVICES

	# phones	Allocation %	July 2016	August 2016	September 2016	October 2016	November 2016	December 2016	January 2017	February 2017	March 2017	April 2017	May 2017	June 2017	Annual Total
Social Services Agency	**1**	**16.67%**	**$ 39.33**	**$ 19.67**	**$ 19.67**	**$ 19.67**	**$ 19.67**	**$ 19.67**	**$ 19.67**	**$ 19.67**	**$ 19.67**	**$ 19.67**	**$ 19.67**	**$ 19.67**	**$ 255.67**
Health Care Agency - Total	**4**	**66.67%**	**$ 78.67**	**$ 78.67**	**$ 78.67**	**$ 78.67**	**$ 78.67**	**$ 78.67**	**$ 78.67**	**$ 78.67**	**$ 78.67**	**$ 78.67**	**$ 78.67**	**$ 78.67**	**$ 944.00**
- Environmental Health	3	50.00%	$ 59.00	$ 59.00	$ 59.00	$ 59.00	$ 59.00	$ 59.00	$ 59.00	$ 59.00	$ 59.00	$ 59.00	$ 59.00	$ 59.00	$ 708.00
- AMHS	0.5	8.33%	$ 9.83	$ 9.83	$ 9.83	$ 9.83	$ 9.83	$ 9.83	$ 9.83	$ 9.83	$ 9.83	$ 9.83	$ 9.83	$ 9.83	$ 118.00
- Public Health Nursing	0.5	8.33%	$ 9.83	$ 9.83	$ 9.83	$ 9.83	$ 9.83	$ 9.83	$ 9.83	$ 9.83	$ 9.83	$ 9.83	$ 9.83	$ 9.83	$ 118.00
Clerk-Recorder	**0**	**0.00%**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
OC Community Resources - Total	**0**	**0.00%**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
Cal Optima	**1**	**16.67%**	**$ -**	**$ 19.67**	**$ 19.67**	**$ 19.67**	**$ 19.67**	**$ 19.67**	**$ 19.67**	**$ 19.67**	**$ 19.67**	**$ 19.67**	**$ 19.67**	**$ 19.67**	**$ 216.33**
TOTAL	**6**	**100%**	**$ 118.00**	**$ 118.00**	**$ 118.00**	**$ 118.00**	**$ 118.00**	**$ 118.00**	**$ 118.00**	**$ 118.00**	**$ 118.00**	**$ 118.00**	**$ 118.00**	**$ 118.00**	**$ 1,416.00**

Monthly Telephone Service Costs	$ 118.00
Annual Telephone Service Costs	$ 1,416.00

JANITORIAL SERVICES

	sq ft	Allocation %	July 2016	August 2016	September 2016	October 2016	November 2016	December 2016	January 2017	February 2017	March 2017	April 2017	May 2017	June 2017	Annual Total

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Social Services Agency	**177.25**	**16.43%**	**$**	**219.95**	**$**	**94.46**	**$**	**94.46**	**$**	**94.46**	**$**	**94.46**	**$**	**94.46**	**$**	**94.46**	**$**	**94.46**	**$**	**94.46**	**$**	**94.46**	**$**	**1,258.98**
Health Care Agency - Total	**666.25**	**61.75%**	**$**	**355.05**	**$**	**355.05**	**$**	**355.05**	**$**	**355.05**	**$**	**355.05**	**$**	**355.05**	**$**	**355.05**	**$**	**355.05**	**$**	**355.05**	**$**	**355.05**	**$**	**4,260.54**
- Environmental Health	379.05	35.13%	$	202.00	$	202.00	$	202.00	$	202.00	$	202.00	$	202.00	$	202.00	$	202.00	$	202.00	$	202.00	$	2,423.95
- AMHS	232.7	21.57%	$	124.01	$	124.01	$	124.01	$	124.01	$	124.01	$	124.01	$	124.01	$	124.01	$	124.01	$	124.01	$	1,488.07
- Public Health Nursing	54.5	5.05%	$	29.04	$	29.04	$	29.04	$	29.04	$	29.04	$	29.04	$	29.04	$	29.04	$	29.04	$	29.04	$	348.52
Clerk-Recorder	**0**	**0.00%**	**$**	**-**	**$**	**-**	**$**	**-**	**$**	**-**	**$**	**-**	**$**	**-**	**$**	**-**	**$**	**-**	**$**	**-**	**$**	**-**	**$**	**-**
OC Community Resources - Total	**0**	**0.00%**	**$**	**-**	**$**	**-**	**$**	**-**	**$**	**-**	**$**	**-**	**$**	**-**	**$**	**-**	**$**	**-**	**$**	**-**	**$**	**-**	**$**	**-**
Cal Optima	**235.5**	**21.83%**	**$**	**-**	**$**	**125.50**	**$**	**125.50**	**$**	**125.50**	**$**	**125.50**	**$**	**125.50**	**$**	**125.50**	**$**	**125.50**	**$**	**125.50**	**$**	**125.50**	**$**	**1,380.48**
TOTAL	**1079**	**100%**	**$**	**575.00**	**$**	**575.00**	**$**	**575.00**	**$**	**575.00**	**$**	**575.00**	**$**	**575.00**	**$**	**575.00**	**$**	**575.00**	**$**	**575.00**	**$**	**575.00**	**$**	**6,900.00**

Total leased space: 2080 sq. ft.

Monthly Janitorial Costs $ 575.00
12 mo. Annual Janitorial Costs $ 6,900.00

ELECTRICAL/UTILITIES

	sq ft	Allocation %	219.9548193	94.45667285	94.45667285	94.45667285	94.45667285	94.45667285	94.45667285	94.45667285	94.45667285	94.45667285	94.45667285	94.45667285	Annual Total
Social Services Agency	**1**	**12.50%**	**$ 50.00**	**$ 25.00**	**$ 25.00**	**$ 25.00**	**$ 25.00**	**$ 25.00**	**$ 25.00**	**$ 25.00**	**$ 25.00**	**$ 25.00**	**$ 25.00**	**$ 25.00**	**$ 325.00**
Health Care Agency - Total	**6**	**75.00%**	**$ 150.00**	**$ 150.00**	**$ 150.00**	**$ 150.00**	**$ 150.00**	**$ 150.00**	**$ 150.00**	**$ 150.00**	**$ 150.00**	**$ 150.00**	**$ 150.00**	**$ 150.00**	**$ 1,800.00**
- Environmental Health	5	62.50%	$ 125.00	$ 125.00	$ 125.00	$ 125.00	$ 125.00	$ 125.00	$ 125.00	$ 125.00	$ 125.00	$ 125.00	$ 125.00	$ 125.00	$ 1,500.00
- AMHS	0.5	6.25%	$ 12.50	$ 12.50	$ 12.50	$ 12.50	$ 12.50	$ 12.50	$ 12.50	$ 12.50	$ 12.50	$ 12.50	$ 12.50	$ 12.50	$ 150.00
- Public Health Nursing	0.5	6.25%	$ 12.50	$ 12.50	$ 12.50	$ 12.50	$ 12.50	$ 12.50	$ 12.50	$ 12.50	$ 12.50	$ 12.50	$ 12.50	$ 12.50	$ 150.00
Clerk-Recorder	**0**	**0.00%**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
OC Community Resources - Total	**0**	**0.00%**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
Cal Optima	**1**	**12.50%**	**$ -**	**$ 25.00**	**$ 25.00**	**$ 25.00**	**$ 25.00**	**$ 25.00**	**$ 25.00**	**$ 25.00**	**$ 25.00**	**$ 25.00**	**$ 25.00**	**$ 25.00**	**$ 275.00**
TOTAL	**8**	**100%**	**$ 200.00**	**$ 200.00**	**$ 200.00**	**$ 200.00**	**$ 200.00**	**$ 200.00**	**$ 200.00**	**$ 200.00**	**$ 200.00**	**$ 200.00**	**$ 200.00**	**$ 200.00**	**$ 2,400.00**

Total leased space: 2080 sq. ft.

Estimated Utility Costs $ 200.00
12 mo. Annual Janitorial Costs $ 2,400.00

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Annex - 15496 Magnolia Ave, CCSC

Previous site amount	Variance
$ 11,476.51	$34,736.14

Total Annual Charges - check

$ 70,822.40

CODING

SSA INVOICE				Cost Apply - Other Agency			
Fund/Dept/Budget Control	Unit	Object	Job #	Fund/Dept/Budget Control	Unit	Object	Job #
100/063/063	2211	2200	S34000	--	--	--	--
100/063/063	2211	2200	S34007	See below			
See above				100/042/042	6600	2200	H4046800
See above				100/042/042	2100	2200	H2407N70
See above				100/042/042	1520	2200	H1120800
100/063/063	2211	2200	S34006	100/059/059	--	2200	PCW002
100/063/063	2211	2200	S34008	See below			
	2211	2200	S34009	NA - will be invoiced			
Default SSA coding	--	--	--	--	--	--	--
100/063/063	2211	2200	S34000	--	--	--	--

Lease, Janitorial & Utility Allocation	sq ft	Allocation %
Social Services Agency	177.25	16.427%
Health Care Agency	666.25	61.747%
- Environmental	379.05	35.130%
- AMHS	232.7	21.566%
- Public Health	54.5	5.051%
Clerk-Recorder	0	0.000%
OC Community Resources	0	0.000%
CalOptima	235.5	21.826%
TOTAL	1079	161.7%

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West Annex Community Customer Service Center
15496 Magnolia Street
Westminster, CA 92683

LEASE

THIS IS A LEASE (hereinafter referred to as "**Lease**"), made July 1, 2016, ("**Effective Date**") by and between CHARLES H. MANH and ANH MANH, Co-Trustees of the MANH FAMILY TRUST, under declaration of trust dated August 15, 2006 ("**LESSOR**") and the COUNTY OF ORANGE, a political subdivision of the State of California ("**COUNTY**"), without regard to number and gender. The LESSOR and COUNTY may individually be referred to herein as a "**Party**," or collectively as the "**Parties**.

1. DEFINITIONS (1.2 S)

"Board of Supervisors" means the Board of Supervisors of the County of Orange, a political subdivision of the State of California.

"County Executive Officer" means the County Executive Officer, County Executive Office, County of Orange, or designee, or upon written notice to LESSOR, such other person or entity as shall be designated by the Board of Supervisors.

"CEO Real Estate"" means the County Executive Office's Real Estate team, or upon written notice to LESSOR, such other person or entity as shall be designated by the Chief Real Estate Officer, County of Orange, or designee.

"Chief Real Estate Officer" means the Chief Real Estate Officer for the County of Orange, or designee or upon written notice to LESSOR, such other person or entity as shall be designated by the County Executive Officer or r the Board of Supervisors.

"County Counsel" means the County Counsel, County of Orange, or designee, or upon written notice to LESSOR, such other person or entity as shall be designated by the Board of Supervisors.

"Risk Manager" means the Risk Manager, County Executive Office, Risk Management, County of Orange, or designee, or upon written notice to LESSOR, such other person or entity as shall be designated by the County Executive Officer or the Board of Supervisors.

2. PREMISES (1.3 S)

LESSOR leases to COUNTY that certain property consisting of 2,120 square feet, located at 15496 Magnolia Street, Suite 111, Westminster, CA and described in Exhibit A and shown on Exhibit B, which exhibits are attached hereto and by reference made a part hereof (hereinafter referred to as "**Premises**"),, together with non-exclusive, in common use of LESSOR's elevators, stairways, washrooms, hallways, parking areas, driveways for vehicle ingress and egress, pedestrian walkways, other facilities and common areas appurtenant to the Premises created by this Lease.

3. PARKING (1.4 S)

LESSOR, throughout the term of this Lease, shall provide a total of thirteen (13) parking spaces for COUNTY's free and non-exclusive use. Said parking spaces are to be located in the parking areas adjacent to the Premises. LESSOR shall designate three (3) parking spaces adjacent to the Premises to be reserved for use by COUNTY clients. Said parking spaces shall contain signs above the space indicating that the spaces are reserved for COUNTY use.

In addition to said parking spaces, LESSOR shall also provide parking for disabled persons in accordance with the Americans with Disabilities Act, Section 7102 of the California Uniform Building Code and the applicable codes and/or ordinances relating to parking for disabled persons as established by the local jurisdiction in which the Premises is located where the provisions of such local codes and/or ordinances exceed or supersede the State requirements.

4. TERM (2.2 N)

The term of this Lease shall be one (1) year ("**Term**"), commencing upon the first of the next month following execution of this Lease by the COUNTY Chief Real Estate Officer or upon LESSOR's delivery and COUNTY's acceptance of the Premises, whichever is later ("**Commencement Date**").
Parties agree that the Commencement Date of this Lease will be confirmed in writing by either Party upon demand by the other.

5. RENT (3.1 N)

COUNTY agrees to pay LESSOR as rent for the Premises the sum of Five Thousand Dollars ($5,000.00) per month pursuant to the following rent payment schedule ("**Rent**").

MONTH	MONTHLY RENT	MONTH	MONTHLY RENT
1	$0.00	7	$5,000.00
2	$0.00	8	$5,000.00
3	$5,000.00	9	$5,000.00
4	$5,000.00	10	$5,000.00
5	$5,000.00	11	$5,000.00
6	$5,000.00	12	$5,000.00

To obtain rent payments LESSOR (or LESSOR's designee) shall submit to the COUNTY, in a form acceptable to said COUNTY, a written claim for payment of applicable Rent and COUNTY's share of the NNN Expenses, as defined in Section 6, below.

Payment shall be due and payable by direct deposit into a bank account specified by LESSOR within twenty (20) days after the later of the following:

A. The first day of the month following the month earned; or
B. Receipt of LESSOR's written claim by COUNTY.

Should COUNTY occupy the Premises before the Commencement Date, LESSOR shall be entitled to pro rata Rent for the period of occupancy occupied prior to the Commencement Date based upon the monthly Rent above. Said Rent shall be included in the rent claim submitted by LESSOR for the first full month of the Term and shall be paid by COUNTY at the time of payment for said month.

6. REIMBURSEMENT OF LESSOR'S OPERATING EXPENSES (6.0 N)

LESSOR and COUNTY agree pursuant to Section 5, above, that COUNTY shall pay the fixed amount of $657.20 ($.31/sf/mo.) per month for the term of the lease, as reimbursement for COUNTY's pro rata share of LESSOR's expenses related to the items described in Section 6A, 6B, 6C and 6D of this Lease for the property in which the Premises is located ("**NNN Expenses**"). LESSOR shall submit to COUNTY a separate monthly invoice .in addition to the monthly Rent invoice.

The pro rata share of LESSOR's NNN Expenses as defined above is determined according to the gross leasable area of the Premises as it relates to the total gross leasable area of the building that contains the Premises. The percent of COUNTY's occupancy which LESSOR and COUNTY agree is 12.47% (the "**pro rata share**"): the Premises is 2,120 gross square feet; and the total building area is 17,000 gross square feet.

COUNTY shall reimburse LESSOR for COUNTY's pro rata share of the NNN Expenses only for the items in Section 6A, 6B and 6C and 6D below:

A. Property Taxes and Property Tax Assessments pursuant to Section 13 of this Lease.
B. Maintenance and repair, and janitorial services for the common area restrooms in the building in which the Premises is located pursuant to Section 9 of this Lease.
C. Common area maintenance and repair of the building, parking lots, landscaping, lighting, and other common area maintenance and repair costs pursuant to Section 9 of this Lease.
D. Commercial Property Insurance and Commercial General Liability Insurance pursuant to Section 11 of this Lease.

7. ALTERATIONS (4.4 S)

COUNTY may make improvements and changes in the Premises, including but not limited to the installation of fixtures, partitions, counters, shelving, and equipment as deemed necessary or appropriate. It is agreed that any such fixtures, partitions, counters, shelving, or equipment attached to or placed upon the Premises by COUNTY shall be considered as personal property of COUNTY, who shall have the right to remove same. COUNTY agrees that the Premises shall be left in as good condition as when received, reasonable wear and tear excepted.

8. ORANGE COUNTY INFROMATION TECHNOLOGY SYSTEM S (OCIT) (4.5 N)

LESSOR agrees that COUNTY may install, at COUNTY's sole cost and expense, computer and telecommunication devices in, on, or around the Premises and LESSOR's building in accordance with COUNTY's plans and specifications provided that the provisions of the Clause entitled ALTERATIONS, of this Lease, shall be applicable to such work. It shall be COUNTY's responsibility to obtain all governmental permits and/or approvals required for such installation; however, LESSOR shall reasonably cooperate with COUNTY as necessary or appropriate, to obtain said permits and/or approvals.

9. REPAIR, MAINTENANCE, AND JANITORIAL SERVICES (5.1 N)

LESSOR shall keep, maintain, and repair the building and other improvements upon the Premises in good and sanitary order and condition (except as otherwise provided in this Lease) including without limitation, the maintenance and repair of the roof, parking lot, sidewalks, common area restrooms including janitorial supplies and services, landscaping, store front, doors, window casements, glazing, plumbing, pipes, electrical wiring, and conduits, and the heating and air conditioning system including the maintenance of a service contract with a heating and air conditioning contractor, as necessary to maintain the property in

which the Premises is located in good and sanitary order, condition, and repair. COUNTY shall reimburse LESSOR for the County's pro rata share of said expenses in accordance with Section 6 of the Lease. Notwithstanding the language in the paragraph above, COUNTY shall provide at its own cost and expense all repair and maintenance and services to the interior of the Premises.

A. Heating, Ventilation and Air Conditioning System (HVAC)

During all operating hours the HVAC system serving the Premises, to be repaired and maintained by the LESSOR, shall be capable of maintaining the Premises at 78º Dry Bulb at a maximum range of 40% to 60% Relative humidity during the summer when the outdoor temperature is 95º Dry Bulb, and at 68º Dry Bulb in the winter when the outside temperature is 35º Dry Bulb.

In order for the COUNTY to comply with the California Code of Regulations, Title 8, Section 5142, and as it may be subsequently amended, LESSOR shall inspect the HVAC system at least once annually or on a schedule agreed to in writing by LESSOR and COUNTY, and provide repair and maintenance accordingly. LESSOR's inspections and maintenance of the HVAC system shall be documented in writing. The LESSOR shall at a minimum, maintain a record of: (a) the name of the individual(s) inspecting and/or maintaining the system, (b) the date of the inspection and/or maintenance, and (c) the specific findings and actions taken. The LESSOR shall ensure that such records are retained for at least five (5) years. The LESSOR shall make all HVAC records required by this section available to COUNTY for examination and copying, within forty-eight (48) hours of a written request from COUNTY. LESSOR acknowledges that COUNTY may be subject to fines and/or penalties for failure to provide said records to regulatory agencies within the given timeframes. Should COUNTY incur fines and/or penalties as a direct result of LESSOR's failure to provide said records to COUNTY, LESSOR shall reimburse COUNTY for said fines and/or penalties within thirty (30) days upon written notice. Should LESSOR fail to reimburse COUNTY within thirty (30) days, COUNTY may deduct the amount of the fine and/or penalty from any rent payable.

B. Janitorial Supplies and Services

LESSOR shall provide janitorial supplies and services on a five-day-per-week basis (Monday through Friday) to the common areas and common area restrooms in accordance with Exhibit D (JANITORIAL SPECIFICATIONS) attached hereto and by reference made a part hereof.

If LESSOR fails to provide satisfactory janitorial supplies to Premises, the Chief Real Estate Officer, or designee may notify LESSOR either verbally or in writing; and if LESSOR does not provide janitorial supplies within twenty-four (24) hours after LESSOR has received such written notice from COUNTY, COUNTY may provide the janitorial supplies necessary or have others do

so, and deduct the cost thereof, including labor, materials and COUNTY's administrative costs from any rent payable.

If LESSOR or its representative cannot be contacted by COUNTY for emergency repairs and/or services the same day any emergency repairs and/or services are necessary to remedy the emergency condition, or if LESSOR following such contact by COUNTY is unable or refuses to make the necessary repairs within a reasonable time or provide the necessary services, as determined by the Chief Real Estate Officer, COUNTY may at its option have the necessary repairs made and/or provide services to remedy the emergency condition, and deduct the cost thereof, including labor, materials and COUNTY's administrative costs from any rent payable.

10. ELECTRIC UTILITIES (5.2 N)

COUNTY shall be responsible for and pay, prior to the delinquency date, all charges for electric utilities supplied to the interior of the Premises directly to the utility company.

LESSOR shall be responsible for and pay, prior to the delinquency date, all charges for electric utilities supplied to the exterior of the Premises and to the common areas of the property in which the Premises is located.

INSURANCE (5.3 S)

Commercial Property Insurance: LESSOR shall obtain and keep in force during the term of this Lease a policy or policies of commercial property insurance with all risk or special form coverage, covering the loss or damage to the Premises to the full insurable value of the improvements located on the Premises (including the full value of all improvements and fixtures owned by LESSOR) at least in the amount of the full replacement cost thereof, and in no event less than the total amount required by any lender holding a security interest.

LESSOR agrees to and shall include in the policy or policies of commercial property insurance a standard waiver of the right of subrogation against COUNTY by the insurance company issuing said policy or policies. LESSOR shall provide COUNTY with a Certificate of Insurance as evidence of compliance with these requirements.

Commercial General Liability Insurance: LESSOR shall obtain and keep in force during the term of this Lease a policy or policies of commercial general liability insurance covering all injuries occurring

within the building and the Premises. The policy or policies evidencing such insurance shall provide the following:

a. Name COUNTY as an additional insured;
b. Shall be primary, and any insurance or self-insurance maintained by COUNTY shall be excess and non-contributing;
c. LESSOR shall notify County in writing within thirty (30) days of any policy cancellation and ten (10) days for non-payment of premium and provide a copy of the cancellation notice to County. Failure to provide written notice of cancellation may constitute a material breach of the Lease, upon which the County may suspend or terminate this Lease.
d. Shall provide a limit of One Million Dollars ($1,000,000) per occurrence; and
e. The policy or policies of insurance must be issued by an insurer with a minimum rating of A- (Secure A.M. Best's Rating) and VIII (Financial Size Category as determined by the most current edition of the **Best's Key Rating Guide/Property-Casualty/United States or ambest.com).** It is preferred, but not mandatory, that the insurer be licensed to do business in the state of California (California Admitted Carrier).

If the insurance carrier does not have an A.M. Best Rating of A-/VIII, the CEO/Office of Risk Management retains the right to approve or reject a carrier after a review of the company's performance and financial ratings. Prior to the Commencement Date of this Lease and upon renewal of such policies, LESSOR shall submit to COUNTY a Certificate of Insurance and required endorsements as evidence that the foregoing policy or policies are in effect.

If LESSOR fails to procure and maintain the insurance required to be procured by LESSOR under this Lease, COUNTY may, but shall not be required to, order such insurance and deduct the cost thereof plus any COUNTY administrative charges from the rent thereafter payable.

11. INDEMNIFICATION (5.5 A S)

LESSOR shall defend, indemnify and save harmless COUNTY and COUNTY Parties from and against any and all claims, demands, losses, or liabilities of any kind or nature which COUNTY or the COUNTY Parties may sustain or incur or which may be imposed upon them for injury to or death of persons, or damage to property as a result of, or arising out of, the negligence or intentional misconduct of LESSOR or the LESSOR Parties, in connection with the maintenance or use of the Premises by LESSOR or the LESSOR Parties.

12. TAXES AND ASSESSMENTS (5.6 N)

All taxes and assessments which become due and payable upon the Premises shall be the full responsibility of LESSOR, and LESSOR shall cause said taxes and assessments to be paid prior to the due date.

COUNTY shall reimburse LESSOR for its proportionate share of Taxes and Assessments pursuant to Section 5 of this Lease.

13. BUILDING AND SAFETY REQUIREMENTS (5.7 S)

During the full term of this Lease, LESSOR, at LESSOR's sole cost, agrees to maintain the Premises in compliance with all applicable laws, rules, regulations, building codes, statutes, and orders as they are applicable on the date of this Lease, and as they may be subsequently amended.

Included in this provision is compliance with the Americans with Disabilities Act ("**ADA**") and all other federal, state, and local codes, statutes, and orders relating to disabled access as they are applicable on the dates of this Lease, and as they may be subsequently amended.

LESSOR further agrees to maintain the Premises as a "safe place of employment," as defined in the California Occupational Safety and Health Act (California Labor Code, Division 5, Part 1, Chapter 3, beginning with Section 6400) and the Federal Occupational Safety and Health Act, where the provisions of such Act exceed, or supersede, the California Act, as the provisions of such Act are applicable on the date of this Lease, and as they may be subsequently amended.

In the event LESSOR neglects, fails, or refuses to maintain said Premises as aforesaid, COUNTY may, notwithstanding any other termination provisions contained herein:

A. Terminate this Lease; or

B. At COUNTY's sole option, cure any such default by performance of any act, including payment of money, and subtract the cost thereof plus reasonable administrative costs from the rent.

14. TOXIC MATERIALS (5.9 S)

COUNTY hereby warrants and represents that COUNTY will comply with all laws and regulations relating to the storage, use and disposal of hydrocarbon substances and hazardous, toxic or radioactive matter, including, but not limited to, those materials identified in Title 26 of the California Code of Regulations (collectively "**Toxic Materials**"). COUNTY shall be responsible for and shall defend, indemnify and hold LESSOR, its officers, directors, employees, agents, and representatives, harmless from and against all claims, costs and liabilities, including attorneys' fees and costs arising out of or in connection with the storage, use, and disposal of Toxic Materials on the Premises by COUNTY. If the storage, use, and disposal of Toxic Materials on the Premises by COUNTY results in contamination or

deterioration of water or soil resulting in a level of contamination greater than maximum allowable levels established by any governmental agency having jurisdiction over such contamination, COUNTY shall promptly take any and all action necessary to clean up such contamination.

Likewise, LESSOR hereby warrants and represents that LESSOR has in the past and will hereafter comply with all laws and regulations relating to the storage, use and disposal of hydrocarbon substances and hazardous, toxic or radioactive matter, including, but not limited to, those materials identified in Title 26 of the California Code of Regulations (collectively "Toxic Materials"). LESSOR shall be responsible for and shall defend, indemnify and hold COUNTY, its officers, directors, employees, agents, and representatives, harmless from and against all claims, costs and liabilities, including attorneys' fees and costs arising out of or in connection with the previous, current and future storage, use and disposal of Toxic Materials on the Premises (or building if the Premises comprises only a portion of said building) by LESSOR. If the previous, current and future storage, use, and disposal of Toxic Materials on the Premises by LESSOR results in contamination or deterioration of water or soil resulting in a level of contamination greater than maximum allowable levels established by any governmental agency having jurisdiction over such contamination, LESSOR shall promptly take any and all action necessary to clean up such contamination.

15. SUBORDINATION, ATTORNMENT AND NON-DISTURBANCE (6.4 S)

This Lease and all rights of the COUNTY hereunder are subject and subordinate to any mortgage or deed of trust which does now or may hereafter cover the Premises or any interest of LESSOR therein, and to any and all advances made on the security thereof, and to any and all increases, renewals, modifications, consolidations, replacements and extensions of any such mortgage or deed of trust; except, insofar as COUNTY is meeting its obligations under this Lease, any foreclosure of any mortgage or deed of trust shall not result in the termination of this Lease or the displacement of COUNTY.

In the event of transfer of title to the Premises, including any proceedings brought for foreclosure or in the event of the exercise of the power of sale under any mortgage or deed of trust or by any other transfer of title covering the Premises, COUNTY shall attorn to and recognize any subsequent title holder as the LESSOR under all terms, covenants and conditions of this Lease. COUNTY's possession of the Premises shall not be disturbed by the LESSOR or its successors in interest, and this Lease shall remain in full force and effect. Said attornment shall be effective and self-operative immediately upon succession of the current title holder, or its successors in interest, to the interest of LESSOR under this Lease.

Notwithstanding the above, this Lease is contingent upon LESSOR's obtaining a Subordination, Attornment and Non-Disturbance Agreement from LESSOR’s lender, within thirty (30) days of

LESSOR's execution of this Lease. LESSOR shall require all future lenders on the Premises upon initiation of their interest in the Premises, to enter into a Subordination, Attornment and Non-Disturbance Agreement with COUNTY thereby insuring COUNTY of its leasehold interests in the Premises. Said Subordination, Attornment and Non-Disturbance Agreement shall be in the form of COUNTY's standard form Subordination, Attornment and Non-Disturbance Agreement shown on Exhibit E, attached hereto and by reference made a part hereof, or in a form approved by the Chief Real Estate Officer, and County Counsel.

Foreclosure shall not extinguish this Lease, and any lender or any third party purchasing the Premises at foreclosure sale shall do so subject to this Lease and shall thereafter perform all obligations and be responsible for all liabilities of the LESSOR under the terms of this Lease.

Upon default by LESSOR of any note or deed of trust, COUNTY may, at its option, make all lease payments directly to the lender, and same shall be applied to the payment of any and all delinquent or future installments due under such note or deed of trust.

16. ESTOPPEL CERTIFICATE (6.5 S)

COUNTY agrees that the County Executive Officer shall furnish from time to time upon receipt of a written request from LESSOR or the holder of any deed of trust or mortgage covering the Premises or any interest of LESSOR therein, COUNTY's standard form Estoppel Certificate containing information as to the current status of the Lease. The Estoppel Certificate shall be approved by the Chief Real Estate Officer, and County Counsel.

17. DEFAULTS AND REMEDIES (6.8 S)

The occurrence of any of the following shall constitute an event of default:

- Failure to pay any installment of any monetary amount due and payable hereunder;
- Failure to perform any obligation, agreement or covenant under this Lease.

In the event of any non-monetary breach of this Lease by COUNTY, LESSOR shall notify COUNTY in writing of such breach, and COUNTY shall have fifteen (15) days in which to initiate action to cure said breach.

In the event of any non-monetary breach of this Lease by LESSOR, COUNTY shall notify LESSOR in writing of such breach and LESSOR shall have fifteen (15) days in which to initiate action to cure said

breach.

In the event of any monetary breach of this Lease by COUNTY, LESSOR shall notify COUNTY in writing of such breach, and COUNTY shall have fifteen (15) days in which to cure said breach, unless specified otherwise within this Lease.

In the event of any monetary breach of this Lease by LESSOR, COUNTY shall notify LESSOR in writing of such breach, and LESSOR shall have fifteen (15) days in which to cure said breach, unless specified otherwise within this Lease.

18. DEBT LIMIT (6.9 S)

LESSOR acknowledges and agrees that the obligation of the COUNTY to pay rent under this Lease is contingent upon the availability of COUNTY funds which are appropriated or allocated by the COUNTY's Board of Supervisors for the payment of rent hereunder. In this regard, in the event that this Lease is terminated due to an uncured default of the COUNTY hereunder, LESSOR may declare all rent payments to the end of COUNTY's current fiscal year to be due, including any delinquent rent from prior budget years. In no event shall LESSOR be entitled to a remedy of acceleration of the total rent payments due over the term of the Lease. The Parties acknowledge and agree that the limitations set forth above are required by Article 16, section 18, of the California Constitution. LESSOR acknowledges and agrees that said Article 16, section 18, of the California Constitution supersedes any law, rule, regulation or statute, which conflicts with the provisions of this paragraph. Notwithstanding the foregoing, LESSOR may have other rights or civil remedies to seek relief due to the COUNTY's default under the Lease. Such rights or remedies may include a right to continue the COUNTY's right of possession under the Lease and sue for the rent as it becomes past due.

19. LABOR CODE COMPLIANCE (6.10 S)

LESSOR acknowledges and agrees that all improvements or modifications required to be performed as a condition precedent to the commencement of the term of this Lease or any such future improvements or modifications performed by LESSOR at the request of COUNTY shall be governed by, and performed in accordance with, the provisions of Article 2 of Chapter 1, Part 7, Division 2 of the Labor Code of the State of California (Sections 1770, et seq.). These provisions are applicable to improvements or modifications costing more than $1,000.

Pursuant to the provisions of Section 1773 of the Labor Code of the State of California, the Orange County Board of Supervisors has obtained the general prevailing rate of per diem wages and the general prevailing

rate for holiday and overtime work in the locality applicable to this Lease for each craft, classification, or type of workman needed to execute the aforesaid improvements or modifications from the Director of the State Department of Industrial Relations. Copies of said prevailing wage rates may be obtained from the State of California, Department of Industrial Relations, or the County Executive Officer.

LESSOR hereby agrees to pay or cause its contractors and/or subcontractors to pay said prevailing wage rates at all times for all improvements or modifications to be completed for COUNTY within the premises, and LESSOR herein agrees that LESSOR shall post, or cause to be posted, a copy of the most current, applicable prevailing wage rates at the site where the improvements or modifications are performed.

Prior to commencement of any improvements or modifications, LESSOR shall provide the County Executive Officer with the applicable certified payroll records for all workers that will be assigned to the improvements or modifications. Said payroll records shall contain, but not be limited to, the complete name, address, telephone number, social security number, job classification, and prevailing wage rate for each worker. LESSOR shall provide, the County Executive Officer bi-weekly updated, certified payroll records for all workers that include, but not be limited to, the weekly hours worked, prevailing hourly wage rates, and total wages paid.

If LESSOR neglects, fails, or refuses to provide said payroll records to the County Executive Officer, such occurrence shall constitute an event of default of this lease and COUNTY may, notwithstanding any other termination provisions contained herein:

A. Terminate this Lease; or

B. At COUNTY's sole option, COUNTY may deduct future rent payable to LESSOR by COUNTY as a penalty for such non-compliance of paying prevailing wage, which rent deduction would be COUNTY's estimate, in its sole discretion, or such prevailing wage rates not paid by LESSOR.

Except as expressly set forth in this Lease, nothing herein is intended to grant authority for LESSOR to perform improvements or modifications on space currently leased by COUNTY or for which COUNTY has entered into a lease or lease amendment.

20. CHILD SUPPORT ENFORCEMENT REQUIREMENTS (6.12 S)

In order to comply with child support enforcement requirements of the County of Orange, within thirty (30) days after COUNTY's execution of this Lease agreement, LESSOR agrees to furnish the County Executive Officer, COUNTY's standard form, *Child Support Enforcement Certification Requirements*, which includes the following information:

A. In the case where LESSOR is doing business as an individual, LESSOR's name, date of birth, Social Security number, and residence address;

B. In the case where LESSOR is doing business in a form other than as an individual, the name, date of birth, Social Security number, and residence address of each individual who owns an interest of ten (10) percent or more in the contracting entity;

C. A certification that the LESSOR has fully complied with all applicable federal and state reporting requirements regarding its employees; and

D. A certification that the LESSOR has fully complied with all lawfully served Wage and Earnings Assignment Orders and Notices of Assignment, and will continue to so comply.

Failure of LESSOR to timely submit the data and/or certifications required above or to comply with all federal and state reporting requirements for child support enforcement, or to comply with all lawfully served Wage and Earnings Assignment Orders and Notices of Assignment, shall constitute a material breach of this Lease. Failure to cure such breach within sixty (60) calendar days of notice from the County Executive Officer shall constitute grounds for termination of this Lease.

Notwithstanding any other provisions of this Lease, LESSOR shall be given an opportunity to cure as follows:

A. A notice of any claimed failure to comply shall be given to LESSOR, in writing, by personal delivery, or facsimile transmission, from the County Executive Officer. The written notice shall state the specific data or certification required, the specific federal or state reporting requirements for child support enforcement that has not been complied with or the specific Wage and Earnings Assignment Order and Notice of Assignment that has not been complied with; and

B. LESSOR shall have sixty (60) days from the actual receipt of the written notice to cure the failure to comply specified in the notice, provided that LESSOR's performance to cure within sixty (60) days is not hindered, impaired or prevented by federal, state or local agencies. If the claimed failure as set forth in the written notice is failure to perform an act by a certain time, the failure of performance of said certain act by said certain time shall be deemed cured for purposes of this Lease if it is timely performed in accordance with the provisions of this paragraph.

It is expressly understood that this data will be transmitted to governmental agencies charged with the

establishment and enforcement of child support orders and will not be used for any other purpose.

21. RIGHT TO WORK AND MINIMUM WAGE LAWS (6.13 S)

In accordance with the United States Immigration Reform and Control Act of 1986, LESSOR shall require its employees that directly or indirectly service the Premises or terms and conditions of this Lease, in any manner whatsoever, to verify their identity and eligibility for employment in the United States. LESSOR shall also require and verify that its contractors or any other persons servicing the Premises or terms and conditions of this Lease, in any manner whatsoever, verify the identity of their employees and their eligibility for employment in the United States.

Pursuant to the United States of America Fair Labor Standard Act of 1938, as amended, and State of California Labor Code, Section 1178.5, LESSOR shall pay no less than the greater of the Federal or California minimum wage to all its employees that directly or indirectly service the Premises, in any manner whatsoever. LESSOR shall require and verify that all its contractors or other persons servicing the Premises on behalf of the LESSOR also pay their employees no less than the greater of the Federal or California minimum wage.

LESSOR shall comply and verify that its contractors comply with all other Federal and State of California laws for minimum wage, overtime pay, record keeping, and child labor standards pursuant to the servicing of the Premises or terms and conditions of this Lease.

Notwithstanding the minimum wage requirements provided for in this clause, LESSOR, where applicable, shall comply with the prevailing wage and related requirements, as provided for in the Clause entitled LABOR CODE COMPLIANCE of this Lease.

22. AUTHORITY (N)

The Parties to this Lease represent and warrant that this Lease has been duly authorized and executed and constitutes the legally binding obligation of their respective organization or entity, enforceable in accordance with its terms.

23. NOTICES (8.1 S)

All written notices pursuant to this Lease shall be addressed as set forth below or as either party may hereafter designate by written notice and shall be deemed delivered upon personal delivery, delivery by facsimile machine, or seventy-two (72) hours after deposit in the United States Mail.

TO: LESSOR Charles H. Manh and Anh Manh Manh Family Trust 8990 Westminster Blvd., Second Floor Westminster, CA 92683	TO: COUNTY County of Orange 333 Santa Ana Blvd., 3rd Floor Santa Ana, CA 92701 Attention: Scott Mayer, Chief Real Estate Officer Email: Scott.Mayer@ocgov.com Phone: (714) 834-3046

24. ATTACHMENTS (8.2 S)

This Lease includes the following, which are attached hereto and made a part hereof:

I. GENERAL CONDITIONS
II. EXHIBITS
   A. Description - Premises
   B. Plot Plan - Premises
   C. Performance Specifications
   D. Janitorial Specifications
   E. Subordination, Attornment, and Non-Disturbance Agreement

25. MISCELLANEOUS (N)

COUNTY may remove and dispose, and in a manner best suited for such removal and disposition, of any item(s) of furniture ("**Furniture Items**") off the Premises, which is (are) personal property of the LESSOR, as COUNTY deems appropriate or is of no use for COUNTY. LESSOR hereby waives all claims and recourse against COUNTY including the right of contribution for loss or damage of property arising from, growing out of or in any way connected with or related to the removal and disposition of the Furniture Items except claims arising from the concurrent active negligence of COUNTY, its officers, agents, and employees.

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IN WITNESS WHEREOF, the parties have executed this Agreement the day and year first above written.

LESSOR

CHARLES H. MANH and ANH MANH,
Co-Trustees of the MANH FAMILY TRUST, dated August 15, 2006

By: _____ May 25th, 2016
CHARLES H. MANH, Co-Trustee

By: _____ May 25th, 2016
ANH MANH, Co-Trustee

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APPROVED AS TO FORM:

OFFICE OF COUNTY COUNSEL
ORANGE COUNTY, CALIFORNIA

By _____
Deputy County Counsel

COUNTY

COUNTY OF ORANGE
Chief Real Estate Officer

_____
By: Scott D. Mayer Per Ordinance No. 15-009 of the Board of Supervisors and Minute Order dated June 9, 2015

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GENERAL CONDITIONS (9.1-9.17 S)

1. LEASE ORGANIZATION (9.1 S)

The various headings in this Lease, the numbers thereof, and the organization of the Lease into separate sections and paragraphs are for purposes of convenience only and shall not be considered otherwise.

2. INSPECTION (9.2 N)

LESSOR or his authorized representative shall have the right at all reasonable times and upon reasonable advance notice to COUNTY, which authorization shall not be unreasonably withheld, to inspect the Premises to determine, if COUNTY is complying with all the provisions of this Lease.

3. SUCCESSORS IN INTEREST (9.3 S)

Unless otherwise provided in this Lease, the terms, covenants, and conditions contained herein shall apply to and bind the heirs, successors, executors, administrators, and assigns of all the parties hereto, all of whom shall be jointly and severally liable hereunder.

4. DESTRUCTION OF OR DAMAGE TO PREMISES (9.4 S)

"Partial Destruction" of the Premises shall mean damage or destruction to the Premises, for which the repair cost is less than 25% of the then replacement cost of the Premises (including tenant improvements), excluding the value of the land.

"Total Destruction" of the Premises shall mean damage or destruction to the Premises, for which the repair cost is 25% or more of the then replacement cost of the Premises (including tenant improvements), excluding the value of the land.

In the event of a Partial Destruction of the Premises, LESSOR shall immediately pursue completion of all repairs necessary to restore the Premises to the condition which existed immediately prior to said Partial Destruction. Said restoration work (including any demolition required) shall be completed by LESSOR, at LESSOR's sole cost, within sixty (60) days of the occurrence of said Partial Destruction or within an extended time frame as may be authorized, in writing, by COUNTY. The Partial Destruction of the Premises shall in no way render this Lease and/or any option to purchase null and void; however, rent payable by COUNTY under the Lease shall be abated in proportion to the extent COUNTY's use and occupancy of the Premises is adversely affected by said Partial Destruction, demolition, or repair work

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required thereby. Should LESSOR fail to complete necessary repairs, for any reason, within sixty (60) days, or other time frame as may be authorized by COUNTY, COUNTY may, at COUNTY's sole option, terminate the Lease or complete necessary repair work and deduct the cost thereof, including labor, materials, and overhead from any rent thereafter payable.

In the event of Total Destruction of the Premises or the Premises being legally declared unsafe or unfit for occupancy, this Lease and/or any option shall in no way be rendered null and void and LESSOR shall immediately instigate action to rebuild or make repairs, as necessary, to restore the Premises (including replacement of all tenant improvements) to the condition which existed immediately prior to the destruction. All rent payable by COUNTY shall be abated until complete restoration of the Premises is accepted by COUNTY. In the event LESSOR refuses to diligently pursue or is unable to restore the Premises to an occupiable condition (including replacement of all tenant improvements) within 180 days of the occurrence of said destruction or within an extended time frame as may be authorized, in writing, by COUNTY, COUNTY may, at COUNTY's sole option, terminate this Lease or complete the restoration and deduct the entire cost thereof, including labor, materials, and overhead from any rent payable thereafter.

Further, LESSOR, at COUNTY's request, shall provide a suitable, COUNTY-approved temporary facility ("**Facility**") for COUNTY's use during the restoration period for the Premises. The Facility may be leased, at market rate, under a short term lease, for which the COUNTY will reimburse LESSOR the cost thereof, on a monthly basis.

5. AMENDMENT (9.5 S)

This Lease sets forth the entire agreement between LESSOR and COUNTY and any modification must be in the form of a written amendment.

6. PARTIAL INVALIDITY (9.6 S)

If any term, covenant, condition, or provision of this Lease is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remainder of the provisions hereof shall remain in full force and effect and shall in no way be affected, impaired, or invalidated thereby.

7. CIRCUMSTANCES WHICH EXCUSE PERFORMANCE (9.7 S)

If either Party hereto shall be delayed or prevented from the performance of any act required hereunder by reason of acts of God, performance of such act shall be excused for the period of the delay; and the period for the performance of any such act shall be extended for a period equivalent to the period of such

delay. Financial inability shall not be considered a circumstance excusing performance under this Lease.

8. WAIVER OF RIGHTS (9.9 S)

The failure of LESSOR or COUNTY to insist upon strict performance of any of the terms, conditions, and covenants in this Lease shall not be deemed a waiver of any right or remedy that LESSOR or COUNTY may have, and shall not be deemed a waiver of any right or remedy for a subsequent breach or default of the terms, conditions, and covenants herein contained.

9. HOLDING OVER (9.10 S)

In the event COUNTY shall continue in possession of the Premises after the term of this Lease, such possession shall not be considered a renewal of this Lease but a tenancy from month to month and shall be governed by the conditions and covenants contained in this Lease.

10. HAZARDOUS MATERIALS (9.11 S)

LESSOR warrants that the Premises is free and clear of all hazardous materials or substances.

11. EARTHQUAKE SAFETY (9.12 N)

LESSOR is informed and believes that the Premises is not in violation of any applicable seismic safety regulations and building codes.

12. QUIET ENJOYMENT (9.13 S)

LESSOR agrees that, subject to the terms, covenants and conditions of this Lease, COUNTY may, upon observing and complying with all terms, covenants and conditions of this Lease, peaceably and quietly occupy the Premises.

13. WAIVER OF JURY TRIAL (9.15 S)

Each Party acknowledges that it is aware of and has had the advice of Counsel of its choice with respect to its rights to trial by jury, and each party, for itself and its successors and assigns, does hereby expressly and knowingly waive and release all such rights to trial by jury in any action, proceeding or counterclaim brought by any party hereto against the other (and/or against its officers, directors, employees, agents, or subsidiary or affiliated entities) on or with regard to any matters whatsoever arising out of or in any way

connected with this agreement and/or any claim of injury or damage.

14. GOVERNING LAW AND VENUE. (9.16 S)

This agreement has been negotiated and executed in the State of California and shall be governed by and construed under the laws of the State of California. In the event of any legal action to enforce or interpret this agreement, the sole and exclusive venue shall be a court of competent jurisdiction located in Orange County, California, and the parties hereto agree to and do hereby submit to the jurisdiction of such court, notwithstanding Code of Civil Procedure section 394.

15. TIME (9.17 S)

Time is of the essence of this Lease.

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EXHIBIT A

DESCRIPTION OF PREMISES (10.1 N)

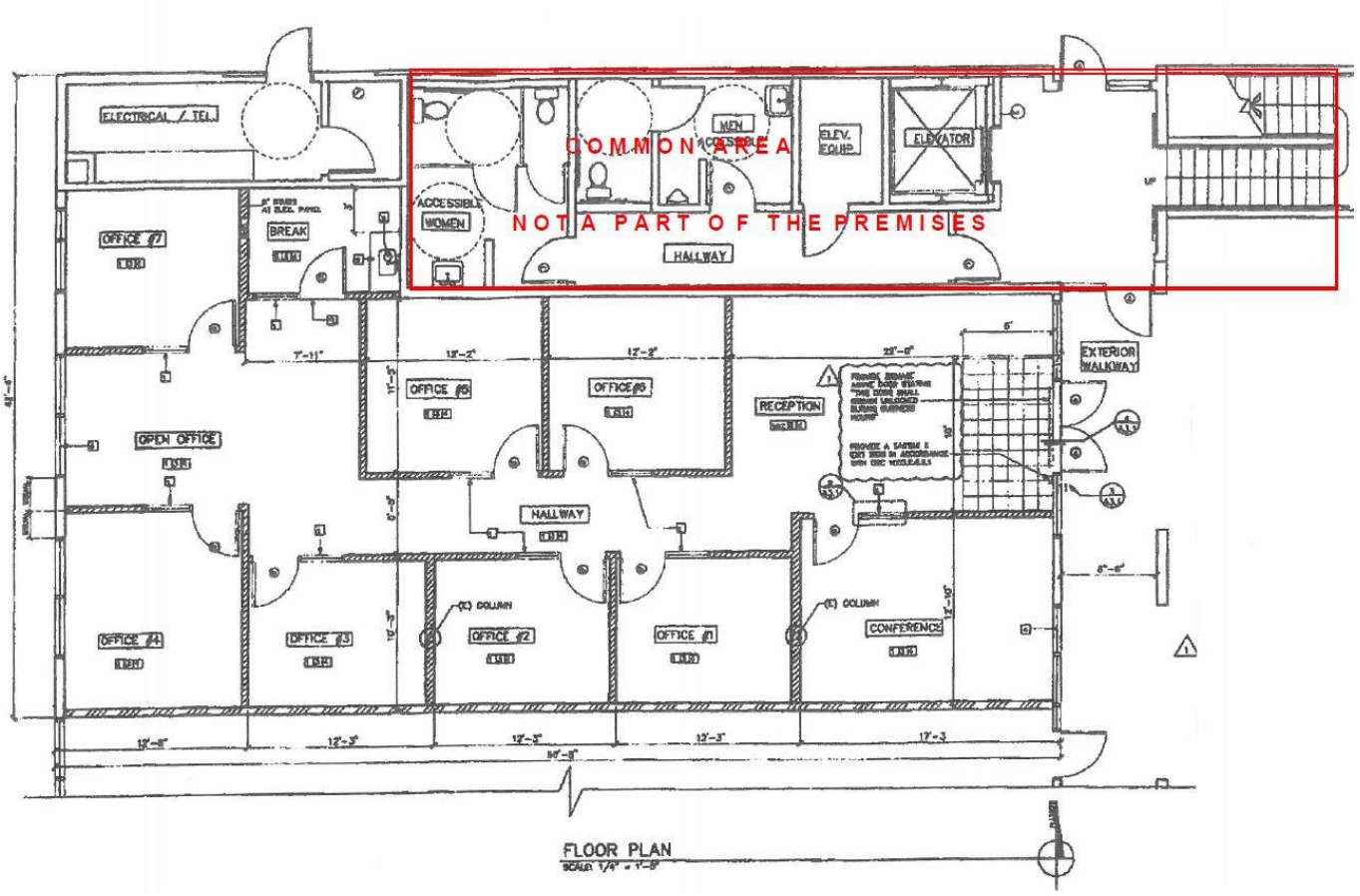
PROJECT: Community Customer Service Annex

All the Premises shown as the floor plan marked Exhibit B, attached hereto and made a part hereof, being a portion of the first floor of that certain two (2) story building located at 15496 Magnolia Street, Suite 111, in the City of Westminster, County of Orange, State of California, together with non-exclusive use of common area restrooms and thirteen (13) parking spaces in the parking areas shown on Exhibit B.

NOT TO BE RECORDED

EXHIBIT B
FLOOR PLAN OF PREMISES

15496 MAGNOLIA STREET, SUITE 111,
WESTMINSTER, CA



Gross Leasable Area: 2,120 Square Feet

EXHIBIT C

PERFORMANCE SPECIFICATIONS (10.3N) LESSOR shall perform the following Work prior to the Commencement Date of this Lease and according to the Tenant Improvement Performance Specifications that follow:

Specific locations to be identified by COUNTY prior to lease execution

1. Repair or replace door closer.
2. Replace stained ceiling tiles.
3. Repair or replace door closer.
4. Remove any signage from previous tenant that exists inside or outside of the Premises
5. Re-key front door and any internal door locks.
6. Provide the security code for existing alarm system.
7. Deliver the Premises with all electrical, plumbing and HVAC systems in proper working order.
8. Repair or replace any HVAC components resulting from findings of COUNTY's inspection of the HVAC system.

1. HEAT, VENT & AIR CONDITION ("HVAC")

A. Heating & air conditioning equipment shall have the capability of maintaining all occupied indoor areas at the room temperatures shown when outdoor temperatures are as follows:

OUTDOORS	*MAINTAIN INDOORS*
Summer – 95° Dry Bulb	78° Dry Bulb at a maximum range of 40% to 60% Relative humidity
Winter – 35° Dry Bulb	68° Dry Bulb

B. All HVAC controls pertinent to the Premises are to be located within the Premises.

C. All HVAC thermostats shall be concealed by a clear plastic tamper proof lock box.

2. ELECTRICAL & COMMUNICATIONS

A. Provide and install fluorescent lighting at all interior spaces that meet code and provide the following minimum lighting intensities at desk level:

LOCATION	*MINIMUM FOOT CANDLES:*
General Offices/Utility Rooms	60
Public Areas	30
General Corridors	20
LOCATION	*MINIMUM FOOT CANDLES:*
Other interior areas	I.E.S. Recommended Levels
Parking Lot	1

B. All Lighting controls pertinent to the Premises shall be located within the Premises.

COMPLIANCE WITH AMERICANS WITH DISABILITIES ACT ("ADA")

LESSOR shall assure that the Premises and Property are in compliance with current standards of the Americans with Disabilities Act for ingress and egress to the Premises and Property.

EXHIBIT D

JANITORIALSPECIFICATIONS (10.4 N)

It is the intent of this Exhibit to provide general guidelines for minimum janitorial service. Any absence of a specific janitorial service from this Exhibit does not relieve LESSOR of the obligation to provide such service should it become necessary.

Janitorial service as required in the clause entitled (REPAIR, MAINTENANCE AND JANITORIAL SERVICE) of this Lease, shall be inclusive of, but not limited to, the services as detailed below:

RESTROOMS

A. **NIGHTLY**:

1. Clean and damp-mop floors;
2. Wash all mirrors, bright work and enameled surfaces;
3. Wash and sanitize all basins, bowls, urinals, and toilet seats;
4. Dust, clean, and wash where necessary, all partitions, tile walls, dispensers, and receptacles;
5. Empty and sanitize all receptacles and sanitary napkin disposals;
6. Provide materials and fill all toilet tissue, towel, seat cover, sanitary napkin, and soap dispensers.

B. **MONTHLY**:

1. Machine strip restroom floors and apply finish/sealer where applicable;
2. Wash all partitions, tile walls, and enamel surfaces;
3. Vacuum all louvers, vents, and dust light fixtures.

MISCELLANEOUS SERVICES

1. Maintain building common/shared areas, corridors, and other public areas in a clean condition;
2. Surface parking lot is to be cleaned on a monthly or more frequent basis;
3. All interior and exterior windows of the building are to be cleaned quarterly.

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EXHIBIT E

SUBORDINATION, ATTORNMENT AND NON-DISTURBANCE AGREEMENT

THIS IS A SUBORDINATION, ATTORNMENT AND NON-DISTURBANCE AGREEMENT, made _____, 20__, by and between the County of Orange ("COUNTY") and _____ ("LENDER").

A. By lease dated _____, ("Lease"), _____ ("LESSOR") leased to COUNTY and COUNTY leased from LESSOR those certain Premises described as: _____.

B. LENDER is the holder or about to become the holder of a mortgage or Deed of Trust ("Note") which constitutes or will constitute a lien against the Premises leased by COUNTY pursuant to the aforesaid Lease.

C. LENDER has requested that _____ execute a Subordination, Attornment and Non-Disturbance Agreement in accordance with the terms of the Lease.

NOW, THEREFORE, the parties hereto do hereby agree as follows:

1. Subject to the terms and conditions of the Lease, all rights of COUNTY thereunder are or shall become subordinate to the Note and to any and all advances made on the security thereof, and to any and all increases, renewals, modifications, consolidations, replacements and extensions thereof.

2. In the event that LENDER succeeds to the interest of LESSOR under the Lease, by reason of foreclosure of the Note, by other proceedings brought to enforce any rights of LENDER under the Note, by deed in lieu of foreclosure, or by any other method, COUNTY shall promptly attorn to LENDER under all of the terms, covenants, and conditions of the Lease for the balance of the then-current term (and any extension or renewals thereof which may be effective in accordance with any option therefore contained in the Lease), with the same force and effect as if LENDER were the Lessor under the Lease. So long as COUNTY is not in default under the Lease, LENDER or its successors in interest shall not disturb the interests of COUNTY under said Lease, but shall allow said interests to continue in full force and effect for the balance of the then-current term and any extension available to COUNTY which may be provided in accordance with the Lease. Said attornment shall be effective and self-operative immediately upon LENDER'S succession to the interest of LESSOR under the Lease.

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3. This agreement may not be modified orally or in any manner other than by written agreement signed by the parties hereto or their respective successors or assigns. All of the terms, covenants, and conditions herein shall run with the land and shall be binding upon and inure to the benefit of the parties hereto and their respective successors and assigns.

COUNTY:

COUNTY OF ORANGE

By:_____

County Chief Real Estate Officer

LENDER:

By:_____

Print Name:_____

Title:_____

APPROVAL AS TO FORM:
OFFICE OF THE COUNTY COUNSEL
ORANGE COUNTY, CALIFORNIA

By:_____

Deputy County Counsel

Date:_____

H.L. MILLER incorporated

A General Construction Company

PROPOSAL

Date	Proposal #
7/27/2016	3827

Name / Address
SOCIAL SERVICES AGENCY 500 N. State College Blvd. Orange, CA 92868 ATTN: AL PASILLAS E: Al.Pasillas@ssa.ocgov.com

Description	Total
JOB SITE: 15946 Magnolia, Suite 111 - Wall Removal REF: MA-063-16011114	
1. Remove 18' x 9' of wall with one window and one door and haul away. 2. Finish corner and replace any ceiling tiles damaged from the wall removal. Remove switches in conference room and tie lighting in both rooms to one set of switches. CARPENTER: 17 Hours at $85/Hr = $1,445.00 DRYWALL: 6 Hours at $90/Hr = $540.00 PAINTING: 4 Hours at $80/Hr = $320.00 ELECTRICAL: 9 Hours at $75/Hr = $675.00 ELECTRICAL HELPER: 9 Hours at $50/Hr = $450.00 ESTIMATED MATERIAL: $350.00 + 10% = $385.00	3,815.00
3. Remove carpet in both rooms and haul away. Prep floor and install 65.5 Sq. Yds. of level loop light to medium beige carpet. FLOORING: 18 Hours at $61/Hr - $1,098.00 ESTIMATED MATERIAL: $1,902.41 + 10% = $2,091.55	3,189.55
4. Repair carpet with similar color where wall was removed. (4" x 15'). FLOORING: 6 Hours at $61/Hr = $366.00 ESTIMATED MATERIAL: $250.00 + 10% = $275.00	641.00
Howard L. Miller, President JA QUOTE IS GOOD FOR 60 DAYS.	

Please make checks payable to:H.L. Miller, Inc. CA State Contractors Lic. #385912 Tax ID 56-2399764	**Total** $7,645.55

PURSUANT TO CALIFORNIA PUBLIC CONTRACT CODE, SECTION 20104.50, INTEREST IS DUE IF NOT PAID WITHIN 30 DAYS OF THE ABOVE DATE, AT THE RATE ALLOWED IN THE CODE OF CIVIL PROCEDURE SECTION 685.101.

2201 E. Winston Road, Unit I, Anaheim, CA 92806-5537
Phone: (714) 998-8699 • Fax: (714) 998-8698 • Email: hlmcinc@aol.com

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 1, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

34. Consider Authorizing Extension of License Agreement with the County of Orange for Use of Space at the County Community Service Center

Contact

Phil Tsunoda, Executive Director Public Policy and Public Affairs, (714) 246-8400

Recommended Actions

1. Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to negotiate an Amendment to the License Agreement compliant with CalOptima's obligations under applicable state and federal laws regarding the privacy of CalOptima members and their protected health information and extend the License Agreement with the County of Orange for up to an additional four years through June 30, 2021, which allows use of approximately 362 square feet of space at the County Community Service Center (CCSC), located at 15496 Magnolia Street, Suite 111, Westminster, CA 92683;
2. Approve allocation of $18,831.76, which has been included in CalOptima's proposed Fiscal Year (FY) 2017-2018 Operating Budget to fund the extension of the License Agreement; and .
3. Authorize staff expenditures of $66,230 in FY 2017-18, plus equipment for a full time Customer Service Representative (CSR) at the licensed site.

Background

As a public agency and community health plan that serves the low-income Medi-Cal population in Orange County, CalOptima has been committed to member outreach, health education and engagement since its inception. By actively engaging our members in efforts with our community-based organizations, we increase opportunities for our members to receive information regarding our programs, learn about their benefits and be more proactive participants in their own health care.

Since 2008, CalOptima utilized space at the main CCSC office at no cost to CalOptima to offer monthly education seminars to increase our members' knowledge about CalOptima's programs and services and information to support our members' health care needs. Due to CalOptima's growth in membership and programs and increased interest in the health education seminars, the space at the main office limited the number of members served at the main CCSC office.

In May 2016, Orange County Social Services Agency informed CalOptima of an opportunity to expand our capacity at the CCSC by licensing space located across the parking lot from the main CCSC office. The licensed space provides one dedicated office and access to a shared conference room 50 percent of the time. On August 4, 2016, CalOptima's Board of Directors authorized the CEO to enter into a one-year license agreement with the County of Orange for usage of the space at the CCSC at a cost of approximately $23,000 for removal of a wall and licensing fees through June 30, 2017.

Since September 2016, CalOptima staff has been on-site to provide information and education about CalOptima's programs and services, enhanced customer service support, and additional monthly

educational seminars. The satellite office is centrally-located in the county and may be more convenient for certain CalOptima members who reside in the cities of Santa Ana, Garden Grove and Westminster. While visitation has been limited to an average of less than two members per day to date, staff is hopeful that a greater number of members will be receiving information at the site in the future.

Since the CCSC grand opening in September 2016, staff from various CalOptima departments have been on-site to serve members including Behavioral Health Integration, Program of All-Inclusive Care (PACE), OneCare Connect Sales and Marketing, Customer Service and Community Relations Departments. Services offered on-site include information and referrals for our programs and services, information and enrollment in the PACE and OneCare Connect programs, assistance with navigating health care benefits, educational seminars and customer service related issues including provider and health network selection, referrals, and requesting replacementID cards.

Since the opening of the new CCSC site, CalOptima has increased the health education seminars from one Vietnamese health education seminar to three seminars per month to include English and Spanish seminars, expanding our reach to English and Spanish-speaking members. CalOptima collaborated with community-based organization and internal departments to provide 21 educational seminars over the past nine months, or roughly three events per month, at the CCSC site. Topics presented include:

- The Importance of Vaccinations
- Understanding Social Security Programs and Benefits
- Dementia: The Basics: What it is and is not?
- Who is CalOptima? Understanding Your Medi-Cal Benefits
- Good Oral Care: Understanding Your Denti-Cal Benefits and Accessing Dental Services
- Mental Health Wellness: Understanding and Accessing Behavioral Health Benefits and Services

In January 2017, CalOptima started offering New Member Orientations for our Vietnamese-speaking members at the satellite office. A total of six New Member Orientations were conducted for our Medicare/Medi-Cal members and new Medi-Cal members.

Over 350 members have been provided with information and health education at the licensed site through the activities listed above in the nine months since the site's opening in September 2016. Foot traffic has averaged one to two members daily, and staff is hopeful that more members will receive information from the location with increased awareness of the licensed site and additional outreach efforts to members, providers and community-based organizations.

In addition to CalOptima's services, the CCSC offers a variety of health and human services to local residents including resources and referrals, application assistance and education workshops to assist with housing, mental and public health and support services for older adults. Representatives from Health Care Agency, Housing Authority, Family Caregiver Resource Center, and Office on Aging and Council on Aging are available to assist members on designated days.

CalOptima's primary challenge at the licensed site has been the lack of full-time staff available to serve our members on-site. While staff has made many efforts to provide full-time coverage by developing shifts for various departments, we still received feedback from members about the importance of having a full-time Customer Service Representative on-site. Staff has addressed this concern by budgeting for an additional full-time, bi-lingual Customer Service Representative who will begin duties at the CCSC in late May 2017.

To increase awareness of the licensed site in the community, CalOptima is implementing a number of outreach strategies to members, internal departments, health networks, providers and community-based organizations to increase utilization of services available. Activities include mailers to members residing in a two-mile radius of the satellite office, communications to health networks and providers through CalOptima's newsletters and weekly communications, and targeted site visits to providers, health clinics and community-based organizations within a two-mile radius.

Discussion

Staff recommends authorization to negotiate an amendment to the License Agreement to ensure compliance with applicable state and federal privacy laws and to extend the License Agreement with the County of Orange. The licensed site establishes a presence in the community and is available to provide information to members regarding benefits and health education to support their health care needs.

The current License Agreement allows for one dedicated office, shared use of a conference room and use of the common area. The total leased space for the CCSC is comprised of 2,080 square feet with CalOptima's use of 109 square feet for the dedicated office, 253 square feet for the shared conference room, and estimated 21 percent use of the common area. The License Agreement was approved by CalOptima's Board of Directors on August 4, 2016 for the license period of August 5, 2016 through June 30, 2017.

The proposed extension of the License Agreement for the CCSC would include an increase in the license term for an additional four years through June 30, 2021, increase in the monthly license fee from $1,453.02 per month to $1,560.98 per month for the months of July 1, 2017 through June 30, 2021, and the addition of a new standard insurance clause requiring CalOptima to meet all County insurance's requirements. CalOptima would also negotiate additional amendments as necessary to ensure compliance with applicable state and federal privacy requirements.

The Director of Financial Compliance reviewed the insurance requirements in the Amendment with CalOptima's broker and confirmed that CalOptima can meet these requirements; as proposed, this location can be added to CalOptima's General Liability policy at an additional annual premium of no more than $100.

	Total Amount
License Fee (July 2017 - June 2018) • Fee includes leased space, IT services, telephone services, janitorial services, and electrical/utilities	$18,731.76
Standard Insurance	$100.00
Computer and telecommunications equipment	$5,000.00
Full time bilingual customer service representative	$66,230.00
Total	$90,061.76

As proposed, the amended License Agreement would take effect on July 1, 2017, contingent on successful negotiations with the County and the agreement being fully executed and approved by the County of Orange's Board of Supervisors. The contract allows CalOptima to cancel the contract with 30-day's notice at any time.

The County of Orange's proposed extension to the License Agreement is for up to four additional years for the period of July 1, 2017 through June 30, 2021. Staff is proposing approval of the License Agreement for this period.

Fiscal Impact

The fiscal impact to execute a license agreement amendment to extend the term of the contract with the County of Orange for the period of July 2, 2017 through June 30, 2021, is approximately $75,000. Of this amount, $18,831.76 is budgeted under the proposed CalOptima FY 2017-18 Operating Budget pending Board approval for the period of July 1, 2017 through June 30, 2018. In addition, the annual cost of placing a full time bilingual customer service representative at the site is projected to total $66,230 in FY2017-18, plus $5,000 for computer/telework equipment for a total of $90,061.76 for FY 2017-18.

Rationale for Recommendation

As part of CalOptima's mission, staff works toward providing access to health care services for our members. By operating a licensed site in central Orange County, CalOptima is able to expand services to our members and build a presence in the community. The satellite office provides CalOptima with an opportunity to expand services to its members and provide direct support, increasing their ability to access health care.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Fully Executed County of Orange License Agreement-Original
2. CCSC Cost Apply

/s/ Michael Schrader — *5/25/2017*

Authorized Signature — **Date**

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LICENSE AGREEMENT

This LICENSE AGREEMENT (**"License"**) is made and entered into August 4, 2016 (**"Effective Date"**), by and between, CALOPTIMA, (hereinafter referred to as **"LICENSEE"**) and COUNTY OF ORANGE, a political subdivision of the State of California (hereinafter referred to as **"COUNTY"**) without regard to number and gender. LICENSEE and COUNTY may individually be referred to herein as a "**Party**," or collectively as the "**Parties**."

RECITALS

I. COUNTY leases that certain real property located at 15496 Magnolia in the City of Westminster, (**"County Property"**) pursuant to a lease dated July 1, 2016 for COUNTY's Social Services Agency's (**"SSA"**) Orange County Community Service Center Annex (**"OCCSCA"**).

II. The Services provided by LICENSEE will include a convenient on-site source while SSA clients are at the SSA Office.

III. COUNTY agrees to provide LICENSEE sufficient office space within the SSA Office for LICENSEE to provide the Services.

NOW THEREFORE, in consideration of the Recitals above, incorporated herein by reference, COUNTY and LICENSEE do hereby agree as follows:

1. DEFINITIONS (AMLC-2.1 S)

The following words in this License have the significance attached to them in this clause, unless otherwise apparent from context:

"Board of Supervisors" means the Board of Supervisors of the County of Orange, a political subdivision of the State of California.

"Chief Real Estate Officer" means the Chief Real Estate Officer, County Executive Office, County of Orange, or designee or upon written notice to LESSOR, such other person or entity as shall be designated by the County Executive Officer.

"County Counsel" means the County Counsel, County of Orange, or designee, or upon written notice to LICENSEE, such other person or entity as shall be designated by the Board of Supervisors.

"County Executive Officer" means the County Executive Officer, County Executive Office, County of Orange, or designee, or upon written notice to LICENSEE, such other person or entity as shall be designated by the Board of Supervisors.

"**Facilities Services Manager**" means the Manager of the Social Services Agency, Facilities Services, County of Orange, or designee, or upon written notice to LICENSEE, such other person or entity as shall be designated by the Director of Social Services Agency.

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"Risk Manager" means the Manager of County Executive Office, Risk Management, for the County of Orange, or upon written notice to LICENSEE, such entity as shall be designated by the County Executive Officer.

"SSA Director" means the Director of Social Services Agency, County of Orange, or designee, or upon written notice to LICENSEE, such other person or entity as shall be designated by the County Executive Officer or the Board of Supervisors.

2. TERM (AMLC-3.1 N)

The term of this License shall commence on the Effective Date and terminate on June 30, 2017, unless terminated as provided in Clause 3 (TERMINATION) of this License.

3. TERMINATION (AMLC-3.3 S)

This License shall be revocable by either COUNTY's SSA Director or LICENSEE at any time; however, as a courtesy the Parties will attempt to give thirty (30) days written notice to the other Party upon revocation.

4. LICENSE AREA (AMLC-4.2 N)

COUNTY grants to LICENSEE the non-exclusive right to use that certain property hereinafter referred to as **"License Area,"** shown on Exhibit A, attached hereto and by reference made a part hereof, for the purposes set forth in Clause 6 (USE) of this License together with non-exclusive, in common use of COUNTY's elevators, stairways, washrooms, hallways, driveways for vehicle ingress and egress, pedestrian walkways, other facilities and common areas appurtenant to LICENSEE's License Area created by this License.

During the term of this License, the dates and times for use of the License Area will be determined by the Facilities Services Manager, and the location of the License Area is subject to relocation at the sole discretion of the Facilities Operations Manager.

5. PARKING (AMLC-4.4 S)

Throughout the term of this License COUNTY shall provide one (1) parking space for LICENSEE's free and non-exclusive use.

6. USE (AMLC-5.1 N)

LICENSEE's use of the License Area shall be limited to general office to provide clients with health related workshops and information regarding their Medi-Cal benefits.

LICENSEE agrees not to use the License Area for any other purpose nor to engage in or permit any other activity within or from the License Area without prior written permission from the Facilities Services Manager. LICENSEE further agrees not to conduct or permit to be conducted any public or private nuisance in, on, or from the License Area, not to commit or permit to be committed waste on the License Area, and to comply with all governmental laws and regulations in connection with its use of the License Area.

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NO ALCOHOLIC BEVERAGES OR TOBACCO PRODUCTS SHALL BE SOLD OR CONSUMED WITHIN THE LICENSE AREA.

7. LICENSE FEE (AMLC-6.1 S)

LICENSEE agrees to pay COUNTY from and after the effective date of this License according to the following schedule:

MONTH	MONTHLY LICENSE FEE
1	$0.00
2	$361.73
3	$1,453.02
4	$1,453.02
5	$1,453.02
6	$1,453.02
7	$1,453.02
8	$1,453.02
9	$1,453.02
10	$1,453.02
11	$1,453.02
12	$1,453.02

The monthly License Fee shall be payable in advance, without prior notice or demand on the first day of each calendar month while this License is in effect without deduction or offset in lawful money of the United States.

In the event the obligation to pay the License Fee begins or terminates on some day other than the first day or last day of the month, the License Fee shall be prorated to reflect the actual period of use on the basis of a thirty (30) day month. The fee for any partial calendar month during which this License becomes effective will be payable on such effective date.

8. PAYMENT PROCEDURE (AMLC-7.1 N)

All payments shall be delivered to the County of Orange, Office of the Auditor-Controller, P. O. Box 567 (630 N. Broadway), Santa Ana, California 92702. The designated place of payment may be changed at any time by COUNTY upon ten (10) days written notice to LICENSEE. License Fee payments may be made by check payable to the County of Orange. Said License Fee payment shall include a payment voucher indicating that the payment is for the monthly License Fee for office space at the Orange County Community Service Center Annex in Westminster, California. A duplicate copy of the payment voucher shall be mailed to the County of Orange, Social Services Agency, 500 N. State College Boulevard, Orange, California,

92868, Attention: Facilities Services Manager. LICENSEE assumes all risk of loss if payments are made by mail.

No payment by LICENSEE or receipt by COUNTY of a lesser amount than the payment due shall be deemed to be other than on account of the payment due, nor shall any endorsement or statement on any check or any letter accompanying any check or payment as payment be deemed an accord and satisfaction, and COUNTY shall accept such check or payment without prejudice to COUNTY's right to recover the balance of said payment or pursue any other remedy in this License.

9. CHARGE FOR LATE PAYMENT (AMLC-7.2 S)

LICENSEE hereby acknowledges that late payment of sums due hereunder will cause COUNTY to incur costs not contemplated by this License, the exact amount of which will be extremely difficult to ascertain. Such costs include but are not limited to costs such as administrative processing of delinquent notices, increased accounting costs, etc.

Accordingly, if any payment pursuant to this license is not received by COUNTY by the due date, a late charge of one and one-half percent (1.5%) of the payment due and unpaid plus $100 shall be added to the payment, and the total sum shall become immediately due and payable to the COUNTY. An additional charge of one and one-half percent (1.5%) of said payment, excluding late charges, shall be added for each additional month that said payment remains unpaid.

LICENSEE and COUNTY hereby agree that such late charges represent a fair and reasonable estimate of the costs that COUNTY will incur by reason of LICENSEE's late payment.

Acceptance of such late charges (and/or any portion of the overdue payment) by COUNTY shall in no event constitute a waiver of LICENSEE's default with respect to such overdue payment, or prevent COUNTY from exercising any of the other rights and remedies granted hereunder.

10. UTILITIES, JANITORIAL, MAINTENANCE AND REPAIR (AMLC-9.3 N)

COUNTY shall be responsible for all charges for all utilities (water, gas and sewer),. County shall be responsible for all maintenance and repairs (including but not limited to: fire alarm, fire extinguisher, HVAC system, elevator maintenance, landscaping, pest control, and trash). COUNTY shall be responsible for telephone service, internet service and janitorial service. All charges for services provided by COUNTY pursuant to this Clause shall be included in LICENSEE's "MONTHLY LICENSE FEE" pursuant to Clause 7. (LICENSE FEE) of the License.

11. CONSTRUCTION AND/OR ALTERATION BY LICENSEE (AMD2.1 S)

COUNTY's Consent. No structures, improvements, or facilities shall be constructed, erected, altered, or made by LICENSEE within the License Area without prior written consent of the Facilities Services Manager. Any conditions relating to the manner, method, design, and construction of said structures, improvements, or facilities fixed by the Facilities Services Manager as a condition to granting such consent, shall be conditions hereof as though originally stated herein. LICENSEE may, at any time and at its sole expense, install and place business fixtures and equipment within License Area.

Strict Compliance with Plans and Specifications. All improvements constructed by LICENSEE within the

License Area shall be constructed in strict compliance with detailed plans and specifications approved by the Facilities Services Manager.

COUNTY shall contract with a licensed contractor to remove the existing wall between the "Reception Area" and "Room #1" as depicted in Exhibit B, to replace existing carpet, and repair any areas resulting from removing said wall. LICENSEE shall reimburse COUNTY in the amount not to exceed Seven Thousand six hundred forty-five dollars and fifty-five cents ($7,645.55) within twenty (20) business days of COUNTY's submittal to LICENSEE of an invoice from COUNTY.

12. MECHANICS LIENS OR STOP-NOTICES (AMD4.1 S)

LICENSEE shall at all times indemnify, defend with counsel approved in writing by COUNTY and save COUNTY harmless from all claims, losses, demands, damages, cost, expenses, or liability costs for labor or materials in connection with construction, repair, alteration, or installation of structures, improvements, equipment, or facilities within the License Area, and from the cost of defending against such claims, including attorney fees and costs.

In the event a lien or stop-notice is imposed upon the License Area as a result of such construction, repair, alteration, or installation, LICENSEE shall either:

A. Record a valid Release of Lien, or

B. Procure and record a bond in accordance with Section 3143 of the Civil Code, which frees the License Area from the claim of the lien or stop-notice and from any action brought to foreclose the lien.

Should LICENSEE fail to accomplish either of the two optional actions above within fifteen (15) days after the filing of such a lien or stop-notice, the License shall be in default and shall be subject to immediate termination.

13. OWNERSHIP OF IMPROVEMENTS (AMD6.1 N)

All improvements, exclusive of trade fixtures, constructed or placed within the License Area by LICENSEE must, upon completion, be free and clear all liens, claims, or liability for labor or material and at COUNTY's option shall be the property of COUNTY's at the expiration of this License or upon earlier termination hereof. COUNTY retains the right to require LICENSEE, at LICENSEE's cost, to remove all LICENSEE's improvements located on the License Area at the expiration or termination hereof.

14. INSURANCE (AML10.1 N)

LICENSEE agrees to purchase all required insurance at LICENSEE's expense and to deposit with COUNTY certificates of insurance, including all endorsements required herein, necessary to satisfy COUNTY that the insurance provisions of this License have been complied with and to keep such insurance coverage and the certificates and endorsements therefore on deposit with COUNTY during the entire term of this License. This License shall automatically terminate at the same time LICENSEE's insurance coverage is terminated. If within ten (10) business days after termination under this Clause LICENSEE obtains and provides evidence of the required insurance coverage acceptable to Facilities Services Manager, this License may be reinstated at the sole discretion of Facilities Services Manager.

LICENSEE agrees that LICENSEE shall not operate on the License Area at any time the required insurance is not in full force and effect as evidenced by a certificate of insurance and necessary endorsements or, in the interim, an official binder being in the possession of Facilities Services Manager. In no cases shall assurances by LICENSEE, its employees, agents, including any insurance agent, be construed as adequate evidence of insurance. Facilities Services Manager will only accept valid certificates of insurance and

endorsements, or in the interim, an insurance binder as adequate evidence of insurance. LICENSEE also agrees that upon cancellation, termination, or expiration of LICENSEE's insurance, COUNTY may take whatever steps are necessary to interrupt any operation from or on the License Area until such time as the Facilities Services Manager reinstates the License.

If LICENSEE fails to provide Facilities Services Manager with a valid certificate of insurance and endorsements, or binder at any time during the term of the License, COUNTY and LICENSEE agree that this shall constitute a material breach of the License. Whether or not a notice of default has or has not been sent to LICENSEE, said material breach shall permit COUNTY to take whatever steps necessary to interrupt any operation from or on the License Area, and to prevent any persons, including, but not limited to, members of the general public, and LICENSEE's employees and agents, from entering the License Area until such time as Facilities Services Manager is provided with adequate evidence of insurance required herein. LICENSEE further agrees to hold COUNTY harmless for any damages resulting from such interruption of business and possession, including, but not limited to, damages resulting from any loss of income or business resulting from the COUNTY's action.

All contractors performing work on behalf of LICENSEE pursuant to this License shall obtain insurance subject to the same terms and conditions as set forth herein for LICENSEE. LICENSEE shall not allow contractors or subcontractors to work if contractors have less than the level of coverage required by COUNTY from LICENSEE under this License. It is the obligation of LICENSEE to provide written notice of the insurance requirements to every contractor and to receive proof of insurance prior to allowing any contractor to begin work within the License Area. Such proof of insurance must be maintained by LICENSEE through the entirety of this License and be available for inspection by a COUNTY representative at any reasonable time.
All self-insured retentions (**"SIRs"**) and deductibles shall be clearly stated on the Certificate of Insurance. If no SIRs or deductibles apply, indicate this on the Certificate of Insurance with a "0" by the appropriate line of coverage. Any **SIR** or deductible in excess of $25,000 ($5,000 for automobile liability), shall specifically be approved by COUNTY's Risk Manager.

If LICENSEE fails to maintain insurance acceptable to COUNTY for the full term of this License, COUNTY may terminate this License.

Qualified Insurer

The policy or policies of insurance must be issued by an insurer licensed to do business in the state of California (California Admitted Carrier) or have a minimum rating of A- (Secure A.M. Best's Rating) and VIII (Financial Size Category) as determined by the most current edition of the **Best's key Rating Guide/Property-Casualty/United States or ambest.com**.

If the insurance carrier is not an admitted carrier in the state of California and does not have an A.M. Best rating of A-/VIII, COUNTY's Risk Manager retains the right to approve or reject a carrier after a review of the company's performance and financial ratings.

The policy or policies of insurance maintained by LICENSEE shall provide the minimum limits and coverage as set forth below:

Coverages	Minimum Limits

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Coverages	Minimum Limits
Commercial General Liability	$1,000,000 per occurrence $2,000,000 aggregate
Automobile Liability including coverage for owned, non-owned and hired vehicles	$1,000,000 limit per occurrence
Workers' Compensation	Statutory
Employers' Liability Insurance	$1,000,000 per occurrence

Required Coverage Forms

The Commercial General Liability coverage shall be written on Insurance Services Office (**"ISO"**) form CG 00 01, or a substitute form providing liability coverage at least as broad.
The Business Auto Liability coverage shall be written on ISO form CA 00 01, CA 00 05, CA 00 12, CA 00 20, or a substitute form providing liability coverage as broad.

Required Endorsements

The following endorsements must be submitted with the Certificate of Insurance:

a) The Commercial General Liability policy shall contain an Additional Insured endorsement using ISO form CG 2010 or CG 2033 or a form at least as broad naming the COUNTY, its elected and appointed officials, officers, employees, and agents as Additional Insureds.

b) The Commercial General Liability policy shall contain a primary non-contributing endorsement evidencing that the LESSEE's insurance is primary and any insurance or self-insurance maintained by the COUNTY shall be excess and non-contributing.

c) The Workers' Compensation policy shall contain a waiver of subrogation endorsement waiving all rights of subrogation against the COUNTY, and members of the Board of Supervisors, its elected and appointed officials, officers, agents and employees.

d) The Commercial Property policy shall contain a Loss Payee endorsement naming the COUNTY as respects the COUNTY's financial interest when applicable.

All insurance policies required by this contract shall waive all rights of subrogation against the COUNTY and members of the Board of Supervisors, its elected and appointed officials, officers, agents and employees when acting within the scope of their appointment or employment.

All insurance policies required by this contract shall give COUNTY thirty (30) days notice in the event of cancellation and ten (10) days for non-payment of premium. This shall be evidenced by policy provisions or an endorsement separate from the Certificate of Insurance.

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The Commercial General Liability policy shall contain a severability of interests' clause, also known as a "separation of insureds" clause (standard in the ISO CG 001 policy).

Insurance certificates should be forwarded to COUNTY's address provided in Clause 17 (NOTICES) below or to an address provided by SSA/Facilities Services Manager. LICENSEE has ten (10) business days to provide adequate evidence of insurance or this License may be cancelled.

COUNTY expressly retains the right to require LICENSEE to increase or decrease insurance of any of the above insurance types throughout the term of this License. Any increase or decrease in insurance will be as deemed by COUNTY's Risk Manager as appropriate to adequately protect COUNTY.

COUNTY shall notify LICENSEE in writing of changes in the insurance requirements. If LICENSEE does not deposit copies of acceptable certificates of insurance and endorsements with COUNTY incorporating such changes within thirty (30) days of receipt of such notice, this License may be in breach without further notice to LICENSEE, and COUNTY shall be entitled to all legal remedies.

The procuring of such required policy or policies of insurance shall not be construed to limit LICENSEE's liability hereunder nor to fulfill the indemnification provisions and requirements of this License, nor in any way to reduce the policy coverage and limits available from the insurer.

15. OPERATIONS (AMLC-11.1 N)

LICENSEE shall keep and maintain the License Area and all improvements of any kind in good condition and in substantial repair. COUNTY will, on LICENSEE's behalf, provide all maintenance and repairs to the License Area during the term of the License. LICENSEE is required to notify COUNTY of any and all necessary maintenance and repairs to the License Area on a timely basis.

LICENSEE expressly agrees to maintain the License Area in a safe, clean, wholesome, and sanitary condition, to the complete satisfaction of COUNTY and in compliance with all applicable laws. LICENSEE further agrees to keep the License Area free and clear of rubbish and litter. COUNTY shall have the right to enter upon and inspect the License Area at any time for cleanliness and safety.

LICENSEE shall designate in writing to COUNTY an on-site representative who shall be responsible for the day to day operation and level of maintenance, cleanliness, and general order.

16. LIMITATION OF THE LICENSE (AMLC-13.1 S)

This License and the rights and privileges granted LICENSEE in and to the License Area are subject to all covenants, conditions, restrictions, and exceptions of record or apparent from a physical inspection of the License Area. Nothing contained in this License or in any document related hereto shall be construed to imply the conveyance to LICENSEE of rights in the License Area, which exceed those owned by COUNTY.

17. HIPAA NOTICE (N)

LICENSEE acknowledges that the Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA) requires COUNTY to safeguard and maintain the confidentiality of any Protected Health Information (PHI). LICENSEE hereby agrees not to access, remove, destroy, or relocate any property used by COUNTY to safeguard and store PHI. LICENSEE further agrees to use appropriate safeguards and to

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take all reasonable steps to prevent access to any PHI stored on the premises, including informing its workforce, contractors and vendors of the confidential nature of the records maintained by COUNTY. LICENSEE agrees to report to COUNTY within ten (10) calendar days any unauthorized use or any disclosure of PHI, which LICENSEE becomes aware. Upon COUNTY's knowledge of any breach, disclosure, or unauthorized use of PHI by LICENSEE, COUNTY shall:

a. Provide an opportunity for LICENSEE to cure the breach or end the violation. If LICENSEE does not cure the breach or end the violation within thirty (30) days or shorter period as required by COUNTY, COUNTY shall terminate this Agreement; or

b. Immediately terminate this Agreement if cure is not possible.

18. HAZARDOUS MATERIALS (AMLC-16.1 S)

A. Definition of Hazardous Materials. For purposes of this License, the term **"Hazardous Material"** or "Hazardous Materials" shall mean any hazardous or toxic substance, material, product, byproduct, or waste which is or shall become regulated by any governmental entity, including, without limitation, the COUNTY acting in its governmental capacity, the State of California or the United States government.

B. Use of Hazardous Materials. LICENSEE or LICENSEE's employees, agents, independent contractors or invitees (collectively **"LICENSEE Parties"**) shall not cause or permit any Hazardous Materials to be brought upon, stored, kept, used, generated, released into the environment or disposed of on, under, from or about the License Area (which for purposes of this clause shall include the subsurface soil and ground water). Notwithstanding the foregoing, LICENSEE may keep on or about the License Area small quantities of Hazardous Materials that are used in the ordinary, customary and lawful cleaning of and business operations on the License Area.

C. LICENSEE Obligations. If the presence of any Hazardous Materials on, under or about the License Area caused or permitted by LICENSEE or LICENSEE Parties results in (i) injury to any person, (ii) injury to or contamination of the License Area (or a portion thereof), or (iii) injury to or contamination or any real or personal property wherever situated, LICENSEE, at its sole cost and expense, shall promptly take all actions necessary or appropriate to return the License Area to the condition existing prior to the introduction of such Hazardous Materials to the License Area and to remedy or repair any such injury or contamination. Without limiting any other rights or remedies of COUNTY under this License, LICENSEE shall pay the cost of any cleanup or remedial work performed on, under or about the License Area as required by this License or by applicable laws in connection with the removal, disposal, neutralization or other treatment of such Hazardous Materials caused or permitted by LICENSEE or LICENSEE Parties. Notwithstanding the foregoing, LICENSEE shall not take any remedial action in response to the presence, discharge or release, of any Hazardous Materials on, under or about the License Area caused or permitted by LICENSEE or LICENSEE Parties, or enter into any settlement agreement, consent decree or other compromise with any governmental or quasigovernmental entity without first obtaining the prior written consent of the COUNTY. All work performed or caused to be performed by LICENSEE as provided for above shall be done in good and workmanlike manner and in compliance with plans, specifications, permits and other requirements for such work approved by COUNTY.

D. Indemnification for Hazardous Materials. To the fullest extent permitted by law, LICENSEE hereby agrees to indemnify, hold harmless, protect and defend (with attorneys acceptable to COUNTY) COUNTY, its elected officials, officers, employees, agents and independent contractors and the

License Area, from and against any and all liabilities, losses, damages (including, but not limited, damages for the loss or restriction on use of rentable or usable space or any amenity of the License Area or damages arising from any adverse impact on marketing of the License Area), diminution in the value of the License Area, judgments, fines, demands, claims, recoveries, deficiencies, costs and expenses (including, but not limited to, reasonable attorneys' fees, disbursements and court costs and all other professional or consultant's expenses), whether foreseeable or unforeseeable, arising directly or indirectly out of the presence, use, generation, storage, treatment, on or off-site disposal or transportation of Hazardous Materials on, into, from, under or about the License Area by LICENSEE or LICENSEE's Parties. The foregoing indemnity shall also specifically include the cost of any required or necessary repair, restoration, clean-up or detoxification of the License Area and the preparation of any closure or other required plans.

19. NOTICES (AMLC-14.1 S)

All notices pursuant to this License shall be addressed as set forth below or as either Party may hereafter designate by written notice and shall be sent through the United States mail in the State of California duly registered or certified with postage prepaid. If any notice is sent by registered or certified mail, as aforesaid, the same shall be deemed served or delivered twenty-four (24) hours after mailing thereof as above provided. Notwithstanding the above, COUNTY may also provide notices to LICENSEE by personal delivery, by regular mail, or by electric mail and any such notice so given shall be deemed to have been given upon receipt.

TO: COUNTY

County of Orange
Social Services Agency
Facilities Services
500 N. State College Boulevard
Orange, CA 92868

With a copy to:

County Executive Office
Attention: Chief Real Estate Officer
333 W. Santa Ana Boulevard, 3rd Floor
Santa Ana, CA 92701

TO: LICENSEE

CalOptima
15496 Magnolia, #111
Westminster, CA 92806
Phil Tsunoda, Executive Director,
Public Policy & Public Affairs
ptsunoda@caloptima.org

20. ATTACHMENTS TO LICENSE (AMLC-15.1 S)

This License includes the following, which are attached hereto and made a part hereof:

I. GENERAL CONDITIONS
II. EXHIBITS
Exhibit A - License Description
Exhibit B – Floor Plan

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WITNESS WHEREOF, the parties have executed this License the day and year first above written

APPROVED AS TO FORM:
OFFICE OF COUNTY COUNSEL
ORANGE COUNTY, CALIFORNIA

By _____
Deputy County Counsel

Date: 8/25/16

LICENSEE
CalOptima

By _____

Name: Michael Schrader
Title: CEO

RECOMMENDED FOR APPROVAL

Social Services Agency

By _____
Carol Wiseman, Chief Deputy Director

CEO Real Estate Services

By _____
John Buck, Administrative Manager

COUNTY

COUNTY OF ORANGE

By _____
Scott Mayer, Chief Real Estate Officer
County Executive Office
Per Resolution No. 14-014 of the Board of Supervisors and Minute Order dated January 28, 2014

Date: 8.29.16

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GENERAL CONDITIONS (AMLC-GC l-17 S)

1. PERMITS AND LICENSES (AMLC - GC2 S)

LICENSEE shall be required to obtain any and all permits and/or licenses which may be required in connection with the operation of the License Area as set out herein. No permit, approval, or consent given hereunder by COUNTY, in its governmental capacity, shall affect or limit LICENSEE's obligations hereunder, nor shall any approvals or consents given by COUNTY, as a Party to this License, be deemed approval as to compliance or conformance with applicable governmental codes, laws, rules, or regulations.

2. SIGNS (AMLC-GC3 S)

LICENSEE agrees not to construct, maintain, or allow any signs, banners, flags, etc., upon License Area except as approved by Facilities Operations Manager unapproved signs, banners, flags, etc., may be removed.

3. LICENSE ORGANIZATION (AMLC-GC4 S)

The various headings and numbers herein, the grouping of provisions of this License into separate clauses and paragraphs, and the organization hereof, are for the purpose of convenience only and shall not be considered otherwise.

4. AMENDMENTS (AMLC-GC5 S)

This License is the sole and only agreement between the Parties regarding the subject matter hereof; other agreements, either oral or written, are void. Any changes to this License shall be in writing and shall be properly executed by both Parties.

5. UNLAWFUL USE (AMLC-GC6 S)

LICENSEE agrees no improvements shall be erected, placed upon, operated, nor maintained on the License Area, nor any business conducted or carried on therein or there from, in violation of the terms of this License, or of any regulation, order of law, statute, bylaw, or ordinance of a governmental agency having jurisdiction.

6. INSPECTION (AMLC-GC7 S)

COUNTY or its authorized representative shall have the right at all reasonable times to inspect the operation to determine if the provisions of this License are being complied with.

7. INDEMNIFICATION (AMLC-GC8 S)

LICENSEE hereby waives all claims and recourse against COUNTY including the right of contribution for loss or damage of persons or property arising from, growing out of, or in any way connected with or related to this License except claims arising from the concurrent active or sole negligence of COUNTY, its officers, agents, and employees. LICENSEE hereby agrees to indemnify, hold harmless, and defend with counsel acceptable to COUNTY, its officers, agents, and employees against any and all claims, loss, demands, damages, cost, expenses, or liability costs arising out of the operation, use, or maintenance of the property

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described herein, and/or LICENSEE's exercise of the rights under this License, except for liability arising out of the concurrent active or sole negligence of COUNTY, its officers, agents, or employees, including the cost of defense of any lawsuit arising there from.

In the event COUNTY is named as co-defendant, LICENSEE shall notify COUNTY of such fact and shall represent COUNTY with counsel acceptable to COUNTY in such legal action unless COUNTY undertakes to represent itself as co-defendant in such legal action, in which event LICENSEE shall pay to COUNTY its litigation costs, expenses, and attorney's fees. In the event judgment is entered against COUNTY and LICENSEE because of the concurrent active negligence of COUNTY and LICENSEE, their officers, agents, or employees, an apportionment of liability to pay such judgment shall be made by a court of competent jurisdiction. Neither Party shall request a jury apportionment.

8. TAXES AND ASSESSMENTS (AMLC-GC9 S)

Although not anticipated, should this License create a possessory interest which is subject to the payment of taxes levied on such interest, it is understood and agreed that all taxes and assessments (including but not limited to said possessory interest tax) which become due and payable in connection with this License or upon fixtures, equipment, or other property used in connection with this License, shall be the full responsibility of LICENSEE, and LICENSEE shall cause said taxes and assessments to be paid promptly.

9. PARTIAL INVALIDITY (AMLC-GC10 S)

If any term, covenant, condition, or provision of this License is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remainder of the provisions hereof shall remain in full force and effect and shall in no way be affected, impaired, or invalidated thereby.

10. WAIVER OF RIGHTS (AMLC-GC11 S)

The failure of COUNTY to insist upon strict performance of any of the terms, covenants, or conditions of this License shall not be deemed a waiver of any right or remedy that COUNTY may have, and shall not be deemed a waiver of the right to require strict performance of all the terms, covenants, and conditions of the License thereafter, nor a waiver of any remedy for the subsequent breach or default of any term, covenant, or condition of the License. Any waiver, in order to be effective, must be signed by the Party whose right or remedy is being waived.

11. CONDITION OF LICENSE AREA UPON TERMINATION (AMLC-GC12 S)

Except as otherwise agreed to herein, upon termination of this License, LICENSEE shall redeliver possession of said License Area to COUNTY in substantially the same condition that existed immediately prior to LICENSEE's entry thereon, reasonable wear and tear, flood, earthquakes, and any act of war excepted.

12. DISPOSITION OF ABANDONED PERSONAL PROPERTY (AMLC-GC13 S)

If LICENSEE abandons the License Area or is dispossessed thereof by process of law or otherwise, title to any personal property belonging to LICENSEE and left on the License Area ten (10) days after such event shall be deemed, at COUNTY's option, to have been transferred to COUNTY. COUNTY shall have the

right to remove and to dispose of such property without liability there from to LICENSEE or to any person claiming under LICENSEE, and shall have no need to account therefore.

13. TIME OF ESSENCE (AMLC-GC14 S)

Time is of the essence of this License. Failure to comply with any time requirements of this License shall constitute a material breach of this License.

14. NO ASSIGNMENT (AMLC-G15 S)

The License granted hereby is personal to LICENSEE and any assignment of said license by LICENSEE, voluntarily or by operation of law, shall automatically terminate the License granted hereby.

15. CHILD SUPPORT ENFORCEMENT REQUIREMENTS (AMLC-GC16 S)

In order to comply with child support requirements of the County of Orange, LICENSEE hereby furnishes COUNTY's Facilities Operations Manager, COUNTY's standard form, Child Support Enforcement Certification Requirements. COUNTY acknowledges receipt of the aforementioned form, which contains the following information:

a) In the case where LICENSEE is doing business as an individual, LICENSEE's name, date of birth, Social Security number, and residence address;

b) In the case where LICENSEE is doing business in a form other than as an individual, the name, date of birth, Social Security number, and residence address of each individual who owns an interest of ten (10) percent or more in the contracting entity;

c) A certification that LICENSEE has fully complied with all applicable federal and state reporting requirements regarding its employees; and

d) A certification that LICENSEE has fully complied with all lawfully served Wage and Earnings Assignment Orders and Notices of Assignment and will continue to so comply.

Failure of LICENSEE to continuously comply with all federal and state reporting requirements for child support enforcement or to comply with all lawfully served Wage and Earnings Assignment Orders and Notices of Assignment shall constitute a material breach of this License. Failure to cure such breach within sixty (60) calendar days of notice from COUNTY's shall constitute grounds for termination of this License.

It is expressly understood that this data will be transmitted to governmental agencies charged with the establishment and enforcement of child support orders and will not be used for any other purpose.

16. RIGHT TO WORK AND MINIMUM WAGE LAWS (AMLC-GC17 S)

In accordance with the United States Immigration Reform and Control Act of 1986, LICENSEE shall require its employees that directly or indirectly service the License Area or terms and conditions of this License, in any manner whatsoever, to verify their identity and eligibility for employment in the United States. LICENSEE shall also require and verify that its contractors or any other persons servicing the License Area

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or terms and conditions of this License, in any manner whatsoever, verify the identity of their employees and their eligibility for employment in the United States.

Pursuant to the United States of America Fair Labor Standard Act of 1938, as amended, and State of California Labor Code, Section 1178.5, LICENSEE shall pay no less than the greater of the Federal or California Minimum Wage to all its employees that directly or indirectly service the License Area, in any manner whatsoever. LICENSEE shall require and verify that all its contractors or other persons servicing the License Area on behalf of LICENSEE also pay their employees no less than the greater of the Federal or California Minimum Wage.

LICENSEE shall comply and verify that its contractors comply with all other Federal and State of California laws for minimum wage, overtime pay, record keeping, and child labor standards pursuant to the servicing of the License Area or terms and conditions of this License.

Notwithstanding the minimum wage requirements provided for in this clause, LICENSEE, where applicable, shall comply with the prevailing wage and related requirements pursuant to the provisions of Section 1773 of the Labor Code of the State of California.

17. BEST MANAGEMENT PRACTICES (AMLC 15.1 S)

LICENSEE and all of LICENSEE's, agents, employees and contractors shall conduct operations under this License so as to assure that pollutants do not enter municipal storm drain systems which systems are comprised of, but are not limited to curbs and gutters that are part of the street systems ("**Stormwater Drainage System**"), and to ensure that pollutants do not directly impact "**Receiving Waters**" (as used herein, Receiving Waters include, but are not limited to, rivers, creeks, streams, estuaries, lakes, harbors, bays and oceans).

The Santa Ana and San Diego Regional Water Quality Control Boards have issued National Pollutant Discharge Elimination System ("**NPDES**") permits ("**Stormwater Permits**") to the County of Orange, and to the Orange County Flood Control District and cities within Orange County, as co-permittees (hereinafter collectively referred to as "**County Parties**") which regulate the discharge of urban runoff from areas within the County of Orange, including the License Area. The County Parties have enacted water quality ordinances that prohibit conditions and activities that may result in polluted runoff being discharged into the Stormwater Drainage System.

To assure compliance with the Stormwater Permits and water quality ordinances, the County Parties have developed a Drainage Area Management Plan ("**DAMP**") which includes a Local Implementation Plan ("**LIP**") for each jurisdiction that contains Best Management Practices ("**BMP(s)**") that parties using properties within Orange County must adhere to. As used herein, a BMP is defined as a technique, measure, or structural control that is used for a given set of conditions to manage the quantity and improve the quality of stormwater runoff in a cost effective manner. These BMPs are found within the COUNTY's LIP in the form of Model Maintenance Procedures and BMP Fact Sheets (the Model Maintenance Procedures and BMP Fact Sheets contained in the DAMP/LIP shall be referred to hereinafter collectively as "**BMP Fact Sheets**") and contain pollution prevention and source control techniques to eliminate non-stormwater discharges and minimize the impact of pollutants on stormwater runoff.

The use under this License does not require BMP Fact Sheets.

18. PAYMENT CARD COMPLIANCE (AMLC-G15 S)

Should LICENSEE conduct credit/debit card transactions in conjunction with their business with the COUNTY, on behalf of the COUNTY, or as part of the business that they conduct, LICENSEE covenants and warrants that it is currently Payment Card Industry Data Security Standard (**"PCI DSS"**) and Payment Application Data Security Standards (**"PA DSS"**) compliant and will remain compliant during the entire duration of this License. LICENSEE agrees to immediately notify COUNTY in the event LICENSEE should ever become non-compliant, and will take all necessary steps to return to compliance and shall be compliant within ten (10) days of the commencement of any such interruption.

Upon demand by COUNTY, LICENSEE shall provide to COUNTY written certification of LICENSEE's PCI DSS and/or PA DSS compliance.

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LICENSE DESCRIPTION (10.1 S)

PROJECT NO: GA 1213-236 DATE: 6/29/16

PROJECT: CalOptima
15496 Magnolia, #111
Westminster, CA 92806

WRITTEN BY: EAS

All the License Area referenced on a Floor Plan marked Exhibit B, attached hereto and made a part hereof, being approximately Three Hundred Sixty Two (362) rentable square feet of COUNTY-designated space for LICENSEE's non-exclusive use, which space may vary from time-to-time based on COUNTY's pre-approval in writing, and being a portion of the Orange County Community Service Center Annex building located at 15496 Magnolia, Suite 111, Rooms 1 and 2 in the City of Westminster, County of Orange, State of California, together with appurtenant right to use common areas located thereon, and the non-exclusive use of one parking space in the adjacent parking lot.

NOT TO BE RECORDED

EXHIBIT A

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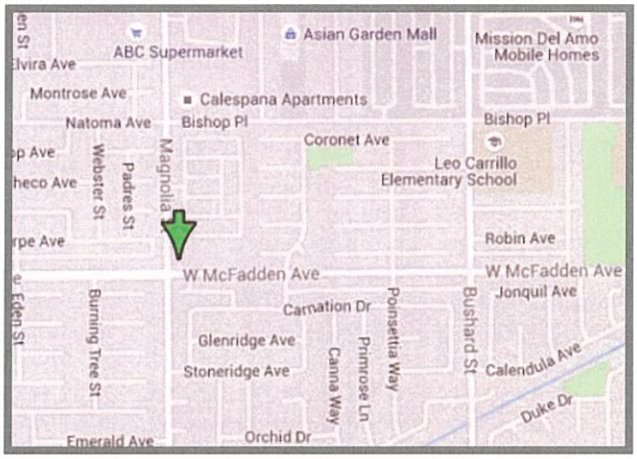
GA 1213-237
SSA/CalOptima



Location Map

N

License Area:
Rooms 1 & 2

15496 Magnolia St. Suite 111 Westminster Ca. 92683

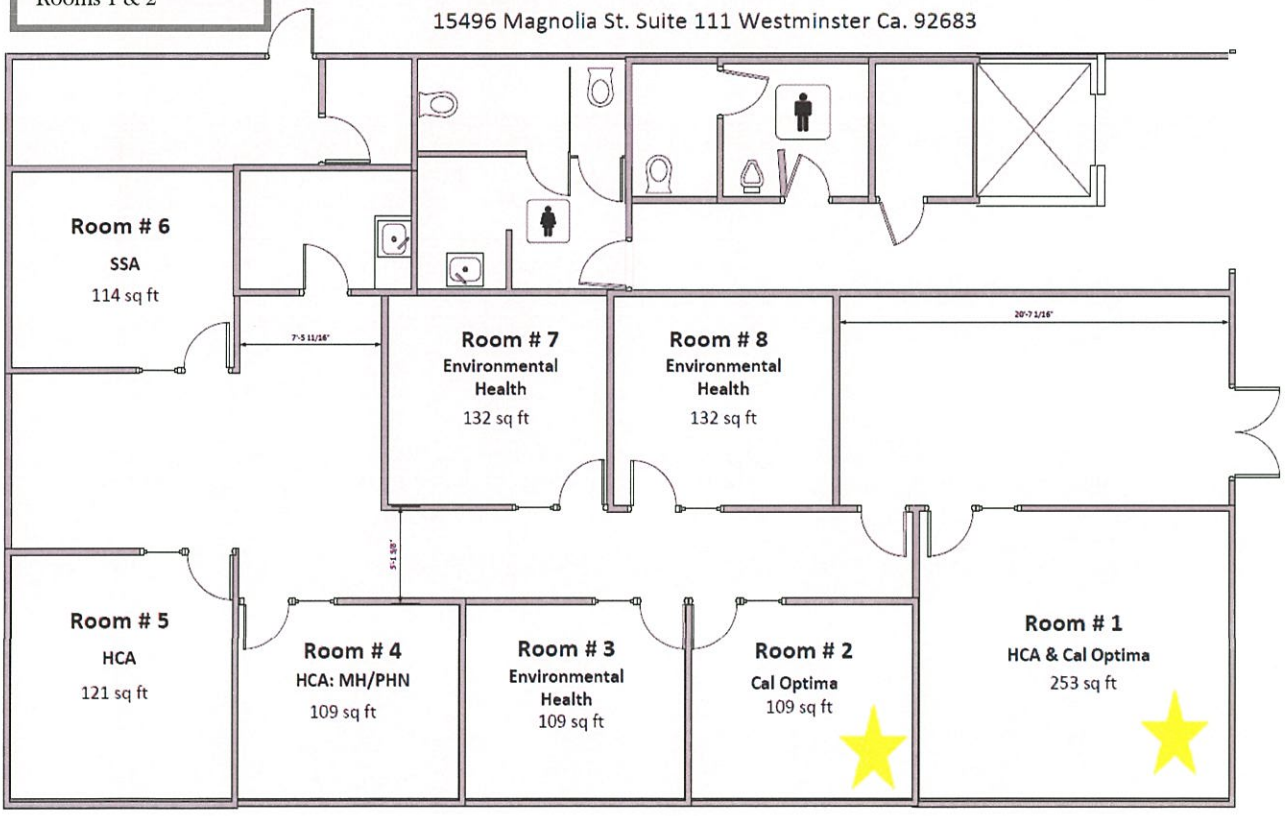


EXHIBIT B

CCSC COST APPLY - 15496 Magnolia Street, Westminster

FY 2017-18 MONTHLY INVOICE CODING SUMMARY

Invoice Coding and Job Number Allocation.

	Fund/Dept/Budget Control Unit/Object/Job No.	July 2017	August 2017	September 2017	October 2017	November 2017	December 2017	January 2018	February 2018	March 2018	April 2018	May 2018	June 2018	Annual Total
CalOptima	100/063/063 2211/2200/S34009	$ 1,560.98	$ 1,560.98	$ 1,560.98	$ 1,560.98	$ 1,560.98	$ 1,560.98	$ 1,560.98	$ 1,560.98	$ 1,560.98	$ 1,560.98	$ 1,560.98	$ 1,560.98	**$ 18,731.77**

LEASED SPACE

	Fund/Dept/Budget Control /Unit/Object/Job No	sq ft	Allocation %	July 2017	August 2017	September 2017	October 2017	November 2017	December 2017	January 2018	February 2018	March 2018	April 2018	May 2018	June 2018	Annual Total
Cal Optima	**100/063/063 2211/2200/S34009**	**235.55**	**21.83%**	**$ 1,424.19**	**$ 1,424.19**	**$ 1,424.19**	**$ 1,424.19**	**$ 1,424.19**	**$ 1,424.19**	**$ 1,424.19**	**$ 1,424.19**	**$ 1,424.19**	**$ 1,424.19**	**$ 1,424.19**	**$ 1,424.19**	**$ 17,090.27**

Total leased space: 1079 sq. ft.

Lease rates: Monthly Fiscal Year total:

Rent: July 1, 2017 - June 30, 2018 $ 6,524.00 $ 78,288.00

Operating Expenses

charge by Charles H Manh and Anh Manh	Fund/Dept/Budget Control /Unit/Object/Job No	sq ft	Allocation %	July 2017	August 2017	September 2017	October 2017	November 2017	December 2017	January 2018	February 2018	March 2018	April 2018	May 2018	June 2018	Annual Total
Cal Optima	**100/063/063 2211/1000/S34009**	**235.55**	**21.83%**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**

Total leased space: 1079 sq. ft.

Monthly Fiscal Year total:

Operating Expenses: July 1 2017 - June 30, 2018 $ - $ -

IT SERVICES - Internet by Time W

	Fund/Dept/Budget Control /Unit/Object	# computers	Allocation %	July 2017	August 2017	September 2017	October 2017	November 2017	December 2017	January 2018	February 2018	March 2018	April 2018	May 2018	June 2018	Annual Total
Cal Optima	**100/063/063 2211/1000/S34009**	**1**	**16.67%**	**$ 65.84**	**$ 65.84**	**$ 65.84**	**$ 65.84**	**$ 65.84**	**$ 65.84**	**$ 65.84**	**$ 65.84**	**$ 65.84**	**$ 65.84**	**$ 65.84**	**$ 65.84**	**$ 790.02**

Monthly IT rates $ 395.01 2016-17 Rate + 2.60% CPI

Annual High Speed Internet Service Cost $ 4,740.12

TELEPHONE SERVICES

	Fund/Dept/Budget Control /Unit/Object	# phones	Allocation %	July 2017	August 2017	September 2017	October 2017	November 2017	December 2017	January 2018	February 2018	March 2018	April 2018	May 2018	June 2018	Annual Total
Cal Optima	**100/063/063 2211/1000/S34009**	**1**	**12.50%**	**$ 19.27**	**$ 19.27**	**$ 19.27**	**$ 19.27**	**$ 19.27**	**$ 19.27**	**$ 19.27**	**$ 19.27**	**$ 19.27**	**$ 19.27**	**$ 19.27**	**$ 19.27**	**$ 231.25**

Monthly Average Telephone Service Costs $ 154.17 2016-17 Rate + 2.60% CPI

Annual Telephone Service Costs $ 1,850.00

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JANITORIAL SERVICES	Fund/Dept/Budget Control /Unit/Object	sq ft	Allocation %	July 2017	August 2017	September 2017	October 2017	November 2017	December 2017	January 2018	February 2018	March 2018	April 2018	May 2018	June 2018	Annual Total		
Cal Optima	**100/063/063 2211/1000/S34009**	**235.55**	**21.83%**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**		

Total leased space: 1079 sq. ft.

Monthly Janitorial Costs $ - 2016-17 Rate + 2.60% CPI
12 mo. Annual Janitorial Costs $ -

ELECTRICAL/UTILITIES Acct 3045332860 by Al Pasillas	Fund/Dept/Budget Control /Unit/Object	sq ft	Allocation %	July 2017	August 2017	September 2017	October 2017	November 2017	December 2017	January 2018	February 2018	March 2018	April 2018	May 2018	June 2018	Annual Total		
Cal Optima	**100/063/063 2211/1000/S34009**	**235.55**	**21.83%**	**$ 51.69**	**$ 51.69**	**$ 51.69**	**$ 51.69**	**$ 51.69**	**$ 51.69**	**$ 51.69**	**$ 51.69**	**$ 51.69**	**$ 51.69**	**$ 51.69**	**$ 51.69**	**$ 620.23**		

Total leased space: 1079 sq. ft.

Average Utility Costs $ 236.76 2016-17 Rate + 2.60% CPI
12 mo. Annual Janitorial Costs $ 2,841.17

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FIRST AMENDMENT TO LICENSE

This FIRST AMENDMENT TO LICENSE AGREEMENT (**"First Amendment"**) is made and entered into August 23, 2017, by and between CALOPTIMA (hereinafter referred to as **"LICENSEE"**) and COUNTY OF ORANGE, a political subdivision of the State of California (hereinafter referred to as **"COUNTY"**) without regard to number and gender. LICENSEE and COUNTY may individually be referred to herein as a "**Party**" or collectively as the "**Parties**."

RECITALS

I. COUNTY leases that certain real property located at 15496 Magnolia in the City of Westminster, State of California, License Area, pursuant to a lease dated July 1, 2016 for COUNTY's Social Services Agency's (**"SSA"**) Orange County Community Service Center Annex (**"OCCSCA"**).

II. The term of this License commenced on August 4, 2016, and will terminate on June 30, 2017.

III. The Parties have agreed to amend the License to extend the term for four (4) additional years.

NOW, THEREFORE, in consideration of the Recitals, above, incorporated by reference herein, and the mutual covenants and agreements hereinafter contained, COUNTY and LICENSEE mutually agree to amend the License effective July 1, 2017 (**"Effective Date"**) as follows:

A. Clause 2. [TERM (AMLC-3.1N)] is hereby deleted in its entirety from the License and replaced with the following:

"2. TERM (AMLC-3.1 N)

The term of this License commenced on August 4, 2016 and shall terminate on June 30, 2021 ("**Term**"). Said License shall continue in effect for the Term, unless otherwise terminated as provided in Clause 3 (TERMINATION) of this License.

B. Clause 4. [LICENCE AREA (AMLC-4.2N)] is hereby deleted in its entirety from the License and replaced with the following:

"4. LICENSE AREA (AMLC-4.2 N)

COUNTY grants to LICENSEE the exclusive right to use that certain property referred to as Room #2 and non-exclusive right to use that certain property referred to as Room #1. hereinafter referred to as **"License Area,"** described on Revised Exhibit A and shown on Exhibit B, attached hereto and by reference made a part hereof, for the purposes set forth in Clause 6 (USE) of this License together with non-exclusive, in common use of COUNTY's elevators, stairways, washrooms, hallways, driveways for vehicle ingress and egress, parking, pedestrian walkways, other facilities and common areas appurtenant to LICENSEE's License Area created by this License.

During the term of this License, the dates and times for use of Room #1of the License Area will be determined by the Facilities Services Manager to ensure LICENSEE has access to Room #1 for fifty percent (50%) of the time, and the location of Room #2 as shown on Exhibit B of the License Area is subject to relocation at the sole discretion of the Facilities Operations Manager.

C. Clause 6. [USE (AMLC-5.1 N)] is hereby deleted in its entirety from the License and replaced with the following:

"6. USE (AMLC-5.1 N)

LICENSEE's use of the License Area shall be limited to general office to provide clients with health related workshops and information regarding their CalOptima Programs, to store CalOptima materials, and to provide private space to meet with CalOptima Members or potential members.

LICENSEE agrees not to use the License Area for any other purpose nor to engage in or permit any other activity within or from the License Area without prior written permission from the Facilities Services Manager. LICENSEE further agrees not to conduct or permit to be conducted any public or private nuisance in, on, or from the License Area, not to commit or permit to be committed waste on the License Area, and to comply with all governmental laws and regulations in connection with its use of the License Area.

D. Clause 7. [LICENCE FEE (AMLC-6.1S)] is hereby deleted in its entirety from the License and replaced with the following:

"7. LICENSE FEE (AMLC-6.1 S)

LICENSEE agrees to pay COUNTY from and after the Effective Date of this License according to the following schedule:

Commencing	Monthly License Fee
July 1, 2017	$1,560.98
July 1, 2018	$1,607.81
July 1, 2019	$1,656.04
July 1, 2020	$1,705.72

The monthly License Fee shall be payable in advance, without prior notice or demand on the first day of each calendar month while this License is in effect without deduction or offset in lawful money of the United States.

In the event the obligation to pay the License Fee begins or terminates on some day other than the first day or last day of the month, the License Fee shall be prorated to reflect the actual period of use on the basis of a thirty (30) day month.

E. Clause 10. [UTILITIES, JANITORIAL, MAINTENANCE AND REPAIR (AMLC-9.3 N) is hereby deleted in its entirety from the License and replaced with the following:

"10. UTILITIES, JANITORIAL, MAINTENANCE AND REPAIR (AMLC-9.3 N)

COUNTY shall be responsible for all charges for all utilities (water, gas, electricity and sewer). County shall be responsible for all maintenance and repairs (including but not limited to: fire alarm, fire extinguisher, HVAC system, elevator maintenance, landscaping, pest control, and trash). LICENSEE shall be responsible for telephone service, internet service and janitorial service.

F. Clause 14. [INSURANCE (AML-10.1S)] is hereby deleted in its entirety from the License and replaced with the following:

"14. INSURANCE (AML-6.1 S)

LICENSEE agrees to purchase all required insurance at LICENSEE's expense and to deposit with the COUNTY certificates of insurance, including all endorsements required herein, necessary to satisfy the COUNTY that the insurance provisions of this License have been complied with and to keep such insurance coverage and the certificates and endorsements therefore on deposit with the COUNTY during the entire term of this License.

LICENSEE agrees that LICENSEE shall not operate on the License Area at any time the required insurance is not in full force and effect as evidenced by a certificate of insurance and necessary endorsements or, in the interim, an official binder being in the possession of Facilities Service Manager. In no cases shall assurances by LICENSEE, its employees, agents, including any insurance agent, be construed as adequate evidence of insurance. Facilities Service Manager will only accept valid certificates of insurance and endorsements, or in the interim, an insurance binder as adequate evidence of insurance. LICENSEE also agrees that upon cancellation, termination, or expiration of LICENSEE's insurance, COUNTY may take whatever steps are necessary to interrupt any operation from or on the License Area until such time as the Facilities Service Manager reinstates the License.

If LICENSEE fails to provide Facilities Service Manager with a valid certificate of insurance and endorsements, or binder at any time during the term of the License, COUNTY and LICENSEE agree that this shall constitute a material breach of the License. Whether or not a notice of default has or has not been sent to LICENSEE, said material breach shall permit COUNTY to take whatever steps necessary to interrupt any operation from or on the License Area, and to prevent any persons, including, but not limited to, members of the general public, and LICENSEE's employees and agents, from entering the License Area until such time as Facilities Service Manager is provided with adequate evidence of insurance required herein. LICENSEE further agrees to hold COUNTY harmless for any damages resulting from such interruption of business and possession, including, but not limited to, damages resulting from any loss of income or business resulting from the COUNTY's action.

LICENSEE may occupy the [Premises] only upon providing to County the required insurance stated herein and maintain such insurance for the entire term of this LICENSE. County reserves the right to terminate this LICENSE at any time LICENSEE's insurance is canceled or terminated and not reinstated within ten (10) days of said cancellation or termination. LICENSEE shall provide to County immediate notice of said insurance cancellation or termination.

All contractors performing work on behalf of LICENSEE pursuant to this License shall obtain insurance subject to the same terms and conditions as set forth herein for LICENSEE. LICENSEE shall not allow contractors or subcontractors to work if contractors have less than the level of coverage required by the COUNTY from the LICENSEE under this License. It is the obligation of the LICENSEE to provide written notice of the insurance requirements to every contractor and to receive proof of insurance prior to allowing any contractor to begin work within the License Area. Such proof of insurance must be maintained by LICENSEE through the entirety of this License and be available for inspection by a COUNTY representative at any reasonable time.

All self-insured retentions (SIRs) shall be clearly stated on the Certificate of Insurance. Any self-insured retention (SIR) in an amount in excess of Fifty Thousand Dollars ($50,000) shall specifically be approved by the County's Risk Manager, or designee, upon review of LICENSEE's current audited financial report. If LICENSEE's SIR is approved, LICENSEE, in addition to, and without limitation of, any other indemnity provision(s) in this License, agrees to all of the following:

1) In addition to the duty to indemnify and hold the County harmless against any and all liability, claim, demand or suit resulting from LICENSEE's, its agents, employee's or subcontractor's performance of this Agreement, LICENSEE shall defend the County at its sole cost and expense with counsel approved by Board of Supervisors against same; and
2) LICENSEE's duty to defend, as stated above, shall be absolute and irrespective of any duty to indemnify or hold harmless; and
3) The provisions of California Civil Code Section 2860 shall apply to any and all actions to which the duty to defend stated above applies, and the LICENSEE's SIR provision shall be interpreted as though the LICENSEE was an insurer and the County was the insured.

If the LICENSEE fails to maintain insurance acceptable to the COUNTY for the full term of this License, the COUNTY may terminate this License.

Qualified Insurer

The policy or policies of insurance must be issued by an insurer with a minimum rating of A- (Secure A.M. Best's Rating) and VIII (Financial Size Category as determined by the most current edition of the **Best's Key Rating Guide/Property-Casualty/United States or ambest.com).** It is preferred, but not mandatory, that the insurer be licensed to do business in the state of California (California Admitted Carrier).

If the insurance carrier does not have an A.M. Best Rating of A-/VIII, the CEO/Office of Risk Management retains the right to approve or reject a carrier after a review of the company's performance and financial ratings.

The policy or policies of insurance maintained by the LICENSEE shall provide the minimum limits and coverage as set forth below:

Coverages	Minimum Limits
Commercial General Liability	$1,000,000 per occurrence

Coverages	Minimum Limits
	$2,000,000 aggregate
Automobile Liability including coverage for owned, non-owned and hired vehicles	$1,000,000 limit per occurrence
Workers' Compensation	Statutory
Employers' Liability Insurance	$1,000,000 per occurrence
Commercial Property Insurance on an "All Risk" or "Special Causes of Loss" basis covering all, contents and any tenant improvements including Business Interruption/Loss of Rents with a 12 month limit.	100% of the Replacement Cost Value and no coinsurance provision

Required Coverage Forms

The Commercial General Liability coverage shall be written on Insurance Services Office (ISO) form CG 00 01, or a substitute form providing liability coverage at least as broad.

The Business Auto Liability coverage shall be written on ISO form CA 00 01, CA 00 05, CA 00 12, CA 00 20, or a substitute form providing liability coverage as broad.

Required Endorsements

The Commercial General Liability policy shall contain the following endorsements, which shall accompany the Certificate of insurance:

1) An Additional Insured endorsement using ISO form CG 20 26 04 13 or a form at least as broad naming the ***County of Orange, its elected and appointed officials, officers, employees, agents*** as Additional Insureds. Blanket coverage may also be provided which will state- ***As Required By Written Agreement***.
2) A primary non-contributing endorsement using ISO form CG 20 01 04 13, or a form at least as broad, evidencing that the LICENSEE's insurance is primary and any insurance or self-insurance maintained by the County of Orange shall be excess and non-contributing.

The Workers' Compensation policy shall contain a waiver of subrogation endorsement waiving all rights of subrogation against the ***County of Orange, its elected and appointed officials, officers, agents and employees***. Blanket coverage may also be provided which will state- ***As Required By Written Agreement.***

All insurance policies required by this license shall waive all rights of subrogation against the County of Orange, its elected and appointed officials, officers, agents and employees when acting within the scope of their appointment or employment.

The Commercial Property policy shall contain a Loss Payee endorsement naming the County of Orange as respects the County's financial interest when applicable.

LICENSEE shall notify County in writing within thirty (30) days of any policy cancellation and ten (10) days for non-payment of premium and provide a copy of the cancellation notice to County. Failure to provide written notice of cancellation may constitute a material breach of the LICENSE, upon which the County may suspend or terminate this LICENSE.

The Commercial General Liability policy shall contain a severability of interests clause, also known as a "separation of insureds" clause (standard in the ISO CG 001 policy).

Insurance certificates should be forwarded to the COUNTY address provided in the Clause (NOTICES) below or to an address provided by Facilities Service Manager. LICENSEE has ten (10) business days to provide adequate evidence of insurance or this License may be cancelled.

COUNTY expressly retains the right to require LICENSEE to increase or decrease insurance of any of the above insurance types throughout the term of this License. Any increase or decrease in insurance will be as deemed by County of Orange Risk Manager as appropriate to adequately protect COUNTY.

COUNTY shall notify LICENSEE in writing of changes in the insurance requirements. If LICENSEE does not deposit copies of acceptable certificates of insurance and endorsements with COUNTY incorporating such changes within thirty (30) days of receipt of such notice, this License may be in breach without further notice to LICENSEE, and COUNTY shall be entitled to all legal remedies.

The procuring of such required policy or policies of insurance shall not be construed to limit LICENSEE's liability hereunder nor to fulfill the indemnification provisions and requirements of this License, nor in any way to reduce the policy coverage and limits available from the insurer.

G. Clause 17. [HIPAA (N)] is hereby deleted from the License in its entirety.

H. Clause 18. [HAZARDOUS MATERIALS (AMLC-16.1S)] is hereby deleted from the License in its entirety.

I. Clause 19. [NOTICES (AMLC-14.1S)] is hereby deleted from the License in its entirety and replaced with the following:

"19. NOTICES (AMLC-14.1 S)

All notices pursuant to this License shall be addressed as set forth below or as either Party may hereafter designate by written notice and shall be sent through the United States mail in the State of California duly registered or certified with postage prepaid. If any notice is sent by registered or certified mail, as aforesaid, the same shall be deemed served or delivered twenty-four (24) hours after mailing thereof as above provided. Notwithstanding the above, COUNTY may also provide notices to LICENSEE by personal delivery, by regular mail, or by electric mail and any such notice so given shall be deemed to

have been given upon receipt.

TO: COUNTY	TO: LICENSEE
County of Orange Social Services Agency Facilities Services 500 N. State College Boulevard Orange, CA 92868 Attention: Facilities Services Manager	CalOptima 505 City Parkway West Orange, CA 92868 Attention: Chief Executive Officer mschrader@caloptima.org
With a copy to:	With a copy to:
County Executive Office 333 W. Santa Ana Boulevard, 3rd Floor Santa Ana, CA 92701 Attention: Chief Real Estate Officer	CalOptima 505 City Parkway West Orange, CA 92868 Attention: Legal Counsel gcrockett@caloptima.org

J. Clause 20. [ATTACHMENTS TO LICENSE (AMLC-15.1S)] is hereby deleted from the License in its entirety and replaced with the following:

"**20. ATTACHMENTS TO LICENSE (AMLC-15.1 S)**

This License includes the following, which are attached hereto and made a part hereof:

I. GENERAL CONDITIONS
II. EXHIBITS
Revised Exhibit A - License Description
Exhibit B – Floor Plan

K. Wherever a conflict in the terms or conditions of this First Amendment and the License exists, the terms or conditions of this First Amendment shall prevail. In all other respects, the terms and conditions of the License not specifically changed by this First Amendment shall remain in full force and effect.

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IN WITNESS WHEREOF, the Parties have executed this First Amendment the day and year first above written.

APPROVED AS TO FORM:

OFFICE OF COUNTY COUNSEL
ORANGE COUNTY, CALIFORNIA

By _____
Deputy

Date: 8/21/17

LICENSEE
CALOPTIMA

By _____
Name: Michael Schrader
Title: CEO

RECOMMENDED FOR APPROVAL

SOCIAL SERVICES AGENCY

By _____
Carol Wiseman, Chief Deputy Director

COUNTY

COUNTY OF ORANGE

By _____
Scott Mayer, Chief Real Estate Officer
County Executive Office
Per Resolution No. 14-014 of the Board of Supervisors and Minute Order dated January 28, 2014

Date: 8.23.17

COUNTY EXECUTIVE OFFICE

By _____
Administrative Manager
Real Estate Services

REVISED EXHIBIT A

LICENSE DESCRIPTION (10.1 S)

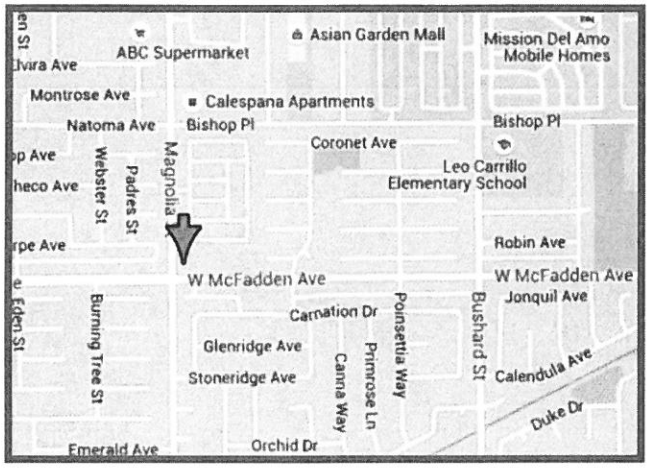
PROJECT NO: GA 1213-236 DATE: 6/13/17

PROJECT: CalOptima
15496 Magnolia, #111
Westminster, CA 92806

WRITTEN BY: EAS

All the License Area referenced on a Floor Plan marked Exhibit B, attached hereto and made a part hereof, being a total of Three Hundred Sixty Two (362) rentable square feet of COUNTY-designated space for LICENSEE's use, which consists of approximately One Hundred Nine (109) rentable square feet identified as Room #2 that shall be exclusive to LICENSEE, and the remaining Two Hundred Fifty Three (253) rentable square feet shall be non-exclusive, identified as Room #1. License Area may vary from time-to-time based on COUNTY's pre-approval in writing, and being a portion of the Orange County Community Service Center Annex building located at 15496 Magnolia, Suite 111, Rooms 1 and 2 in the City of Westminster, County of Orange, State of California, together with appurtenant right to use common areas located thereon, and the non-exclusive use of one parking space in the adjacent parking lot. The parties acknowledge that in the event Room #1 is expanded to include the common area immediately adjacent, such expanded area shall be included in the License Area.

NOT TO BE RECORDED



Location Map

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License Area:
Rooms 1 & 2

15496 Magnolia St. Suite 111 Westminster Ca. 92683

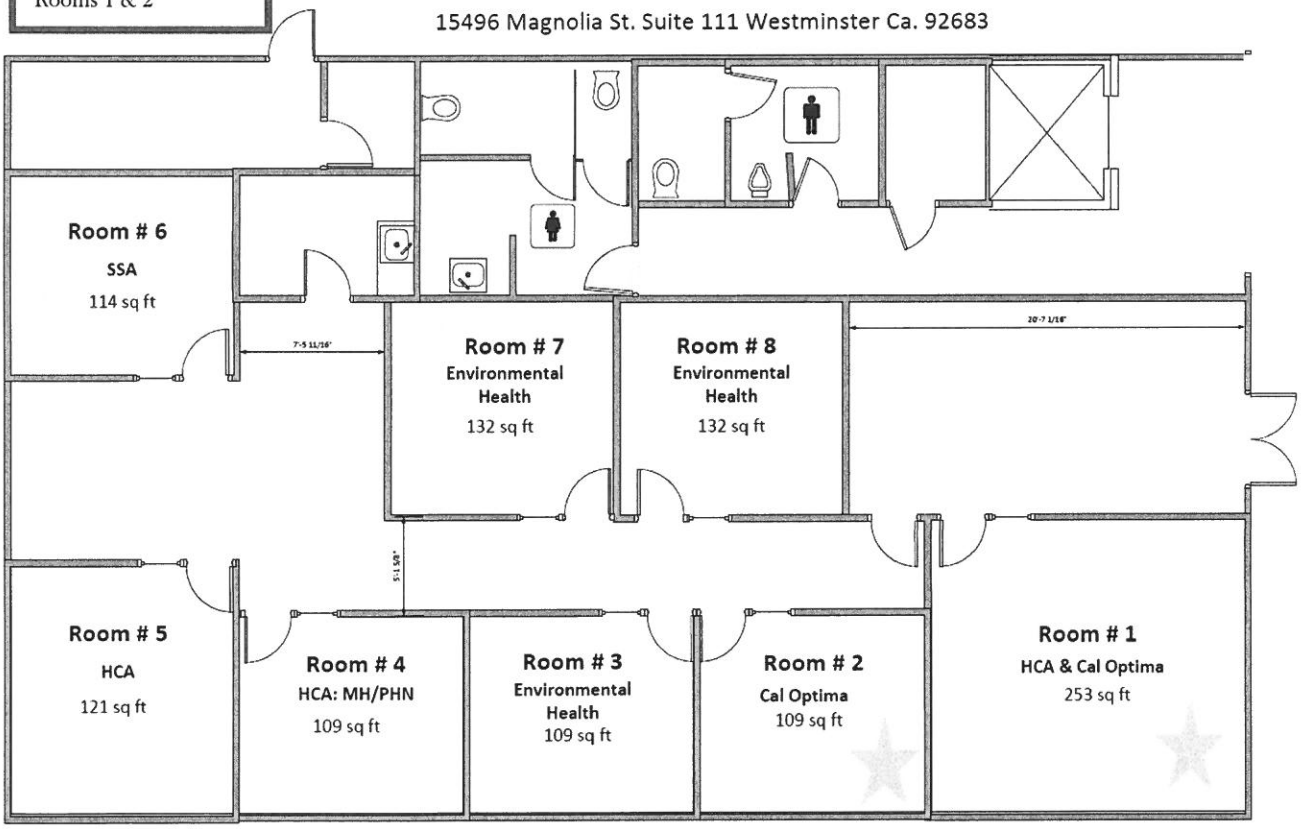

EXHIBIT B

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Attachment F

West Annex Community Customer Service Center
15496 Magnolia Street
Westminster, CA 92683

~~LEASE~~FIRST AMENDMENT TO LEASE

THIS FIRST AMENDMENT TO LEASE (**"First Amendment"**) is made _____, 2017 (**"Effective Date"**) by and between CHARLES H. MANH and ANH MANH, Co-Trustees of the MANH FAMILY TRUST, under declaration of trust dated August 15, 2006, (hereinafter referred to as **"LESSOR"**), and the COUNTY OF ORANGE, a political subdivision of the State of California (hereinafter referred to as **"COUNTY"**), without regard to number and gender. LESSOR and COUNTY may individually be referred to herein as a "**Party"** and collectively as the **"Parties."**

~~THIS IS A LEASE (hereinafter referred to as "**Lease**"), made July 1, 2016, ("**Effective Date**") by and between CHARLES H. MANH and ANH MANH, Co-Trustees of the MANH FAMILY TRUST, under declaration of trust dated August 15, 2006 ("**LESSOR**") and the COUNTY OF ORANGE, a political subdivision of the State of California ("**COUNTY**"), without regard to number and gender. The LESSOR and COUNTY may individually be referred to herein as a "**Party**," or collectively as the "**Parties**.~~

R E C I T A L S

I. Pursuant to a lease agreement dated July 1, 2016 (**"Lease"**), LESSOR leases to COUNTY approximately 2,120 rentable square feet of office space (**"Premises"**) in the building located at 15496 Magnolia Street, in the City of Westminster, California (**"Building"**) for use by the Social Services Agency, which Premises is more particularly described on Exhibit A and Exhibit B of the Lease.

II. The original Lease term of one (1) year commenced on July 1, 2016.

III. LESSOR and COUNTY are willing to amend the Lease to extend the term of the Lease for an additional four (4) years through June 30, 2021 under the terms and conditions set forth below.

1. DEFINITIONS (1.2 S)

"Board of Supervisors" means the Board of Supervisors of the County of Orange, a political subdivision of the State of California.

"County Executive Officer" means the County Executive Officer, County Executive Office, County of Orange, or designee, or upon written notice to LESSOR, such other person or entity as shall be designated by the Board of Supervisors.

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"CEO Real Estate"" means the County Executive Office's Real Estate team, or upon written notice to LESSOR, such other person or entity as shall be designated by the Chief Real Estate Officer, County of Orange, or designee.

"Chief Real Estate Officer" means the Chief Real Estate Officer for the County of Orange, or designee or upon written notice to LESSOR, such other person or entity as shall be designated by the County Executive Officer or r the Board of Supervisors.

"County Counsel" means the County Counsel, County of Orange, or designee, or upon written notice to LESSOR, such other person or entity as shall be designated by the Board of Supervisors.

"Risk Manager" means the Risk Manager, County Executive Office, Risk Management, County of Orange, or designee, or upon written notice to LESSOR, such other person or entity as shall be designated by the County Executive Officer or the Board of Supervisors.

2. PREMISES (1.3 S)

LESSOR leases to COUNTY that certain property consisting of 2,120 square feet, located at 15496 Magnolia Street, Suite 111, Westminster, CA and described in Exhibit A and shown on Exhibit B, which exhibits are attached hereto and by reference made a part hereof (hereinafter referred to as "**Premises**"),, together with non-exclusive, in common use of LESSOR's elevators, stairways, washrooms, hallways, parking areas, driveways for vehicle ingress and egress, pedestrian walkways, other facilities and common areas appurtenant to the Premises created by this Lease.

3. PARKING (1.4 S)

LESSOR, throughout the term of this Lease, shall provide a total of thirteen (13) parking spaces for COUNTY's free and non-exclusive use. Said parking spaces are to be located in the parking areas adjacent to the Premises. LESSOR shall designate three (3) parking spaces adjacent to the Premises to be reserved for use by COUNTY clients. Said parking spaces shall contain signs above the space indicating that the spaces are reserved for COUNTY use.

In addition to said parking spaces, LESSOR shall also provide parking for disabled persons in accordance with the Americans with Disabilities Act, Section 7102 of the California Uniform Building Code and the applicable codes and/or ordinances relating to parking for disabled persons as established by the local

jurisdiction in which the Premises is located where the provisions of such local codes and/or ordinances exceed or supersede the State requirements.

A. Clause 4. TERM (2.2 N) is hereby deleted in its entirety from the Lease and replaced with the following:

4. TERM (2.2 N)

The term of this Lease commenced on July 1, 2016 (**"Commencement Date"**), and will terminate on June 30, 2021 (**"Term"**)."~~The term of this Lease shall be one (1) year ("**Term**"), commencing upon the first of the next month following execution of this Lease by the COUNTY Chief Real Estate Officer or upon LESSOR's delivery and COUNTY's acceptance of the Premises, whichever is later ("**Commencement Date**").~~

~~Parties agree that the Commencement Date of this Lease will be confirmed in writing by either Party upon demand by the other.~~

B. Clause 5. RENT (3.1 N) is hereby deleted in its entirety from the Lease and replaced with the following:

5. RENT (3.1 N)

~~COUNTY agrees to pay LESSOR as rent for the Premises the sum of Five Thousand Dollars ($5,000.00) per month~~ ~~pursuant to the following rent payment schedule ("**Rent**").~~

~~MONTH~~	~~MONTHLY RENT~~	~~MONTH~~	~~MONTHLY RENT~~
~~1~~	~~$0.00~~	~~7~~	~~$5,000.00~~
~~2~~	~~$0.00~~	~~8~~	~~$5,000.00~~
~~3~~	~~$5,000.00~~	~~9~~	~~$5,000.00~~
~~4~~	~~$5,000.00~~	~~10~~	~~$5,000.00~~
~~5~~	~~$5,000.00~~	~~11~~	~~$5,000.00~~
~~6~~	~~$5,000.00~~	~~12~~	~~$5,000.00~~

The monthly rent payable by COUNTY for the Premises shall be automatically adjusted as follows:

Commencing	Monthly Rent	Per Square Foot
July 1, 2017	$6,524	$3.08
July 1, 2018	$6,720	$3.17
July 1, 2019	$6,921	$3.26
July 1, 2020	$7,129	$3.36

The "Monthly Rent," above, is the amount to be paid by the COUNTY. The "Per Square Foot" rate, above, is an estimate for statistical purposes only and for no other purpose.

To obtain rent payments LESSOR (or LESSOR's designee) shall submit to the COUNTY, in a form acceptable to said COUNTY, a written claim for payment of applicable Rent and COUNTY's share of the NNN Expenses, as defined in Section 6, below.
Payment shall be due and payable by direct deposit into a bank account specified by LESSOR within twenty (20) days after the later of the following:

A. The first day of the month following the month earned; or
B. Receipt of LESSOR's written claim by COUNTY.

Should COUNTY occupy the Premises before the Commencement Date, LESSOR shall be entitled to pro rata Rent for the period of occupancy occupied prior to the Commencement Date based upon the monthly Rent above. Said Rent shall be included in the rent claim submitted by LESSOR for the first full month of the Term and shall be paid by COUNTY at the time of payment for said month.

6. REIMBURSEMENT OF LESSOR'S OPERATING EXPENSES (6.0 N)

LESSOR and COUNTY agree pursuant to Section 5, above, that COUNTY shall pay the fixed amount of $657.20 ($.31/sf/mo.) per month for the term of the lease, as reimbursement for COUNTY's pro rata share of LESSOR's expenses related to the items described in Section 6A, 6B, 6C and 6D of this Lease for the property in which the Premises is located ("**NNN Expenses**"). LESSOR shall submit to COUNTY a separate monthly invoice .in addition to the monthly Rent invoice.

The pro rata share of LESSOR's NNN Expenses as defined above is determined according to the gross leasable area of the Premises as it relates to the total gross leasable area of the building that contains the Premises. The percent of COUNTY's occupancy which LESSOR and COUNTY agree is 12.47% (the "**pro rata share**"): the Premises is 2,120 gross square feet; and the total building area is 17,000 gross square feet.

COUNTY shall reimburse LESSOR for COUNTY's pro rata share of the NNN Expenses only for the items in Section 6A, 6B and 6C and 6D below:

A. Property Taxes and Property Tax Assessments pursuant to Section 13 of this Lease.
B. Maintenance and repair, and janitorial services for the common area restrooms in the building in which the Premises is located pursuant to Section 9 of this Lease.
C. Common area maintenance and repair of the building, parking lots, landscaping, lighting, and other common area maintenance and repair costs pursuant to Section 9 of this Lease.
D. Commercial Property Insurance and Commercial General Liability Insurance pursuant to Section 11 of this Lease.

7. ALTERATIONS (4.4 S)

COUNTY may make improvements and changes in the Premises, including but not limited to the installation of fixtures, partitions, counters, shelving, and equipment as deemed necessary or appropriate. It is agreed that any such fixtures, partitions, counters, shelving, or equipment attached to or placed upon the Premises by COUNTY shall be considered as personal property of COUNTY, who shall have the right to remove same. COUNTY agrees that the Premises shall be left in as good condition as when received, reasonable wear and tear excepted.

8. ORANGE COUNTY INFROMATION TECHNOLOGY SYSTEM S (OCIT) (4.5 N)

LESSOR agrees that COUNTY may install, at COUNTY's sole cost and expense, computer and telecommunication devices in, on, or around the Premises and LESSOR's building in accordance with COUNTY's plans and specifications provided that the provisions of the Clause entitled ALTERATIONS, of this Lease, shall be applicable to such work. It shall be COUNTY's responsibility to obtain all governmental permits and/or approvals required for such installation; however, LESSOR shall reasonably cooperate with COUNTY as necessary or appropriate, to obtain said permits and/or approvals.

9. Clause 9. REPAIR, MAINTENANCE, AND JANITORIAL SERVICES (5.1 S) is hereby deleted from the Lease and the following is substituted:

"9. REPAIR, MAINTENANCE, AND JANITORIAL SERVICES (5.1 N)

1. **Lessor Services.** LESSOR shall provide, at its sole cost and expense, except as otherwise provided in this Lease, any and all necessary repair, maintenance and replacement for the Premises and Building and systems therein in good order, condition and repair and in compliance with all applicable laws, including, but not limited to, the replacement, repair and maintenance of the structural portions of the Building, the roof of the Building, the parking facilities and all Building systems including the Heating, Ventilation, Air Conditioning (**"HVAC"**) system, the plumbing

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with the exception that COUNTY shall reimburse LESSOR for any expense incurred for repairing plumbing defects caused by the introduction of foreign matter into the plumbing fixtures, electrical and mechanical systems, fire/life safety system, elevators, roof, paving, fire extinguishers and pest control, and whether capital or non-capital (collectively, and together with the janitorial services described in Clause 9(D) below, the **"Services"**). Upon request, LESSOR shall provide COUNTY with a complete copy of the janitorial and any other contracts for Services of an ongoing nature. Any repairs or replacements performed by LESSOR must be at least equal in quality and workmanship to the original work and be in accordance with all applicable laws. Such repair, maintenance and replacement shall be made promptly to keep the Premises and the Building in the condition described in this Clause 9. Should LESSOR default in its obligations under this clause, the COUNTY may exercise those remedies set forth in Clause 9(B) of this Lease.

2. **County Remedies**. If LESSOR fails to provide the Services within fifteen (15) days after SSA/Facilities Services Manager provides written notice thereof to LESSOR specifying any such default and affording LESSOR such fifteen (15) day period to complete the cure of such default, provided, however, that if the cure cannot reasonably be completed within such time period, LESSOR shall be afforded an additional reasonable amount of time to complete the cure, as long as LESSOR commences the cure within such time period and diligently pursues same to completion, without limiting any available remedy to COUNTY, COUNTY may, upon written notice to LESSOR and LESSOR's lender, to the extent contact information for such lender has been provided in writing to COUNTY, and, at its sole discretion, perform or arrange for the performance of such Services, and deduct the cost thereof plus and administrative charge of ten percent (10%) of the cost from any Monthly Rent payable without further notice. Additionally, in the event that LESSOR fails to provide required Services to the Premises sixty (60) days after the 15-day written notice, above, to LESSOR, LESSOR shall be obligated to pay a penalty to COUNTY of Twenty Five Dollars ($25) per day until such Services are provided by LESSOR.

3. **Warranties**. LESSOR shall initiate at purchase, and keep in force, all manufacturers' warranties including extended warranties for all building equipment. When manufacturer's warranties for the HVAC, roof and elevator expire, LESSOR will contract with an industry standard maintenance company (**"Vendor"**) that specializes in the maintenance of such equipment (and for the roof) for regular and scheduled inspections as recommended by the manufacturer, and immediately authorize said Vendor to perform any and all recommended maintenance to the equipment upon receipt of any inspection report. LESSOR shall authorize Vendors to provide COUNTY with copies of said reports upon COUNTY request. Should LESSOR fail to comply with the provisions of this clause, COUNTY may exercise those remedies set forth in Clause 9(B).

4. **Janitorial Services**. Janitorial supplies and services shall be provided to the Premises consistent with the past practices of LESSOR at the Premises during COUNTY's tenancy on a five (5) day- per-week basis in accordance with Exhibit D (JANITORIAL SPECIFICATIONS). In addition, upon request of COUNTY, LESSOR agrees to provide a copy of the contract with janitorial services as described in Exhibit D, to COUNTY. LESSOR understands that these services are a material consideration of this Lease to COUNTY. Should LESSOR fail to comply with the provisions of this Clause, COUNTY may exercise those remedies set forth in Clause 9(B).

5. **Code Compliance**. LESSOR shall be 100% responsible throughout the Term for any cost in the Premises, including all parking facilities, walkways, entrances, hallways and other public spaces, restrooms, and other devices or pathways for ingress and egress to the Premises regardless of cause with all the requirements of the Americans with Disabilities Act ("**ADA**") and all regulations issued by the U. S. Attorney General or other agencies under the authorization of the ADA, California Building Code, Title 24, Seismic Code, Fire and Life Safety requirements and, if applicable, California Green Building Standard Code. However, LESSOR shall not be responsible for any ADA violations resulting from alterations made by COUNTY or the placement of COUNTY's furniture, fixtures or equipment by COUNTY. LESSOR agrees to reimburse and indemnify, and defend COUNTY for any expenses incurred because of the failure of the Premises to conform with the above cited law and regulations, including the costs of making any alterations, renovations, or accommodations required by the ADA, or any governmental enforcement agency, or any court, any and all fines, civil penalties, and damages awarded against COUNTY resulting from a violation or violations of the above-cited law and regulations, and all reasonable legal expenses incurred in defending claims made under the above-cited law and regulations, including reasonable attorneys' fees. Should LESSOR fail to comply with the provisions of this Clause, the COUNTY may exercise those remedies set forth in Clause 9(B).

6. **HVAC System**. Air conditioning will be supplied to cause the temperature in Premises at a temperature consistent with other office buildings in Orange County, California, which are typically not less than **73**° F nor greater than °**75** F, during all COUNTY Working Hours.

Said temperature requirements shall be maintained during COUNTY's normal business operating hours (**"COUNTY Working Hours"**) which are:

Hours of Operation	Days of Operation
8:00 a.m. to 6:00 p.m.	Monday through Friday

Except for COUNTY Holidays, which holidays shall be provided to LESSOR on a yearly basis upon request to COUNTY. Some additional overtime hours may be used from time-to-time on any day, including Sundays, but said overtime hours shall be restricted to a timer or other limiting measures agreed to by LESSOR and COUNTY.

Notwithstanding the utilities provided during COUNTY Working Hours, LESSOR shall provide HVAC services prior to the beginning of COUNTY Working Hours in order for the temperature parameters required by this Lease, above, to be met and maintained at the beginning and throughout COUNTY Working Hours. There shall be no extra utility charges for HVAC services prior to the beginning of COUNTY Working Hours.

In order for the COUNTY to comply with the California Code of Regulations, Title 8, Section 5142 (**"Regulation 5142"**), and as it may be subsequently amended, LESSOR shall regularly inspect and maintain the HVAC system as required by Regulation 5142 and provide repair and maintenance accordingly. Inspections and maintenance of the HVAC system shall be documented in writing and LESSOR shall retain such records for at least five (5) years. LESSOR shall make all HVAC records required by this section available to COUNTY for examination and copying, within forty-eight (48) hours of a written request. LESSOR acknowledges that COUNTY may be subject to fines and/or penalties for failure to provide said records to regulatory agencies within the given timeframes. Should COUNTY incur fines and/or penalties as a direct result of LESSOR's failure to provide said records to COUNTY in a timely manner and as set forth herein, LESSOR shall reimburse COUNTY for said fines and/or penalties within thirty (30) days upon written notice. Should LESSOR fail to reimburse COUNTY within thirty (30) days, COUNTY may deduct the amount of the fine and/or penalty from any Monthly Rent payable without further notice.

7. **Emergency Services.** If LESSOR or its representative cannot be contacted by COUNTY for emergency repairs, as determined by the COUNTY, and/or Services the same day any emergency repairs and/or Services are necessary to remedy the emergency condition or to prevent imminent danger to persons or property, or if LESSOR following such contact by COUNTY is unable or refuses to make the necessary emergency repairs or provide the necessary Services, COUNTY may at its option have the necessary repairs made and/or provide Services to remedy the emergency condition, and deduct the cost thereof, including labor, materials, and overhead from any Monthly Rent payable without further notice.

8. **County Misconduct**. In the event any damage to the Premises or any systems therein is caused as a result of the negligence or willful misconduct of COUNTY employees or contractors, repairs are to be made by LESSOR, but the cost of such repairs shall be reimbursed by COUNTY, together with an administrative fee of five percent (5%) of such cost, within sixty (60) days from receipt of an invoice by LESSOR detailing materials and labor and paid in accordance with Clause 5 (RENT).

A. **Operations Shutdown.**

B. Should COUNTY be forced to completely shut down its operations within the Premises due to LESSOR's failure to provide Services required by this Clause 9 for a period of three (3) consecutive days, excluding weekends and holidays, and subject to the provisions of Section 4 of the General Conditions to this Lease, LESSOR shall be obligated to pay a penalty to COUNTY of Two Hundred Dollars ($200) per day. Should LESSOR's obligation to pay a penalty arise as a result of a shut down due to LESSOR's failure to provide said Services as set forth herein, LESSOR shall pay COUNTY within thirty (30) days of written notice. Should LESSOR fail to pay COUNTY within thirty (30) days, COUNTY may deduct the amount of the penalty from any Monthly Rent payable without further notice."

~~**9. REPAIR, MAINTENANCE, AND JANITORIAL SERVICES** (5.1 N)~~

~~LESSOR shall keep, maintain, and repair the building and other improvements upon the Premises in good and sanitary order and condition (except as otherwise provided in this Lease) including without limitation, the maintenance and repair of the roof, parking lot, sidewalks, common area restrooms including janitorial supplies and services, landscaping, store front, doors, window casements, glazing, plumbing, pipes, electrical wiring, and conduits, and the heating and air conditioning system including the maintenance of a service contract with a heating and air conditioning contractor, as necessary to maintain the property in which the Premises is located in good and sanitary order, condition, and repair. COUNTY shall reimburse LESSOR for the County's pro rata share of said expenses in accordance with Section 6 of the Lease. Notwithstanding the language in the paragraph above, COUNTY shall provide at its own cost and expense all repair and maintenance and services to the interior of the Premises.~~

~~A. Heating, Ventilation and Air Conditioning System (HVAC)~~

~~During all operating hours the HVAC system serving the Premises, to be repaired and maintained by the LESSOR, shall be capable of maintaining the Premises at 78º Dry Bulb at a maximum range of 40% to 60% Relative humidity during the summer when the outdoor temperature is 95º Dry Bulb, and at 68º Dry Bulb in the winter when the outside temperature is 35º Dry Bulb.~~

~~In order for the COUNTY to comply with the California Code of Regulations, Title 8, Section 5142, and as it may be subsequently amended, LESSOR shall inspect the HVAC system at least once~~

annually or on a schedule agreed to in writing by LESSOR and COUNTY, and provide repair and maintenance accordingly. LESSOR's inspections and maintenance of the HVAC system shall be documented in writing. The LESSOR shall at a minimum, maintain a record of: (a) the name of the individual(s) inspecting and/or maintaining the system, (b) the date of the inspection and/or maintenance, and (c) the specific findings and actions taken. The LESSOR shall ensure that such records are retained for at least five (5) years. The LESSOR shall make all HVAC records required by this section available to COUNTY for examination and copying, within forty-eight (48) hours of a written request from COUNTY. LESSOR acknowledges that COUNTY may be subject to fines and/or penalties for failure to provide said records to regulatory agencies within the given timeframes. Should COUNTY incur fines and/or penalties as a direct result of LESSOR's failure to provide said records to COUNTY, LESSOR shall reimburse COUNTY for said fines and/or penalties within thirty (30) days upon written notice. Should LESSOR fail to reimburse COUNTY within thirty (30) days, COUNTY may deduct the amount of the fine and/or penalty from any rent payable.

B. Janitorial Supplies and Services

LESSOR shall provide janitorial supplies and services on a five day per week basis (Monday through Friday) to the common areas and common area restrooms in accordance with Exhibit D (JANITORIAL SPECIFICATIONS) attached hereto and by reference made a part hereof.

If LESSOR fails to provide satisfactory janitorial supplies to Premises, the Chief Real Estate Officer, or designee may notify LESSOR either verbally or in writing; and if LESSOR does not provide janitorial supplies within twenty-four (24) hours after LESSOR has received such written notice from COUNTY, COUNTY may provide the janitorial supplies necessary or have others do so, and deduct the cost thereof, including labor, materials and COUNTY's administrative costs from any rent payable.

If LESSOR or its representative cannot be contacted by COUNTY for emergency repairs and/or services the same day any emergency repairs and/or services are necessary to remedy the emergency condition, or if LESSOR following such contact by COUNTY is unable or refuses to make the necessary repairs within a reasonable time or provide the necessary services, as determined by the Chief Real Estate Officer, COUNTY may at its option have the necessary repairs made and/or provide services to remedy the emergency condition, and deduct the cost thereof, including labor, materials and COUNTY's administrative costs from any rent payable.

10. ELECTRIC UTILITIES (5.2 N)

COUNTY shall be responsible for and pay, prior to the delinquency date, all charges for electric utilities supplied to the interior of the Premises directly to the utility company.

LESSOR shall be responsible for and pay, prior to the delinquency date, all charges for electric utilities supplied to the exterior of the Premises and to the common areas of the property in which the Premises is located.

INSURANCE (5.3 S)

Commercial Property Insurance: LESSOR shall obtain and keep in force during the term of this Lease a policy or policies of commercial property insurance with all risk or special form coverage, covering the loss or damage to the Premises to the full insurable value of the improvements located on the Premises (including the full value of all improvements and fixtures owned by LESSOR) at least in the amount of the full replacement cost thereof, and in no event less than the total amount required by any lender holding a security interest.

LESSOR agrees to and shall include in the policy or policies of commercial property insurance a standard waiver of the right of subrogation against COUNTY by the insurance company issuing said policy or policies. LESSOR shall provide COUNTY with a Certificate of Insurance as evidence of compliance with these requirements.

Commercial General Liability Insurance: LESSOR shall obtain and keep in force during the term of this Lease a policy or policies of commercial general liability insurance covering all injuries occurring within the building and the Premises. The policy or policies evidencing such insurance shall provide the following:

a. Name COUNTY as an additional insured;
b. Shall be primary, and any insurance or self-insurance maintained by COUNTY shall be excess and non-contributing;
c. LESSOR shall notify County in writing within thirty (30) days of any policy cancellation and ten (10) days for non-payment of premium and provide a copy of the cancellation notice to County. Failure to provide written notice of cancellation may constitute a material breach of the Lease, upon which the County may suspend or terminate this Lease.
d. Shall provide a limit of One Million Dollars ($1,000,000) per occurrence; and
e. The policy or policies of insurance must be issued by an insurer with a minimum rating of A- (Secure A.M. Best's Rating) and VIII (Financial Size Category as determined by the most current edition of the **Best's Key Rating Guide/Property-Casualty/United States or ambest.com).** It

is preferred, but not mandatory, that the insurer be licensed to do business in the state of California (California Admitted Carrier).

If the insurance carrier does not have an A.M. Best Rating of A-/VIII, the CEO/Office of Risk Management retains the right to approve or reject a carrier after a review of the company's performance and financial ratings. Prior to the Commencement Date of this Lease and upon renewal of such policies, LESSOR shall submit to COUNTY a Certificate of Insurance and required endorsements as evidence that the foregoing policy or policies are in effect.

If LESSOR fails to procure and maintain the insurance required to be procured by LESSOR under this Lease, COUNTY may, but shall not be required to, order such insurance and deduct the cost thereof plus any COUNTY administrative charges from the rent thereafter payable.

11. INDEMNIFICATION (5.5 A S)

C. Clause 11. INDEMNIFICATION (5.5 A S) is hereby deleted in its entirety from the Lease and replaced with the following:

"**Clause 11. INDEMNIFICATION (5.5 A S)**

COUNTY shall defend, indemnify and save harmless LESSOR and the LESSOR Parties, from and against any and all claims, demands, losses, or liabilities of any kind or nature which LESSOR or the LESSOR Parties may sustain or incur or which may be imposed upon them for injury to or death of persons, or damage to property as a result of, or arising out of, the negligence or intentional misconduct of COUNTY or the COUNTY Parties, in connection with the occupancy and use of the Premises by COUNTY or the COUNTY Parties.

Likewise LESSOR shall defend, indemnify and save harmless COUNTY and COUNTY Parties from and against any and all claims, demands, losses, or liabilities of any kind or nature which COUNTY or the COUNTY Parties may sustain or incur or which may be imposed upon them for injury to or death of persons, or damage to property as a result of, or arising out of, the negligence or intentional misconduct of LESSOR or the LESSOR Parties, in connection with the maintenance or use of the Premises by LESSOR or the LESSOR Parties."~~LESSOR shall defend, indemnify and save harmless COUNTY and COUNTY Parties from and against any and all claims, demands, losses, or liabilities of any kind or nature which COUNTY or the COUNTY Parties may sustain or incur or which may be imposed upon them for injury to or death of persons, or damage to property as a result of, or arising out of, the negligence or intentional misconduct of LESSOR or the LESSOR Parties, in connection with the maintenance or use of the Premises by LESSOR or the LESSOR Parties.~~

12. TAXES AND ASSESSMENTS (5.6 N)

All taxes and assessments which become due and payable upon the Premises shall be the full responsibility of LESSOR, and LESSOR shall cause said taxes and assessments to be paid prior to the due date. COUNTY shall reimburse LESSOR for its proportionate share of Taxes and Assessments pursuant to Section 5 of this Lease.

13. BUILDING AND SAFETY REQUIREMENTS (5.7 S)

During the full term of this Lease, LESSOR, at LESSOR's sole cost, agrees to maintain the Premises in compliance with all applicable laws, rules, regulations, building codes, statutes, and orders as they are applicable on the date of this Lease, and as they may be subsequently amended.

Included in this provision is compliance with the Americans with Disabilities Act ("**ADA**") and all other federal, state, and local codes, statutes, and orders relating to disabled access as they are applicable on the dates of this Lease, and as they may be subsequently amended.

LESSOR further agrees to maintain the Premises as a "safe place of employment," as defined in the California Occupational Safety and Health Act (California Labor Code, Division 5, Part 1, Chapter 3, beginning with Section 6400) and the Federal Occupational Safety and Health Act, where the provisions of such Act exceed, or supersede, the California Act, as the provisions of such Act are applicable on the date of this Lease, and as they may be subsequently amended.

In the event LESSOR neglects, fails, or refuses to maintain said Premises as aforesaid, COUNTY may, notwithstanding any other termination provisions contained herein:

A. Terminate this Lease; or

B. At COUNTY's sole option, cure any such default by performance of any act, including payment of money, and subtract the cost thereof plus reasonable administrative costs from the rent.

14. TOXIC MATERIALS (5.9 S)

COUNTY hereby warrants and represents that COUNTY will comply with all laws and regulations relating to the storage, use and disposal of hydrocarbon substances and hazardous, toxic or radioactive

matter, including, but not limited to, those materials identified in Title 26 of the California Code of Regulations (collectively "**Toxic Materials**"). COUNTY shall be responsible for and shall defend, indemnify and hold LESSOR, its officers, directors, employees, agents, and representatives, harmless from and against all claims, costs and liabilities, including attorneys' fees and costs arising out of or in connection with the storage, use, and disposal of Toxic Materials on the Premises by COUNTY. If the storage, use, and disposal of Toxic Materials on the Premises by COUNTY results in contamination or deterioration of water or soil resulting in a level of contamination greater than maximum allowable levels established by any governmental agency having jurisdiction over such contamination, COUNTY shall promptly take any and all action necessary to clean up such contamination.

Likewise, LESSOR hereby warrants and represents that LESSOR has in the past and will hereafter comply with all laws and regulations relating to the storage, use and disposal of hydrocarbon substances and hazardous, toxic or radioactive matter, including, but not limited to, those materials identified in Title 26 of the California Code of Regulations (collectively "Toxic Materials"). LESSOR shall be responsible for and shall defend, indemnify and hold COUNTY, its officers, directors, employees, agents, and representatives, harmless from and against all claims, costs and liabilities, including attorneys' fees and costs arising out of or in connection with the previous, current and future storage, use and disposal of Toxic Materials on the Premises (or building if the Premises comprises only a portion of said building) by LESSOR. If the previous, current and future storage, use, and disposal of Toxic Materials on the Premises by LESSOR results in contamination or deterioration of water or soil resulting in a level of contamination greater than maximum allowable levels established by any governmental agency having jurisdiction over such contamination, LESSOR shall promptly take any and all action necessary to clean up such contamination.

15. SUBORDINATION, ATTORNMENT AND NON-DISTURBANCE (6.4 S)

This Lease and all rights of the COUNTY hereunder are subject and subordinate to any mortgage or deed of trust which does now or may hereafter cover the Premises or any interest of LESSOR therein, and to any and all advances made on the security thereof, and to any and all increases, renewals, modifications, consolidations, replacements and extensions of any such mortgage or deed of trust; except, insofar as COUNTY is meeting its obligations under this Lease, any foreclosure of any mortgage or deed of trust shall not result in the termination of this Lease or the displacement of COUNTY.

In the event of transfer of title to the Premises, including any proceedings brought for foreclosure or in the event of the exercise of the power of sale under any mortgage or deed of trust or by any other transfer of title covering the Premises, COUNTY shall attorn to and recognize any subsequent title holder as the

LESSOR under all terms, covenants and conditions of this Lease. COUNTY's possession of the Premises shall not be disturbed by the LESSOR or its successors in interest, and this Lease shall remain in full force and effect. Said attornment shall be effective and self-operative immediately upon succession of the current title holder, or its successors in interest, to the interest of LESSOR under this Lease.

Notwithstanding the above, this Lease is contingent upon LESSOR's obtaining a Subordination, Attornment and Non-Disturbance Agreement from LESSOR's lender, within thirty (30) days of LESSOR's execution of this Lease. LESSOR shall require all future lenders on the Premises upon initiation of their interest in the Premises, to enter into a Subordination, Attornment and Non-Disturbance Agreement with COUNTY thereby insuring COUNTY of its leasehold interests in the Premises. Said Subordination, Attornment and Non-Disturbance Agreement shall be in the form of COUNTY's standard form Subordination, Attornment and Non-Disturbance Agreement shown on Exhibit E, attached hereto and by reference made a part hereof, or in a form approved by the Chief Real Estate Officer, and County Counsel.

Foreclosure shall not extinguish this Lease, and any lender or any third party purchasing the Premises at foreclosure sale shall do so subject to this Lease and shall thereafter perform all obligations and be responsible for all liabilities of the LESSOR under the terms of this Lease.

Upon default by LESSOR of any note or deed of trust, COUNTY may, at its option, make all lease payments directly to the lender, and same shall be applied to the payment of any and all delinquent or future installments due under such note or deed of trust.

16. ESTOPPEL CERTIFICATE (6.5 S)

COUNTY agrees that the County Executive Officer shall furnish from time to time upon receipt of a written request from LESSOR or the holder of any deed of trust or mortgage covering the Premises or any interest of LESSOR therein, COUNTY's standard form Estoppel Certificate containing information as to the current status of the Lease. The Estoppel Certificate shall be approved by the Chief Real Estate Officer, and County Counsel.

17. DEFAULTS AND REMEDIES (6.8 S)

The occurrence of any of the following shall constitute an event of default:

- Failure to pay any installment of any monetary amount due and payable hereunder;

- Failure to perform any obligation, agreement or covenant under this Lease.

In the event of any non-monetary breach of this Lease by COUNTY, LESSOR shall notify COUNTY in writing of such breach, and COUNTY shall have fifteen (15) days in which to initiate action to cure said breach.

In the event of any non-monetary breach of this Lease by LESSOR, COUNTY shall notify LESSOR in writing of such breach and LESSOR shall have fifteen (15) days in which to initiate action to cure said breach.

In the event of any monetary breach of this Lease by COUNTY, LESSOR shall notify COUNTY in writing of such breach, and COUNTY shall have fifteen (15) days in which to cure said breach, unless specified otherwise within this Lease.

In the event of any monetary breach of this Lease by LESSOR, COUNTY shall notify LESSOR in writing of such breach, and LESSOR shall have fifteen (15) days in which to cure said breach, unless specified otherwise within this Lease.

18. DEBT LIMIT (6.9 S)

LESSOR acknowledges and agrees that the obligation of the COUNTY to pay rent under this Lease is contingent upon the availability of COUNTY funds which are appropriated or allocated by the COUNTY's Board of Supervisors for the payment of rent hereunder. In this regard, in the event that this Lease is terminated due to an uncured default of the COUNTY hereunder, LESSOR may declare all rent payments to the end of COUNTY's current fiscal year to be due, including any delinquent rent from prior budget years. In no event shall LESSOR be entitled to a remedy of acceleration of the total rent payments due over the term of the Lease. The Parties acknowledge and agree that the limitations set forth above are required by Article 16, section 18, of the California Constitution. LESSOR acknowledges and agrees that said Article 16, section 18, of the California Constitution supersedes any law, rule, regulation or statute, which conflicts with the provisions of this paragraph. Notwithstanding the foregoing, LESSOR may have other rights or civil remedies to seek relief due to the COUNTY's default under the Lease. Such rights or remedies may include a right to continue the COUNTY's right of possession under the Lease and sue for the rent as it becomes past due.

19. LABOR CODE COMPLIANCE (6.10 S)

LESSOR acknowledges and agrees that all improvements or modifications required to be performed as a condition precedent to the commencement of the term of this Lease or any such future improvements or modifications performed by LESSOR at the request of COUNTY shall be governed by, and performed in accordance with, the provisions of Article 2 of Chapter 1, Part 7, Division 2 of the Labor Code of the State of California (Sections 1770, et seq.). These provisions are applicable to improvements or modifications costing more than $1,000.

Pursuant to the provisions of Section 1773 of the Labor Code of the State of California, the Orange County Board of Supervisors has obtained the general prevailing rate of per diem wages and the general prevailing rate for holiday and overtime work in the locality applicable to this Lease for each craft, classification, or type of workman needed to execute the aforesaid improvements or modifications from the Director of the State Department of Industrial Relations. Copies of said prevailing wage rates may be obtained from the State of California, Department of Industrial Relations, or the County Executive Officer.

LESSOR hereby agrees to pay or cause its contractors and/or subcontractors to pay said prevailing wage rates at all times for all improvements or modifications to be completed for COUNTY within the premises, and LESSOR herein agrees that LESSOR shall post, or cause to be posted, a copy of the most current, applicable prevailing wage rates at the site where the improvements or modifications are performed.

Prior to commencement of any improvements or modifications, LESSOR shall provide the County Executive Officer with the applicable certified payroll records for all workers that will be assigned to the improvements or modifications. Said payroll records shall contain, but not be limited to, the complete name, address, telephone number, social security number, job classification, and prevailing wage rate for each worker. LESSOR shall provide, the County Executive Officer bi-weekly updated, certified payroll records for all workers that include, but not be limited to, the weekly hours worked, prevailing hourly wage rates, and total wages paid.

If LESSOR neglects, fails, or refuses to provide said payroll records to the County Executive Officer, such occurrence shall constitute an event of default of this lease and COUNTY may, notwithstanding any other termination provisions contained herein:

A. Terminate this Lease; or

B. At COUNTY’s sole option, COUNTY may deduct future rent payable to LESSOR by COUNTY as a penalty for such non-compliance of paying prevailing wage, which rent deduction would be COUNTY's estimate, in its sole discretion, or such prevailing wage rates not paid by LESSOR.

Except as expressly set forth in this Lease, nothing herein is intended to grant authority for LESSOR to perform improvements or modifications on space currently leased by COUNTY or for which COUNTY has entered into a lease or lease amendment.

Clause 20. CHILD SUPPORT ENFORCEMENT REQUIREMENTS (6.12 S) is hereby deleted from the Lease.

~~**20. CHILD SUPPORT ENFORCEMENT REQUIREMENTS (6.12 S)**~~

~~In order to comply with child support enforcement requirements of the County of Orange, within thirty (30) days after COUNTY's execution of this Lease agreement, LESSOR agrees to furnish the County Executive Officer, COUNTY's standard form, *Child Support Enforcement Certification Requirements*, which includes the following information:~~

~~A. In the case where LESSOR is doing business as an individual, LESSOR's name, date of birth, Social Security number, and residence address;~~

~~B. In the case where LESSOR is doing business in a form other than as an individual, the name, date of birth, Social Security number, and residence address of each individual who owns an interest of ten (10) percent or more in the contracting entity;~~

~~C. A certification that the LESSOR has fully complied with all applicable federal and state reporting requirements regarding its employees; and~~

~~D. A certification that the LESSOR has fully complied with all lawfully served Wage and Earnings Assignment Orders and Notices of Assignment, and will continue to so comply.~~

~~Failure of LESSOR to timely submit the data and/or certifications required above or to comply with all federal and state reporting requirements for child support enforcement, or to comply with all lawfully served Wage and Earnings Assignment Orders and Notices of Assignment, shall constitute a material breach of this Lease. Failure to cure such breach within sixty (60) calendar days of notice from the County Executive Officer shall constitute grounds for termination of this Lease.~~

~~Notwithstanding any other provisions of this Lease, LESSOR shall be given an opportunity to cure as follows:~~

~~A. A notice of any claimed failure to comply shall be given to LESSOR, in writing, by personal delivery, or facsimile transmission, from the County Executive Officer. The written notice shall state the specific data or certification required, the specific federal or state reporting requirements for child support enforcement that has not been complied with or the specific Wage and Earnings Assignment Order and Notice of Assignment that has not been complied with; and~~

~~B. LESSOR shall have sixty (60) days from the actual receipt of the written notice to cure the failure to comply specified in the notice, provided that LESSOR's performance to cure within sixty (60) days is not hindered, impaired or prevented by federal, state or local agencies. If the claimed failure as set forth in the written notice is failure to perform an act by a certain time, the failure of performance of said certain act by said certain time shall be deemed cured for purposes of this Lease if it is timely performed in accordance with the provisions of this paragraph.~~

~~It is expressly understood that this data will be transmitted to governmental agencies charged with the establishment and enforcement of child support orders and will not be used for any other purpose.~~

~~21.~~20. RIGHT TO WORK AND MINIMUM WAGE LAWS (6.13 S)

In accordance with the United States Immigration Reform and Control Act of 1986, LESSOR shall require its employees that directly or indirectly service the Premises or terms and conditions of this Lease, in any manner whatsoever, to verify their identity and eligibility for employment in the United States. LESSOR shall also require and verify that its contractors or any other persons servicing the Premises or terms and conditions of this Lease, in any manner whatsoever, verify the identity of their employees and their eligibility for employment in the United States.

Pursuant to the United States of America Fair Labor Standard Act of 1938, as amended, and State of California Labor Code, Section 1178.5, LESSOR shall pay no less than the greater of the Federal or California minimum wage to all its employees that directly or indirectly service the Premises, in any manner whatsoever. LESSOR shall require and verify that all its contractors or other persons servicing the Premises on behalf of the LESSOR also pay their employees no less than the greater of the Federal or California minimum wage.

LESSOR shall comply and verify that its contractors comply with all other Federal and State of California laws for minimum wage, overtime pay, record keeping, and child labor standards pursuant to the servicing of the Premises or terms and conditions of this Lease.

Notwithstanding the minimum wage requirements provided for in this clause, LESSOR, where applicable, shall comply with the prevailing wage and related requirements, as provided for in the Clause entitled LABOR CODE COMPLIANCE of this Lease.

~~22.~~21. **AUTHORITY (N)**

The Parties to this Lease represent and warrant that this Lease has been duly authorized and executed and constitutes the legally binding obligation of their respective organization or entity, enforceable in accordance with its terms.

Clause 23. NOTICES (8.1 S) is hereby deleted in its entirety from the Lease and replaced with the following:

~~23.~~22. **NOTICES (8.1 S)**

All notices given pursuant to this Lease shall be in writing (unless otherwise specified herein), addressed as set forth below or as either Party may hereafter designate by notice and shall be deemed delivered (a) upon personal delivery (which shall include delivery by a courier or overnight delivery service), or (b) delivery by e-mail transmission (provided that a copy of such notice is concurrently sent by one of the other methods of service) but only if sent during COUNTY Working Hours, or otherwise on the next business day, or (c) seventy-two (72) hours after deposit in the United States Mail.

TO: LESSOR

Charles Manh and Anh Manh
Manh Family Trust
8990 Westminster Blvd., Second Floor
Westminster, CA 92683
E-mail: CharlieManh@ Hotmail.com

TO: COUNTY

County of Orange
Social Services Agency
500 N. State College Boulevard, 6th Floor
Orange, CA 92868
Attn: Director, Administrative Services
Phone: (714) 541- 7712
E-mail: An.Tran@ssa.ocgov.com

With a copy to:

County Executive Office
333 W. Santa Ana Boulevard, 3rd Floor

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Santa Ana, CA 92701
Attention: Chief Real Estate Officer
Phone: (714) 834-3046
E-mail: Scott.Mayer@ocgov.com"

~~All written notices pursuant to this Lease shall be addressed as set forth below or as either party may hereafter designate by written notice and shall be deemed delivered upon personal delivery, delivery by facsimile machine, or seventy-two (72) hours after deposit in the United States Mail.~~

~~TO:~~ ~~LESSOR~~
~~Charles H. Manh and Anh Manh~~
~~Manh Family Trust~~
~~8990 Westminster Blvd., Second Floor~~
~~Westminster, CA 92683~~

~~TO:~~ ~~COUNTY~~
~~County of Orange~~
~~333 Santa Ana Blvd., 3rd Floor~~
~~Santa Ana, CA 92701~~
~~Attention: Scott Mayer, Chief Real Estate Officer~~
~~Email: Scott.Mayer@ocgov.com~~
~~Phone: (714) 834-3046~~

~~24.~~23. ATTACHMENTS (8.2 S)

This Lease includes the following, which are attached hereto and made a part hereof:

I. GENERAL CONDITIONS
II. EXHIBITS
   A. Description - Premises
   B. Plot Plan - Premises
   C. Plans and Specifications
   D. Janitorial Specifications
   E. Subordination, Attornment, and Non-Disturbance Agreement

25. MISCELLANEOUS (N)

COUNTY may remove and dispose, and in a manner best suited for such removal and disposition, of any item(s) of furniture ("**Furniture Items**") off the Premises, which is (are) personal property of the LESSOR, as COUNTY deems appropriate or is of no use for COUNTY. LESSOR hereby waives all claims and recourse against COUNTY including the right of contribution for loss or damage of property

arising from, growing out of or in any way connected with or related to the removal and disposition of the Furniture Items except claims arising from the concurrent active negligence of COUNTY, its officers, agents, and employees.

D. Clause 26. OPTION TO EXTEND TERM (2.3 N) is hereby added to the Lease:

"Clause 26. OPTION TO EXTEND TERM (2.3 N)

COUNTY's Chief Real Estate Officer or designee, shall have the option to extend the term of this Lease for one (1) four (4) year period (**"Extension Period"**) beyond June 30, 2021, which shall be memorialized in an amendment to the Lease executed by the Chief Real Estate Officer, on the same terms and conditions of this Lease except for (a) the base rent ("**Extension Option Base Rent**"), which shall be negotiated at the time of the option as set forth below and shall not result in a base rent higher than fair market value at the time of the extension option, and (b) the base year for operating expenses, which will be reset to the calendar year prior to the year in which the option is exercised. The Extension Period shall not contain an option for COUNTY to terminate the Lease during the term of the Extension Period. COUNTY shall give to LESSOR written notice of its intent to exercise its option to extend the term of this Lease for one (1) four (4) year period no sooner than twelve (12) months or later than four (4) months prior to the Lease termination date.

Subject to other provisions contained in this Lease, COUNTY shall accept the Premises during the Extension Period in the Premises' "as-is, where-is" condition. The Extension Option Base Rent shall be defined as Fair Market Rental Rate, defined and determined as set forth below in this Clause.

Following COUNTY's notice to LESSOR of its intent to extend the Lease for the Extension Period, COUNTY and LESSOR shall work in good faith and with commercially diligent and good faith efforts for sixty (60) days (the **"Initial Negotiation Period"**) in an effort to agree upon the Fair Market Rental Rate. When the Parties agree that negotiations are concluded, or by the expiration of the Initial Negotiation Period, LESSOR will provide COUNTY written notification of either the agreed upon Fair Market Rental Rate or LESSOR's last best offer (the **"Last Best Offer"**).

In the event that within or at the expiration of the Initial Negotiation Period COUNTY and LESSOR cannot agree upon the Fair Market Rental Rate, COUNTY and LESSOR by the end of the following thirty (30) days (the "**Second Negotiation Period**") shall attempt to determine the Fair Market Rental Rate by surveying and compiling rents for Class A office building properties similar in character, condition and quality to the subject property and located within a five (5) mile radius of the Building (**"Qualified Buildings"**), using industry standard sources and databases which contain lease information, lease comps, building specifications and space availabilities. The "**Fair Market Rental Rate**" shall be determined as follows: LESSOR and COUNTY shall independently survey Qualified Buildings that (i) contain at least 5,000 rentable square feet; (ii) offer a similar quantity of parking as the subject property; (iii) are otherwise similar in quality and function as the subject property; and (iv)

which have either entered into an arms-length transaction with an unaffiliated tenant of at least 2,000 rentable square feet within the past twelve (12) months or which have at least 5,000 rentable square feet of space available for lease (collectively, the "**Criteria**"). LESSOR and COUNTY shall each submit a list of up to five (5) Qualified Buildings. The two lists shall be consolidated into one master list. In the event of a discrepancy involving the same Qualified Building, COUNTY and LESSOR shall use best efforts to reconcile the difference. If either the highest or lowest quoted rates deviate by more than ten percent (10%) from the next closest rate, that building will be eliminated from the final master list (**"Final Master List"**). The per square foot rental rate ("**Rental Rate**") from each building shall be the monthly full service gross base rent per rentable square foot received or quoted by each Qualified Building, the Rental Rate shall exclude rent abatement concessions, but such Rental Rate shall include market tenant improvement allowances for renewing tenants, taking into account the cost to LESSOR to make periodic improvements to the Premises as provided in this Lease. The Rental Rate shall be compiled to the Final Master List and shall be summed and the summation divided by the number of Qualified Buildings (less any omitted Qualified Buildings) as follows:

Total Rental Rate of Considered Bldgs.÷ Number of Considered Bldgs. = Fair Market Rental Rate

The Extension Option Base Rent for the Option Period will be calculated as follows:

Extension Option Base Rent = Fair Market Rental Rate

In no event shall the Extension Option Base Rent for the Option Period be greater than LESSOR's Last Best Offer and the final determination will be binding on both Parties. There shall be no abatement of rent or Tenant Improvements, unless the Parties agree to such terms; the Extension Option Base Rent shall increase by three percent (3%) per annum during the Extension Period; and no other terms of the Lease shall change. COUNTY and LESSOR agree to then enter into a Lease amendment to consummate the transaction within a reasonable time period following determination of the Extension Option Base Rent, with time being of the essence."

E. The INSURANCE Clause is hereby deleted in its entirety from the Lease and replaced with the following:

"**27. INSURANCE**

Commercial Property Insurance: LESSOR shall obtain and keep in force during the term of this Lease a policy or policies of commercial property insurance written on ISO form CP 00 10 10 12, or a substitute form providing coverage at least as broad, with all risk or special form coverage, covering the loss or damage to the Premises to the full insurable value of the improvements located on the Premises (including the full value of all improvements and fixtures

owned by LESSOR) at least in the amount of the full replacement cost thereof, and in no event less than the total amount required by any lender holding a security interest.

LESSOR agrees to and shall include in the policy or policies of commercial property insurance a standard waiver of the right of subrogation against the County of Orange, its elected and appointed officials, officers, agents and employees by the insurance company issuing said policy or policies. LESSOR shall provide the County of Orange with a Certificate of Insurance as evidence of compliance with these requirements.

Commercial General Liability Insurance: LESSOR shall obtain and keep in force during the term of this Lease a policy or policies of commercial general liability insurance covering all injuries occurring within the building and the Premises. The policy or policies evidencing such insurance shall provide the following:

f. An Additional Insured endorsement using ISO form CG 20 26 04 13 or a from at least as broad naming the ***County of Orange, its elected and appointed officials, officers, agents and employees*** as an additional insured, or provide blanket coverage which will state, ***AS REQUIRED BY WRITTEN AGREEMENT***;
g. A primary and non-contributory endorsement using ISO form CG 20 01 04 13, or a form at least as broad evidencing that the Lessor's insurance is primary and any insurance or self-insurance maintained by the County of Orange shall be excess and non-contributing;
h. LESSOR shall notify County in writing within thirty (30) days of any policy cancellation and ten (10) days for non-payment of premium and provide a copy of the cancellation notice to County. Failure to provide written notice of cancellation may constitute a material breach of the Lease, upon which the County may suspend or terminate this Lease.
i. Shall provide a limit of One Million Dollars ($1,000,000) per occurrence with a Two Million Dollars ($2,000,000) aggregate; and
j. The policy or policies of insurance must be issued by an insurer with a minimum rating of A- (Secure A.M. Best's Rating) and VIII (Financial Size Category as determined by the most current edition of the **Best's Key Rating Guide/Property-Casualty/United States or ambest.com).** It is preferred, but not mandatory, that the insurer be licensed to do business in the state of California (California Admitted Carrier).

If the insurance carrier does not have an A.M. Best Rating of A-/VIII, the CEO/Office of Risk Management retains the right to approve or reject a carrier after a review of the company's performance and financial ratings. Prior to the Commencement Date of this Lease and upon renewal of such policies, LESSOR shall submit to COUNTY a Certificate of Insurance and required endorsements as evidence that the foregoing policy or policies are in effect.

If LESSOR fails to procure and maintain the insurance required to be procured by LESSOR under this Lease, COUNTY may, but shall not be required to, order such insurance and deduct the cost thereof plus any COUNTY administrative charges from the rent thereafter payable.

F. Wherever a conflict in the terms or conditions of this Third Amendment and the Lease as previously amended by the First Amendment and Second Amendment exists, the terms and conditions of this Third Amendment shall prevail. In all other respects, the terms and conditions of the Lease, as previously amended and not specifically changed by this Third Amendment, shall remain in full force and effect.

//

Attachment F

IN WITNESS WHEREOF, the parties have executed this Lease the day and year first above written.

LESSOR

CHARLES H. MANH and ANH MANH,
Co-Trustees of the MANH FAMILY TRUST, dated August 15, 2006

By: _____ May ___, 2016
CHARLES H. MANH, Co-Trustee

By: _____ May ___, 2016
ANH MANH, Co-Trustee

APPROVED AS TO FORM:

OFFICE OF COUNTY COUNSEL
ORANGE COUNTY, CALIFORNIA

By_____
Deputy County Counsel

RECOMMENDED FOR APPROVAL:

Social Service Agency

BY: _____
Carol Wiseman, Deputy Director

County Executive Office

~~**COUNTY**~~

~~COUNTY OF ORANGE~~
~~Chief Real Estate Officer~~

_____
~~By: Scott D. Mayer Per Ordinance No. 15-009 of the Board of Supervisors and Minute Order dated June 9, 2015~~

COUNTY

COUNTY OF ORANGE

Attachment F

BY: _____
Gail Dennis, Administrative Manager
Real Estate Services

_____
Chairwoman of the Board of Supervisors
Orange County, California

SIGNED AND CERTIFIED THAT A COPY OF THIS DOCUMENT HAS BEEN DELIVERED TO THE CHAIRWOMAN OF THE BOARD PER GC § 25103, RESO. 79-1535

Attest:

_____
ROBIN STIELER
Clerk of the Board of Supervisors of
Orange County, California

GENERAL CONDITIONS (9.1-9.17 S)

1. LEASE ORGANIZATION (9.1 S)

The various headings in this Lease, the numbers thereof, and the organization of the Lease into separate sections and paragraphs are for purposes of convenience only and shall not be considered otherwise.

2. INSPECTION (9.2 N)

LESSOR or his authorized representative shall have the right at all reasonable times and upon reasonable advance notice to COUNTY, which authorization shall not be unreasonably withheld, to inspect the Premises to determine, if COUNTY is complying with all the provisions of this Lease.

3. SUCCESSORS IN INTEREST (9.3 S)

Unless otherwise provided in this Lease, the terms, covenants, and conditions contained herein shall apply to and bind the heirs, successors, executors, administrators, and assigns of all the parties hereto, all of whom shall be jointly and severally liable hereunder.

4. DESTRUCTION OF OR DAMAGE TO PREMISES (9.4 S)

"Partial Destruction" of the Premises shall mean damage or destruction to the Premises, for which the repair cost is less than 25% of the then replacement cost of the Premises (including tenant improvements), excluding the value of the land.

"Total Destruction" of the Premises shall mean damage or destruction to the Premises, for which the repair cost is 25% or more of the then replacement cost of the Premises (including tenant improvements), excluding the value of the land.

In the event of a Partial Destruction of the Premises, LESSOR shall immediately pursue completion of all repairs necessary to restore the Premises to the condition which existed immediately prior to said Partial Destruction. Said restoration work (including any demolition required) shall be completed by LESSOR, at LESSOR's sole cost, within sixty (60) days of the occurrence of said Partial Destruction or within an extended time frame as may be authorized, in writing, by COUNTY. The Partial Destruction of the Premises shall in no way render this Lease and/or any option to purchase null and void; however, rent payable by COUNTY under the Lease shall be abated in proportion to the extent COUNTY's use and occupancy of the Premises is adversely affected by said Partial Destruction, demolition, or repair work

required thereby. Should LESSOR fail to complete necessary repairs, for any reason, within sixty (60) days, or other time frame as may be authorized by COUNTY, COUNTY may, at COUNTY's sole option, terminate the Lease or complete necessary repair work and deduct the cost thereof, including labor, materials, and overhead from any rent thereafter payable.

In the event of Total Destruction of the Premises or the Premises being legally declared unsafe or unfit for occupancy, this Lease and/or any option shall in no way be rendered null and void and LESSOR shall immediately instigate action to rebuild or make repairs, as necessary, to restore the Premises (including replacement of all tenant improvements) to the condition which existed immediately prior to the destruction. All rent payable by COUNTY shall be abated until complete restoration of the Premises is accepted by COUNTY. In the event LESSOR refuses to diligently pursue or is unable to restore the Premises to an occupiable condition (including replacement of all tenant improvements) within 180 days of the occurrence of said destruction or within an extended time frame as may be authorized, in writing, by COUNTY, COUNTY may, at COUNTY's sole option, terminate this Lease or complete the restoration and deduct the entire cost thereof, including labor, materials, and overhead from any rent payable thereafter.

Further, LESSOR, at COUNTY's request, shall provide a suitable, COUNTY-approved temporary facility ("**Facility**") for COUNTY's use during the restoration period for the Premises. The Facility may be leased, at market rate, under a short term lease, for which the COUNTY will reimburse LESSOR the cost thereof, on a monthly basis.

5. AMENDMENT (9.5 S)

This Lease sets forth the entire agreement between LESSOR and COUNTY and any modification must be in the form of a written amendment.

6. PARTIAL INVALIDITY (9.6 S)

If any term, covenant, condition, or provision of this Lease is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remainder of the provisions hereof shall remain in full force and effect and shall in no way be affected, impaired, or invalidated thereby.

7. CIRCUMSTANCES WHICH EXCUSE PERFORMANCE (9.7 S)

If either Party hereto shall be delayed or prevented from the performance of any act required hereunder by reason of acts of God, performance of such act shall be excused for the period of the delay; and the period for the performance of any such act shall be extended for a period equivalent to the period of such

delay. Financial inability shall not be considered a circumstance excusing performance under this Lease.

8. WAIVER OF RIGHTS (9.9 S)

The failure of LESSOR or COUNTY to insist upon strict performance of any of the terms, conditions, and covenants in this Lease shall not be deemed a waiver of any right or remedy that LESSOR or COUNTY may have, and shall not be deemed a waiver of any right or remedy for a subsequent breach or default of the terms, conditions, and covenants herein contained.

9. HOLDING OVER (9.10 S)

In the event COUNTY shall continue in possession of the Premises after the term of this Lease, such possession shall not be considered a renewal of this Lease but a tenancy from month to month and shall be governed by the conditions and covenants contained in this Lease.

10. HAZARDOUS MATERIALS (9.11 S)

LESSOR warrants that the Premises is free and clear of all hazardous materials or substances.

11. EARTHQUAKE SAFETY (9.12 N)

LESSOR is informed and believes that the Premises is not in violation of any applicable seismic safety regulations and building codes.

12. QUIET ENJOYMENT (9.13 S)

LESSOR agrees that, subject to the terms, covenants and conditions of this Lease, COUNTY may, upon observing and complying with all terms, covenants and conditions of this Lease, peaceably and quietly occupy the Premises.

13. WAIVER OF JURY TRIAL (9.15 S)

Each Party acknowledges that it is aware of and has had the advice of Counsel of its choice with respect to its rights to trial by jury, and each party, for itself and its successors and assigns, does hereby expressly and knowingly waive and release all such rights to trial by jury in any action, proceeding or counterclaim brought by any party hereto against the other (and/or against its officers, directors, employees, agents, or subsidiary or affiliated entities) on or with regard to any matters whatsoever arising out of or in any way

connected with this agreement and/or any claim of injury or damage.

14. GOVERNING LAW AND VENUE. (9.16 S)

This agreement has been negotiated and executed in the State of California and shall be governed by and construed under the laws of the State of California. In the event of any legal action to enforce or interpret this agreement, the sole and exclusive venue shall be a court of competent jurisdiction located in Orange County, California, and the parties hereto agree to and do hereby submit to the jurisdiction of such court, notwithstanding Code of Civil Procedure section 394.

15. TIME (9.17 S)

Time is of the essence of this Lease.

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EXHIBIT A

DESCRIPTION OF PREMISES (10.1 N)

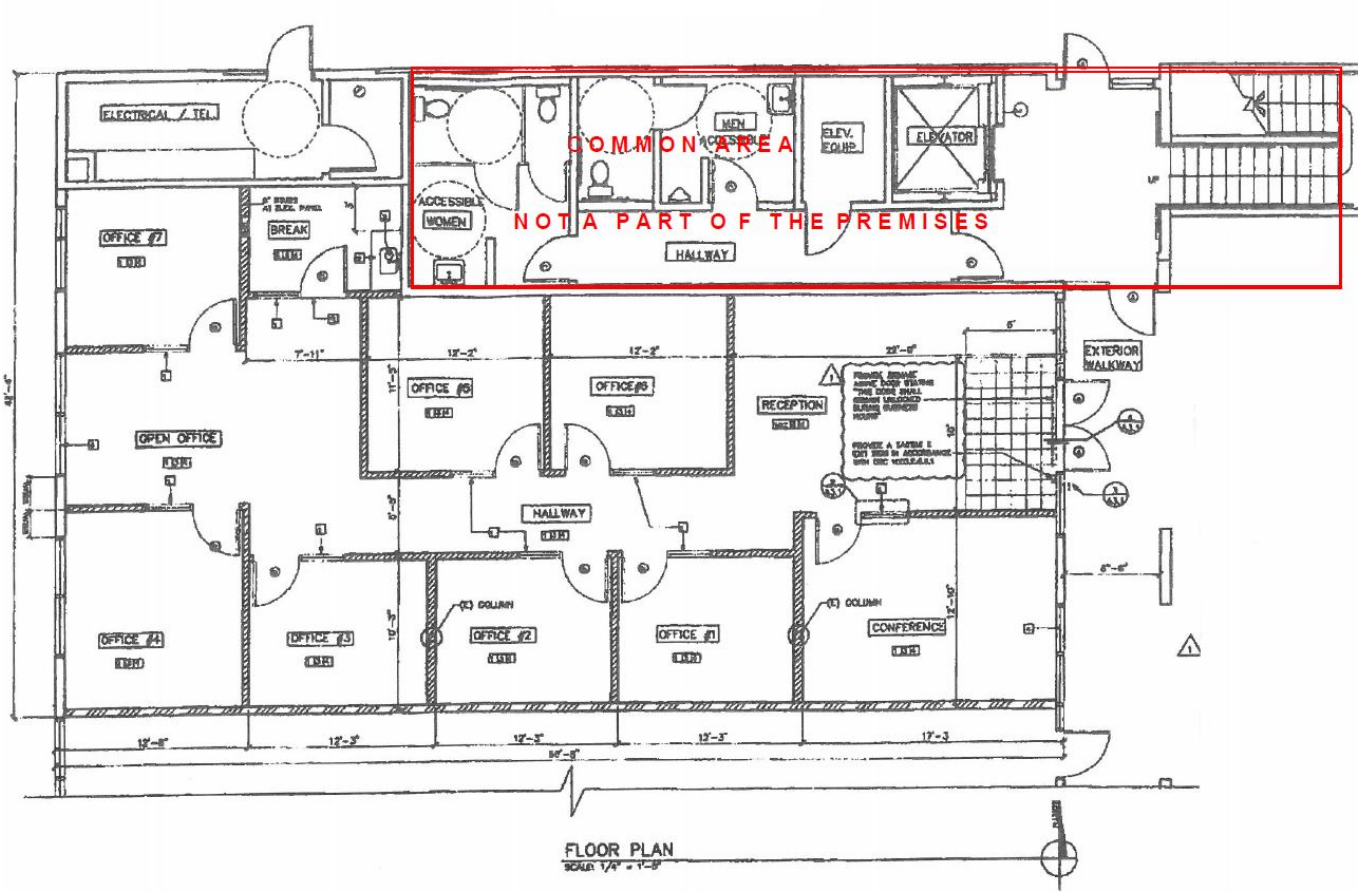
PROJECT: Community Customer Service Annex

All the Premises shown as the floor plan marked Exhibit B, attached hereto and made a part hereof, being a portion of the first floor of that certain two (2) story building located at 15496 Magnolia Street, Suite 111, in the City of Westminster, County of Orange, State of California, together with non-exclusive use of common area restrooms and thirteen (13) parking spaces in the parking areas shown on Exhibit B.

NOT TO BE RECORDED

EXHIBIT B
FLOOR PLAN OF PREMISES

15496 MAGNOLIA STREET, SUITE 111,
WESTMINSTER, CA



Gross Leasable Area: 2,120 Square Feet

EXHIBIT C

PERFORMANCE SPECIFICATIONS (10.3N) LESSOR shall perform the following Work prior to the Commencement Date of this Lease and according to the Tenant Improvement Performance Specifications that follow:

Specific locations to be identified by COUNTY prior to lease execution

1. Repair or replace door closer.
2. Replace stained ceiling tiles.
3. Repair or replace door closer.
4. Remove any signage from previous tenant that exists inside or outside of the Premises
5. Re-key front door and any internal door locks.
6. Provide the security code for existing alarm system.
7. Deliver the Premises with all electrical, plumbing and HVAC systems in proper working order.
8. Repair or replace any HVAC components resulting from findings of COUNTY's inspection of the HVAC system.

1. HEAT, VENT & AIR CONDITION ("HVAC")

A. Heating & air conditioning equipment shall have the capability of maintaining all occupied indoor areas at the room temperatures shown when outdoor temperatures are as follows:

OUTDOORS	*MAINTAIN INDOORS*
Summer – 95° Dry Bulb	78° Dry Bulb at a maximum range of 40% to 60% Relative humidity
Winter – 35° Dry Bulb	68° Dry Bulb

B. All HVAC controls pertinent to the Premises are to be located within the Premises.

C. All HVAC thermostats shall be concealed by a clear plastic tamper proof lock box.

2. ELECTRICAL & COMMUNICATIONS

A. Provide and install fluorescent lighting at all interior spaces that meet code and provide the following minimum lighting intensities at desk level:

LOCATION	*MINIMUM FOOT CANDLES:*
General Offices/Utility Rooms	60
Public Areas	30
General Corridors	20
LOCATION	*MINIMUM FOOT CANDLES:*
Other interior areas	I.E.S. Recommended Levels
Parking Lot	1

B. All Lighting controls pertinent to the Premises shall be located within the Premises.

COMPLIANCE WITH AMERICANS WITH DISABILITIES ACT ("ADA")

LESSOR shall assure that the Premises and Property are in compliance with current standards of the Americans with Disabilities Act for ingress and egress to the Premises and Property.

EXHIBIT D

JANITORIALSPECIFICATIONS (10.4 N)

It is the intent of this Exhibit to provide general guidelines for minimum janitorial service. Any absence of a specific janitorial service from this Exhibit does not relieve LESSOR of the obligation to provide such service should it become necessary.

Janitorial service as required in the clause entitled (REPAIR, MAINTENANCE AND JANITORIAL SERVICE) of this Lease, shall be inclusive of, but not limited to, the services as detailed below:

RESTROOMS

A. **NIGHTLY**:

1. Clean and damp-mop floors;
2. Wash all mirrors, bright work and enameled surfaces;
3. Wash and sanitize all basins, bowls, urinals, and toilet seats;
4. Dust, clean, and wash where necessary, all partitions, tile walls, dispensers, and receptacles;
5. Empty and sanitize all receptacles and sanitary napkin disposals;
6. Provide materials and fill all toilet tissue, towel, seat cover, sanitary napkin, and soap dispensers.

B. **MONTHLY**:

1. Machine strip restroom floors and apply finish/sealer where applicable;
2. Wash all partitions, tile walls, and enamel surfaces;
3. Vacuum all louvers, vents, and dust light fixtures.

MISCELLANEOUS SERVICES

1. Maintain building common/shared areas, corridors, and other public areas in a clean condition;
2. Surface parking lot is to be cleaned on a monthly or more frequent basis;
3. All interior and exterior windows of the building are to be cleaned quarterly.

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EXHIBIT E

SUBORDINATION, ATTORNMENT AND NON-DISTURBANCE AGREEMENT

THIS IS A SUBORDINATION, ATTORNMENT AND NON-DISTURBANCE AGREEMENT, made _____, 20__, by and between the County of Orange ("COUNTY") and _____ ("LENDER").

A. By lease dated _____, ("Lease"), _____ ("LESSOR") leased to COUNTY and COUNTY leased from LESSOR those certain Premises described as: _____.

B. LENDER is the holder or about to become the holder of a mortgage or Deed of Trust ("Note") which constitutes or will constitute a lien against the Premises leased by COUNTY pursuant to the aforesaid Lease.

C. LENDER has requested that _____ execute a Subordination, Attornment and Non-Disturbance Agreement in accordance with the terms of the Lease.

NOW, THEREFORE, the parties hereto do hereby agree as follows:

1. Subject to the terms and conditions of the Lease, all rights of COUNTY thereunder are or shall become subordinate to the Note and to any and all advances made on the security thereof, and to any and all increases, renewals, modifications, consolidations, replacements and extensions thereof.

2. In the event that LENDER succeeds to the interest of LESSOR under the Lease, by reason of foreclosure of the Note, by other proceedings brought to enforce any rights of LENDER under the Note, by deed in lieu of foreclosure, or by any other method, COUNTY shall promptly attorn to LENDER under all of the terms, covenants, and conditions of the Lease for the balance of the then-current term (and any extension or renewals thereof which may be effective in accordance with any option therefore contained in the Lease), with the same force and effect as if LENDER were the Lessor under the Lease. So long as COUNTY is not in default under the Lease, LENDER or its successors in interest shall not disturb the interests of COUNTY under said Lease, but shall allow said interests to continue in full force and effect for the balance of the then-current term and any extension available to COUNTY which may be provided in accordance with the Lease. Said attornment shall be effective and self-operative immediately upon LENDER'S succession to the interest of LESSOR under the Lease.

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3. This agreement may not be modified orally or in any manner other than by written agreement signed by the parties hereto or their respective successors or assigns. All of the terms, covenants, and conditions herein shall run with the land and shall be binding upon and inure to the benefit of the parties hereto and their respective successors and assigns.

COUNTY:

COUNTY OF ORANGE

By:_____

County Chief Real Estate Officer

Name:_____

LENDER:

By:

Print

Title:

APPROVAL AS TO FORM:
OFFICE OF THE COUNTY COUNSEL
ORANGE COUNTY, CALIFORNIA

By:_____

Deputy County Counsel

Date:_____

Attachment F

GA1213-237-2
SSA/CalOptima
15496 Magnolia Avenue
Westminster, CA 92683

SECOND AMENDMENT TO LICENSE

THIS SECOND AMENDMENT TO LICENSE AGREEMENT ("**Second Amendment**") is made and entered into on June 14, 2021, by and between CALOPTIMA, a public agency (hereinafter referred to as "**Licensee**") and the COUNTY OF ORANGE, a political subdivision of the State of California (hereinafter referred to as "**County**"), without regard to number and gender. County and Licensee may sometimes hereinafter be referred to individually as "**Party**" or jointly as "**Parties**."

RECITALS

I. Pursuant to a lease dated July 1, 2016, County leases that certain real property located at 15496 Magnolia in the City of Westminster, State of California ("**Lease**"), commonly known as the Orange County Community Service Center Annex ("**OCCSCA**"), for County's Social Services Agency ("**SSA**").

II. Pursuant to that certain license agreement dated August 4, 2016, ("**License**"), the County licenses to Licensee for its use a total of three hundred and sixty-two (362) rentable square feet ("**RSF**"), of the OCCSCA ("**Licensed Area**"), more particularly shown in Exhibit B, attached to the License. The License sets out the terms and conditions of Licensee's use of the License Area to provide health related services workshops and information regarding Medi-Cal benefits ("**Services**").

III. The License was amended on August 23, 2017 ("**First Amendment**") to extend the term for four years, which will expire on June 30, 2021.

IV. The Parties have agreed to amend the License to extend the term for one additional year through June 30, 2022, for Licensee to continue to provide the Services.

NOW, THEREFORE, in consideration of the Recitals, above, which are incorporated herein by this reference, the Parties do herby agree to amend the License as of the date entered above, ("**Effective Date**") as follows:

A. Clause 2 TERM (AMLC-3.1 N) is hereby deleted from the License in its entirety and the following clause is substituted:

"**2. TERM (AMLC-3.1 N)**

The License commenced on August 4, 2016, and shall terminate on June 30, 2022, unless otherwise terminated consistent with Clause 3 (TERMINATION) of this License."

B. Clause 7 LICENSE FEE (AMLC-6.1 S) is hereby deleted from the License in its entirety and the following clause is substituted:

"**7. LICENSE FEE (AMLC-6.1 S)**

Licensee agrees to pay County consistent with the following schedule:

Back to Agenda Back to Item

Commencing	Monthly License Fee
July 1, 2017	$1,560.98
July 1, 2018	$1,607.81
July 1, 2019	$1,656.04
July 1, 2020	$1,705.72
July 1, 2021	$1,705.72

The Monthly License Fee shall be payable in advance, without prior notice or demand on the first day of each calendar month while this License is in effect without deduction or offset in lawful money of the United States.

In the event the obligation to pay the Monthly License Fee begins or terminates on some day other than the first day or last day of the month, the Monthly License Fee shall be prorated to reflect the actual period of use on the basis of a thirty (30) day month."

C. Wherever a conflict in the terms or conditions of this Second Amendment, First Amendment and the original License exists, the terms and conditions of this Second Amendment shall prevail. In all other respects, the terms and conditions of the License and First Amendment not specifically changed by this Second Amendment shall remain in full force and effect.

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IN WITNESS WHEREOF, the Parties have executed this Second Amendment the day and year first above written.

APPROVED AS TO FORM:

Office of County Counsel
Orange County, California

By _____
Deputy County Counsel

Date: 6-4-2021

LICENSEE

CalOptima
CEO, CalOptima

***By _____ DocuSigned by: Richard Sanchez 234AD421BDEC4D9...
Richard Sanchez 05/27/2021

Print Name: _____

***By _____

Print Name: _____

RECOMMENDED FOR APPROVAL

SOCIAL SERVICES AGENCY

By _____
Dorthe Lee, Director of Administration

COUNTY

COUNTY OF ORANGE

By _____
Thomas A. Miller, Chief Real Estate Officer
County Executive Office
Per Resolution No. 19-002 of the Board of Supervisors and Minute Order dated January 8, 2019.

Date: June 14, 2021

COUNTY EXECUTIVE OFFICE

By _____
Steven K. Miller, Administrative Manager
Real Estate Services

*** Pursuant to the requirements of California Corporations Code section 313, one of the following two methods must be used by a corporation when it enters into a contract with the County: Two people must sign the document. One of them must be the chairman of the board, the president or any vice president. The other must be the secretary, any assistant secretary, the chief financial officer or any assistant treasurer. One corporate officer may sign the document, providing that written evidence of the officer's authority to bind the corporation with only his or her signature must be provided. This evidence would ideally be a corporate resolution.

LICENSE AGREEMENT

THIS LICENSE AGREEMENT ("**License**") is made and entered into on June 12, 2022 ("**Effective Date**"), by and between ORANGE COUNTY HEALTH AUTHORITY, DBA CALOPTIMA, a public agency, and the county organized health system for the County of Orange, California, (hereinafter referred to as "**Licensee**") and the COUNTY OF ORANGE, a political subdivision of the State of California (hereinafter referred to as "**County**" or "**Licensor**"), without regard to number and gender. County and Licensee may sometimes hereinafter be referred to individually as "**Party**" or jointly as "**Parties**."

RECITALS

I. County leases that certain real property located at 15496 Magnolia in the City of Westminster, (**"County Property**") pursuant to a lease dated October 6, 2021 for use as the Community Customer Service Center ("**CCSC**").

II. Licensee would like to provide health related services, workshops and information regarding Medi-Cal benefits ("**Services**") at the County Property which will include a convenient on-site source while County clients are at the CCSC.

III. County agrees to provide Licensee sufficient office space within the CCSC for Licensee to provide the Services as defined within this License.

NOW THEREFORE, in consideration of the Recitals above, incorporated herein by reference, County and Licensee do hereby agree as follows:

1. DEFINITIONS (SRLic-1.0 S)

The following words in this License shall have the significance attached to them in this Clause 1 (DEFINITIONS), unless otherwise apparent from context:

"**Board of Supervisors**" means the Board of Supervisors of the County of Orange, a political subdivision of the State of California.

"**CEO/Office of Risk Management**" means the Risk Manager, County Executive Office, Risk Management, County of Orange, or designee, or upon written notice to Licensee, such other person or entity as shall be designated by the County Executive Officer or the Board of Supervisors.

"**Chief Real Estate Officer**" means the Chief Real Estate Officer, County Executive Office, Real Estate Section, County of Orange, or upon written notice to Licensee, such other person as shall be designated by the County Executive Officer.

"**County Executive Officer**" means the County Executive Officer, County Executive Office, County of Orange, or designee, or upon written notice to Licensee, such other person or entity as shall be designated by the Board of Supervisors.

2. LICENSE AREA (SRLic-1.1 S)

County grants to Licensee the right to use approximately five hundred and forty-eight (548) rentable square feet ("**RSF**") of that certain property located at 15496 Magnolia, Westminster, as described in Exhibit A and as shown on Exhibit B, which exhibits are attached hereto and by reference made a part hereof (hereinafter referred to as the "**License Area**"), together with non-exclusive right of common use of elevators, stairways, washrooms, hallways, driveways for vehicle ingress and egress, pedestrian walkways, other facilities and common areas appurtenant to the License Area. This right also includes reasonable and non-exclusive right to access the License Area.

3. USE (SRLic-1.2 S)

Licensee's use of the License Area shall be limited to general office use and providing clients with Services.

Licensee agrees not to use the License Area for any other purpose nor to engage in or permit any other activity within or from the License Area. Licensee further agrees not to conduct or permit to be conducted any public or private nuisance in, on, or from the License Area, not to commit or permit to be committed waste on the License Area, and to comply with all governmental laws and regulations in connection with its use of the License Area.

NO ALCOHOL, TOBACCO, OR MARIJUANA PRODUCTS SHALL BE SOLD FROM OR CONSUMED WITHIN THE LICENSE AREA. DRINKING ALCOHOLIC BEVERAGES AND SMOKING OF ANY KIND IS PROHIBITED INSIDE ANY BUILDING WITHIN THE LICENSE AREA.

4. PARKING (SRLic-1.4 S)

County shall provide one (1) parking space for Licensee's free and non-exclusive use. The location and any rules or instructions for use of these parking space shall be determined by the County.

5. TERM (SRLic-1.6 S)

This License shall become effective upon the Effective Date written above and shall continue in effect until five (5) years from the Effective Date or until terminated as provided in Clause 6 (TERMINATION) of this License, whichever occurs first ("**Term**").

6. TERMINATION (SRLic-1.7 S)

This License shall be revocable by either County or Licensee with thirty (30) days written notice to the non-terminating Party prior to the termination date.

7. LICENSE FEE (SRLic-1.8 N)

Licensee agrees to pay County the sum of Two Thousand One Hundred Thirty-Two Dollars ($2,132.00) per month as a fee for the use of the License Area ("**License Fee**"). Said License Fee shall be payable in advance, without prior notice or demand, on the first day of each calendar month while this License is in effect, without deduction or offset, in lawful money of the United States.

In the event the obligation to pay the License Fee begins or terminates on some day other than the first day or last day of the month, the License Fee shall be prorated to reflect the actual period of use on the basis of a thirty (30) day month.

8. LICENSE FEE ADJUSTMENT (N)

The License Fee payable by Licensee for the License Area shall be automatically adjusted as follows:

Months	Monthly License Fee
13-24	$2,217.28
25-36	$2,305.97
37-48	$2,398.21
49-60	$2,494.14

9. PAYMENT PROCEDURE (SRLic-1.8 N)

All payments shall be delivered to the County of Orange, Office of the Treasurer-Tax Collector, Revenue Recovery/Accounts Receivable Unit, P. O. Box 567 (1770 N. Broadway), Santa Ana, California 92702. The designated place of payment may be changed at any time by County upon ten (10) days written notice to Licensee. Payments may be made by check payable to the County of Orange. License Fee payment shall include a payment voucher indicating that the payment is for the monthly License Fee is for office space at the County Community Service Center in Westminster, California. A duplicate copy of the payment voucher shall be mailed to the County of Orange, County Executive Office, 333 West Santa Ana Blvd., 3rd Floor Santa Ana, California 92701-4084, Attention: Chief Real Estate Officer. Licensee assumes all risk of loss if payments are made by mail.

No payment by Licensee or receipt by County of a lesser amount than the payment due shall be deemed to be other than on account of the payment due, nor shall any endorsement or statement on any check or any letter accompanying any check or payment as payment be deemed an accord and satisfaction, and County shall accept such check or payment without prejudice to County's right to recover the balance of said payment or pursue any other remedy in this License. Nor shall County's acceptance of a lesser amount due or delay in pursuing full payment act as a legal bar against County's recovery of any amount due under this License.

All sums due under this License shall be paid in lawful money of the United States of America, without offset or deduction or prior notice or demand.

10. CHARGE FOR LATE PAYMENT (SRLic-1.9 S)

Licensee hereby acknowledges that late payment of sums due hereunder will cause County to incur costs not contemplated by this License, the exact amount of which will be extremely difficult to ascertain. Such costs include, but are not limited to, costs such as administrative processing of delinquent notices, increased accounting costs, etc.

Accordingly, if any payment pursuant to this License is not received by County by the due date, a late charge of one - and one- half percent (1.5%) of the payment due and unpaid plus one hundred dollars ($100.00) shall be added to the payment, and the total sum shall become immediately due and payable to County. An additional charge of one- and one-half percent (1.5%) of said payment, excluding late charges, shall be added for each additional month that said payment remains unpaid.

Licensee and County hereby agree that such late charges represent a fair and reasonable estimate of the costs that County will incur by reason of Licensee's late payment.

Acceptance of such late charges (and/or any portion of the overdue payment) by County shall in no event constitute a waiver of Licensee's default with respect to such overdue payment, nor act as a legal bar or otherwise prevent County from exercising any of the other rights and remedies granted hereunder.

11. UTILITIES AND JANITORIAL (SRLic-2.3 N)

County shall be responsible for all charges for the following utilities: water, gas, electricity, and sewer. County shall be responsible for all maintenance and repairs (including but not limited to: fire alarm, fire extinguisher, HVAC system, elevator maintenance, landscaping, pest control, and trash) unless such maintenance and repairs arise out of Licensee's negligence or intentional acts not in accordance with the uses permitted herein, per Clause 3 (USE) above, and not including normal wear and tear.

12. OPERATIONAL REQUIREMENTS OF LICENSEE (SRLic-2.7 N)

Licensee expressly agrees to keep the License Area in a safe, clean, wholesome, and sanitary condition, to the complete satisfaction of County and in compliance with all applicable laws. Licensee further agrees to keep the License Area free and clear of rubbish and litter by placing rubbish and litter in appropriate trash or recycle bins. County shall have the right to enter upon and inspect the License Area at any time to verify conformity with any terms and conditions of this License including cleanliness and safety, with minimal interference with Licensee's use.

Upon expiration or termination of the License, the License Area must be returned to its original condition (excluding normal wear and tear), otherwise specified in writing by County, and the Licensee is solely responsible for any costs or damages associated therewith. Notwithstanding the foregoing, Licensee will not be responsible for repairs or costs for reasonable wear and tear.

13. INSURANCE (SRLic-2.8 S)

Licensee agrees to purchase all required insurance at Licensee's expense and to deposit with the County certificates of insurance, including all endorsements required herein, necessary to satisfy the County that the insurance provisions of this License have been complied with and to keep such insurance coverage and the certificates and endorsements therefore on deposit with the County during the entire term of this License.

Licensee agrees that Licensee shall not operate on the License Area at any time the required insurance is not in full force and effect as evidenced by a certificate of insurance and necessary endorsements or, in the interim, an official binder being in the possession of the County. In no cases shall assurances by Licensee, its employees, agents, including any insurance agent, be construed as adequate evidence of insurance. The County will only accept valid certificates of insurance and endorsements, or in the interim, an insurance binder as adequate evidence of insurance. Licensee also agrees that upon cancellation, termination, or expiration of Licensee's insurance, County may take whatever steps are necessary to interrupt any operation from or on the License Area until such time as the County reinstates the License.

If Licensee fails to provide the County with a valid certificate of insurance and endorsements, or binder at any time during the term of the License, County and Licensee agree that this shall constitute a material breach of the License. Whether or not a notice of default has or has not been sent to Licensee, said material breach shall permit County to take whatever steps necessary to interrupt any operation from or on the License Area, and to prevent any persons, including, but not limited to, members of the general public, and Licensee's employees and agents, from entering the License Area until such time as the Chief Real Estate Officer is provided with adequate evidence of insurance required herein. Licensee further agrees to hold County harmless for any damages resulting from such interruption of business and possession, including, but not limited to, damages resulting from any loss of income or business resulting from the County's action.

Licensee may occupy the License Area only upon providing to County the required insurance stated herein and maintain such insurance for the entire term of this License. County reserves the right to terminate this License at any time Licensee's insurance is canceled or terminated and not reinstated within ten (10) days of said cancellation or termination. Licensee shall pay County a fee of two hundred dollars ($200.00) for

processing the reinstatement of the License. Licensee shall provide to County immediate notice of said insurance cancellation or termination.

All contractors performing work on behalf of Licensee pursuant to this License shall obtain insurance subject to the same terms and conditions as set forth herein for Licensee. Licensee shall not allow contractors or subcontractors to work if contractors have less than the level of coverage required by the County from the Licensee under this License. It is the obligation of the Licensee to provide written notice of the insurance requirements to every contractor and to receive proof of insurance prior to allowing any contractor to begin work within the License Area. Such proof of insurance must be maintained by Licensee through the entirety of this License and be available for inspection by a County representative at any reasonable time.

All self-insured retentions (SIRs) shall be clearly stated on the Certificate of Insurance. Any self-insured retention (SIR) in an amount in excess of Fifty Thousand Dollars ($50,000) shall specifically be approved by the County's Risk Manager, or designee, upon review of Licensee's current audited financial report. If Licensee's SIR is approved, Licensee, in addition to, and without limitation of, any other indemnity provision(s) in this License, agrees to all of the following:

1) In addition to the duty to indemnify and hold the County harmless against any and all liability, claim, demand or suit resulting from Licensee's, its agents, employee's or subcontractor's performance of this Agreement, Licensee shall defend the County at its sole cost and expense with counsel approved by Board of Supervisors against same; and
2) Licensee's duty to defend, as stated above, shall be absolute and irrespective of any duty to indemnify or hold harmless; and
3) The provisions of California Civil Code Section 2860 shall apply to any and all actions to which the duty to defend stated above applies, and the Licensee's SIR provision shall be interpreted as though the Licensee was an insurer and the County was the insured.

If the Licensee fails to maintain insurance acceptable to the County for the full term of this License, the County may terminate this License.

Qualified Insurer

The policy or policies of insurance must be issued by an insurer with a minimum rating of A- (Secure A.M. Best's Rating) and VIII (Financial Size Category as determined by the most current edition of the **Best's Key Rating Guide/Property-Casualty/United States or ambest.com).** It is preferred, but not mandatory, that the insurer be licensed to do business in the state of California (California Admitted Carrier).

If the insurance carrier does not have an A.M. Best Rating of A-/VIII, the CEO/Office of Risk Management retains the right to approve or reject a carrier after a review of the company's performance and financial ratings.

The policy or policies of insurance maintained by the Licensee shall provide the minimum limits and coverage as set forth below:

Coverages	Minimum Limits
Commercial General Liability	$1,000,000 per occurrence $2,000,000 aggregate
Automobile Liability including coverage	$1,000,000 limit per occurrence

Coverages	Minimum Limits
for owned, non-owned and hired vehicles	
Workers' Compensation	Statutory
Employers' Liability Insurance	$1,000,000 per occurrence

Required Coverage Forms

The Commercial General Liability coverage shall be written on Insurance Services Office (ISO) form CG 00 01, or a substitute form providing liability coverage at least as broad.

The Business Auto Liability coverage shall be written on ISO form CA 00 01, CA 00 05, CA 00 12, CA 00 20, or a substitute form providing liability coverage at least as broad.

Required Endorsements

The Commercial General Liability policy shall contain the following endorsements, which shall accompany the Certificate of insurance:

1) An Additional Insured endorsement using ISO form CG 20 26 04 13 or a form at least as broad naming the ***County of Orange, its elected and appointed officials, officers, employees, agents*** as Additional Insureds. Blanket coverage may also be provided which will state- ***As Required By Written Agreement***.
2) A primary non-contributing endorsement using ISO form CG 20 01 04 13, or a form at least as broad, evidencing that the Licensee's insurance is primary and any insurance or self-insurance maintained by the County of Orange shall be excess and non-contributing.

The Workers' Compensation policy shall contain a waiver of subrogation endorsement waiving all rights of subrogation against the ***County of Orange, its elected and appointed officials, officers, agents and employees***. Blanket coverage may also be provided which will state- ***As Required By Written Agreement.***

All insurance policies required by this license shall waive all rights of subrogation against the County of Orange, its elected and appointed officials, officers, agents and employees when acting within the scope of their appointment or employment.

The Commercial Property policy shall contain a Loss Payee endorsement naming the County of Orange as respects the County's financial interest when applicable.

Licensee shall notify County in writing within thirty (30) days of any policy cancellation and ten (10) days for non-payment of premium and provide a copy of the cancellation notice to County. Failure to provide written notice of cancellation may constitute a material breach of the License, upon which the County may suspend or terminate this License.

The Commercial General Liability policy shall contain a severability of interests clause, also known as a "separation of insureds" clause (standard in the ISO CG 001 policy).

Insurance certificates should be forwarded to the County address provided in the Clause 35 (NOTICES) below or to an address provided by the Chief Real Estate Officer. Licensee has ten (10) business days to provide adequate evidence of insurance or this License may be cancelled.

County expressly retains the right to require Licensee to increase or decrease insurance of any of the above insurance types throughout the term of this License. Any increase or decrease in insurance will be as deemed by County of Orange Risk Manager as appropriate to adequately protect County.

County shall notify Licensee in writing of changes in the insurance requirements. If Licensee does not deposit copies of acceptable certificates of insurance and endorsements with County incorporating such changes within thirty (30) days of receipt of such notice, this License may be in breach without further notice to Licensee, and County shall be entitled to all legal remedies.

The procuring of such required policy or policies of insurance shall not be construed to limit Licensee's liability hereunder nor to fulfill the indemnification provisions and requirements of this License, nor in any way to reduce the policy coverage and limits available from the insurer.

14. INDEMNIFICATION (SRLic-2.9 S)

Each Party (an "Indemnifying Party") hereby agrees to indemnify, hold harmless, and defend the other Party and the other Party's officers, agents, and employees (each an "Indemnified Party") against any and all claims, losses, demands, damages, costs, expenses, or liability arising out of the Indemnifying Party's negligence or breach of this License.

If a Party is named as co-defendant, the Indemnifying Party shall notify the Indemnified Party of such fact and shall represent the Indemnified Party, with counsel approved by the Indemnified Party, provided that such approval is not unreasonably withheld or delayed, in such legal action unless the Indemnified Party undertakes to represent itself as co-defendant in such legal action, in which event the Indemnifying Party shall pay the Indemnified Party's litigation costs, expenses, and attorneys' fees. If judgment is entered against the Parties because of the concurrent negligence of the Parties, their officers, agents, or employees, an apportionment of liability to pay such judgment shall be made by a court of competent jurisdiction. Neither Party shall request a jury apportionment.

15. LIMITATION OF THE LICENSE (SRLic-3.3 S)

This License and the rights and privileges granted Licensee in and to the License Area are subject to all covenants, conditions, restrictions, and exceptions of record or apparent from a physical inspection of the License Area. Nothing contained in this License or in any document related hereto shall be construed to imply the conveyance to Licensee of rights in the License Area which exceed those owned by County, or any representation or warranty, either express or implied, relating to the nature or condition of the License Area or County's interest therein. Licensee has accepted the License Area in its "as is"/ "where is" condition.

16. NO ASSIGNMENT, SUBAGREEMENTS (SRLic-3.6 S)

The License granted hereby is personal to Licensee and any assignment of said license by Licensee, voluntarily or by operation of law, shall automatically terminate the License granted hereby. Sublicenses or subleases are not authorized under this License and any attempt by Licensee to create any such sublicense or sublease shall be null and void and shall automatically terminate the License.

17. SIGNS (SRLic-4.0 S)

Licensee agrees not to construct, maintain, or allow any signs, banners, flags, etc., upon License Area except as approved by the Chief Real Estate Officer. Unapproved signs, banners, flags, etc., may be removed.

18. AUTHORITY (SRLic-4.1 S)

The persons executing the License below on behalf of County or Licensee warrant that they have the power and authority to bind County or Licensee to this License.

19. LICENSE ORGANIZATION (SRLic-4.2 S)

The various headings and numbers herein, the grouping of provisions of this License into separate clauses and paragraphs, and the organization hereof, are for the purpose of convenience only and shall not be considered otherwise.

20. AMENDMENTS (SRLic-4.3 S)

This License is the sole and only agreement between the Parties regarding the subject matter hereof; other agreements, either oral or written, are void. Any changes to this License shall be in writing and shall be properly executed by both Parties.

21. PARTIAL INVALIDITY (SRLic-4.4 S)

If any term, covenant, condition, or provision of this License is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remainder of the provisions hereof shall remain in full force and effect and shall in no way be affected, impaired, or invalidated thereby.

22. WAIVER OF RIGHTS (SRLic-4.5 S)

The failure of Licensee or County to insist upon strict performance of any of the terms, covenants, or conditions of this License shall not be deemed a waiver of any right or remedy that Licensee or County may have, and shall not be deemed a waiver of the right or act as a legal bar to require strict performance of all the terms, covenants, and conditions of the License thereafter, nor a waiver of any remedy for the subsequent breach or default of any term, covenant, or condition of the License. Any waiver, in order to be effective, must be signed by the Party whose right or remedy is being waived.

23. GOVERNING LAW AND VENUE (SRLic-4.6 S)

This agreement has been negotiated and executed in the State of California and shall be governed by and construed under the laws of the State of California. In the event of any legal action to enforce or interpret this agreement, the sole and exclusive venue shall be a court of competent jurisdiction located in Orange County, California, and the Parties hereto agree to and do hereby submit to the jurisdiction of such court, notwithstanding Code of Civil Procedure section 394.

24. ATTORNEYS' FEES (SRLic-4.7 S)

In the event of a dispute between County and Licensee concerning claims arising out of this License, or in any action or proceeding brought to enforce or interpret any provision of this License or where any provision hereof is validly asserted as a defense, each Party shall bear its own attorneys' fees and costs.

25. TIME OF ESSENCE (SRLic-4.8 S)

Time is of the essence of this License Agreement. Failure to comply with any time requirements of this License shall constitute a material breach of this License.

26. INSPECTION (SRLic-4.9 S)

County or its authorized representative shall have the right at all reasonable times to inspect the operation to determine if the provisions of this License are being complied with.

27. INSPECTION OF LICENSE AREA BY A CERTIFIED ACCESS SPECIALIST (SRLic-5.0 S)

A Certified Access Specialist (CASp) can inspect the subject License Area and determine whether the subject License Area comply with all of the applicable construction-related accessibility standards under state law. Although state law does not require a CASp inspection of the subject License Area, the commercial property owner or lessor may not prohibit the lessee or tenant from obtaining a CASp inspection of the subject License Area for the occupancy or potential occupancy of the licensee, if requested by the licensee. The Parties shall mutually agree on the arrangements for the time and manner of the CASp inspection, the payment of the fee for the CASp inspection, and the cost of making any repairs necessary to correct violations of construction-related accessibility standards within the License Area.

Pursuant to California Civil Code 1938, County hereby represents that the License Area has not undergone an inspection by a certified access specialist and no representations are made with respect to compliance with accessibility standards. If it is determined during this tenancy that a violation of handicapped access laws (including the Americans with Disabilities Act) exists at the License Area, County shall correct such non-compliance at County's cost.

28. PERMITS AND LICENSES (SRLic-5.1 S)

Licensee shall be required to obtain and maintain throughout the Term of this License any and all permits and/or licenses which may be required in connection with the operation of the License Area as set out herein. No permit, approval, or consent given hereunder by County, in its governmental capacity, shall affect or limit Licensee's obligations hereunder, nor shall any approvals or consents given by County, as a Party to this License, be deemed approval as to compliance or conformance with applicable governmental codes, laws, rules, or regulations.

29. PAYMENT CARD COMPLIANCE (SRLic-5.2 S)

Should Licensee conduct credit/debit card transactions in conjunction with their business with the County, on behalf of the County, or as part of the business that they conduct, Licensee covenants and warrants that it is currently Payment Card Industry Data Security Standard ("**PCI DSS**") and Payment Application Data Security Standard ("**PA DSS**") compliant and will remain compliant during the entire duration of this License. Licensee agrees to immediately notify County in the event Licensee should ever become non-compliant, and will take all necessary steps to return to compliance and shall be compliant within ten (10) days of the commencement of any such interruption.

30. NONDISCRIMINATION (SRLic-5.3 S)

Licensee agrees not to discriminate against any person or class of persons by reason of sex, age, race, color, creed, physical handicap, or national origin in employment practices and in the activities conducted pursuant to this License. Licensee shall make its accommodations and services available to the public on fair and reasonable terms.

31. CONDITION OF LICENSE AREA UPON TERMINATION (SRLic-5.4 S)

Except as otherwise agreed to herein, upon termination of this License, Licensee shall redeliver possession of said License Area to County in substantially the same condition that existed immediately prior to Licensee's entry thereon, reasonable wear and tear, flood, earthquakes, war, and any act of war excepted.

32. DISPOSITION OF ABANDONED PERSONAL PROPERTY (SRLic-5.5 S)

If Licensee abandons the License Area or is dispossessed thereof by process of law or otherwise, title to any personal property belonging to Licensee and left on the License Area ten (10) days after such event shall be deemed, at County's option, to have been transferred to County. County shall have the right to remove and to dispose of such personal property without liability therefor to Licensee or to any person claiming under Licensee, and shall have no need to account therefor.

33. PUBLIC RECORDS (SRLic-5.6 S)

Any and all written information submitted to and/or obtained by County from Licensee or any other person or entity having to do with or related to this License and/or the License Area, either pursuant to this License or otherwise, at the option of County, may be treated as a public record open to inspection by the public pursuant to the California Records Act (Government Code Section 6250, et seq.) as now in force or hereafter amended, or any Act in substitution thereof, or otherwise made available to the public and Licensee hereby waives, for itself, its agents, employees, sublicensees, and any person claiming by, through or under Licensee, any right or claim that any such information is not a public record or that the same is a trade secret or confidential information and hereby agrees to indemnify and hold County harmless from any and all claims, demands, liabilities, and/or obligations arising out of or resulting from a claim by Licensee or any third party that such information is a trade secret, or confidential, or not subject to inspection by the public, including without limitation reasonable attorneys' fees and costs.

34. RELATIONSHIP OF PARTIES (SRLic-5.7 S)

The relationship of the parties hereto is that of Licensor and Licensee, and it is expressly understood and agreed that County does not in any way or for any purpose become a partner of or a joint venture with Licensee in the conduct of Licensee's business or otherwise, and the provisions of this License and the agreements relating to rent payable hereunder are included solely for the purpose of providing a method by which rental payments are to be measured and ascertained.

35. NOTICES (SRLic-5.8 S)

All written notices pursuant to this License shall be addressed as set forth below or as either Party may hereafter designate by written notice and shall be deemed delivered upon personal delivery, delivery by facsimile machine, electronic mail, or seventy-two (72) hours after deposit in the United States Mail.

To: County

County of Orange
County Executive Office
333 West Santa Ana Blvd., 3rd Floor
Santa Ana, CA 92701-4084

To: Licensee

CalOptima
505 City Parkway West,
Orange, CA 92868

Attn: Chief Real Estate Officer

Attention: Tiffany Kaaiakamanu,
Community Relations Manager

36. ATTACHMENTS TO LICENSE (SRLic-5.9 S)

This License includes the following, which are attached hereto and made a part hereof:

I. EXHIBITS

Exhibit A – License Area Description
Exhibit B – License Area Depiction

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IN WITNESS WHEREOF, the Parties have executed this License the day and year first above written.

APPROVED AS TO FORM:

Office of County Counsel
Orange County, California

By _____
Deputy County Counsel

Date: 6-7-22

LICENSEE

CalOptima

***By _____ DocuSigned by: Michael Hunn D EDDDDCC19C894FB...

Print Name: Michael Hunn 06/07/2022

***By _____

Print Name: _____

COUNTY

COUNTY OF ORANGE

By _____
Thomas A. Miller, Chief Real Estate Officer
County Executive Office
Per Resolution No. 19-002 of the Board of Supervisors and Minute Order dated January 8, 2019.

Date: June 12, 2022

*** Pursuant to the requirements of California Corporations Code section 313, one of the following two methods must be used by a corporation when it enters into a contract with the County: Two people must sign the document. One of them must be the chairman of the board, the president or any vice president. The other must be the secretary, any assistant secretary, the chief financial officer or any assistant treasurer. One corporate officer may sign the document, providing that written evidence of the officer's authority to bind the corporation with only his or her signature must be provided. This evidence would ideally be a corporate resolution.

EXHIBIT A

LICENSE AREA DESCRIPTION

PROJECT NO: CEO/RFLC 022-021

WRITTEN BY: ES
DATE: 4-28-22

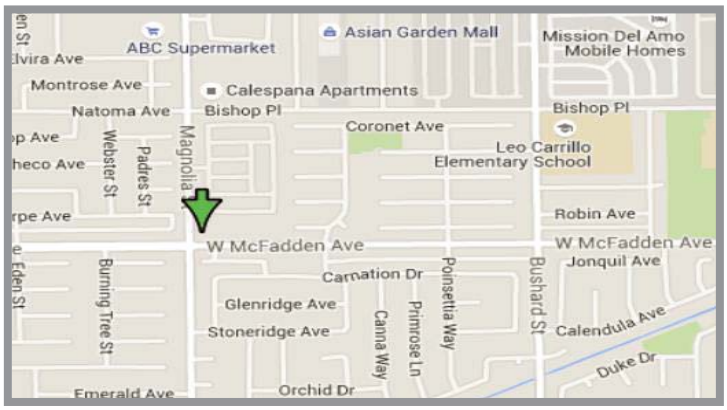
PROJECT: License with CalOptima
15496 Magnolia, Westminster, CA 92683

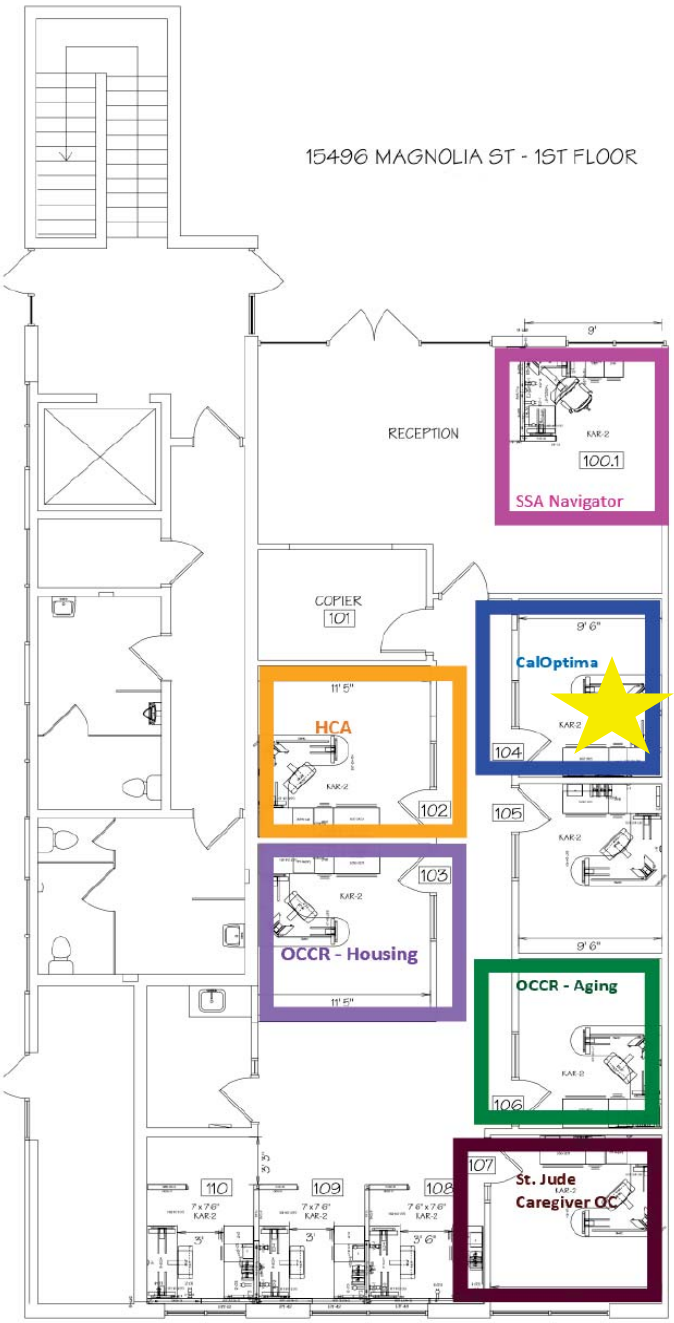
All the License Area referenced on a Floor Plan marked Exhibit B, attached hereto and made a part hereof, being approximately Five Hundred Forty Eight (548) RSF of County-designated space for Licensee's non-exclusive use, which space may vary from time-to-time based on County's pre-approval in writing, and being a portion of the Community Customer Service Center building located at 15496 Magnolia, in the City of Westminster, County of Orange, State of California, together with appurtenant right to use common areas located thereon, and the non-exclusive use of one parking space in the adjacent parking lot.

NOT TO BE RECORDED

EXHIBIT B

LICENSE AREA DEPICTION





License Area: Room 104

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 4, 2022
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

7. Actions for Contracts Related to Proposed Community Living and PACE Center in the City of Tustin

Contact

Yunkyung Kim, Chief Operating Officer, (714) 246-8408

Recommended Actions

1. Ratify CalOptima's contract with Whittingham Public Affairs Advisors for a one-year period, effective June 3, 2022, through June 2, 2023, for consulting and government affairs services to secure necessary approvals from the City of Tustin for a proposed Community Living and PACE Center, and related Fiscal Year (FY) 2021-22 expenditures; and
2. Authorize the Chief Executive Officer to contract with Totum Corporation for conceptual design services related to development of the proposed Community Living and PACE Center in the City of Tustin.

Background

On June 2, 2022, the CalOptima Board of Directors (Board) authorized staff to negotiate the acquisition of real property at 14851 Yorba Street (Yorba site) and 165 North Myrtle Avenue (Myrtle site) in Tustin, California, for the purpose of developing two adjacent buildings into CalOptima's Community Living and Program of All-Inclusive Care for the Elderly (PACE) Center (Center). The Center would provide crucial support services to the older adult unhoused population of Orange County. In addition to PACE, the Center will provide the following CalOptima Community Support services:

- **Recuperative Care:** A 90-day benefit that provides unhoused individuals who no longer require hospitalization but still need to heal from an injury or illness with medical oversight and access to primary and behavioral health services.
- **Post Hospitalization Housing:** A six-month benefit that provides guests exiting recuperative care or other care facilities an opportunity to continue their recuperation, receive case management and identify and secure housing.

With over 75,000 square feet of programmable space, the Center has the potential to provide 140 recuperative care/post hospitalization beds, community spaces, and 500 PACE slots for seniors, including those living at the Center and surrounding communities.

Currently, the Yorba site's existing conditional use permit (CUP) does not explicitly include use for recuperative care. CalOptima may need an amended CUP from the City of Tustin. Also, as a community site, CalOptima wishes to partner closely with the City of Tustin and local community on the development of the Center.

The price and terms of purchase will be considered by the Board at a future meeting contingent on receiving the necessary approvals from the City of Tustin.

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Discussion

Whittingham Public Affairs Advisors Contract

CalOptima currently contracts with outside lobbying firms for state and federal advocacy services. However, CalOptima does not retain a firm for local advocacy services. In order to facilitate the approval of necessary permits, CalOptima sought a contract with a local advocacy firm, Whittingham Public Affairs Advisors (WPAA), to promote CalOptima's interests through government affairs, strategic guidance, public relations, and community outreach and engagement. This includes monitoring and influencing policies, building and maintaining positive and mutually beneficial relationships, and providing CalOptima with necessary advocacy services in the City of Tustin. In furtherance of the Board's discussion on June 3, 2022, CalOptima executed the contract with WPAA on June 23, 2022. Management recommends Board of Directors' ratification of the WPAA contract in order to quickly expedite and advance the site approval and development process.

As proposed, the recommended action ratifies the executed contract with WPAA at a rate of $7,500 per month, which includes direct labor and expenses, overhead costs, fixed fees, subcontracts, leases, materials, and costs arising from or due to termination of the contract. The estimated total cost for the contract for the one-year period is $90,000. The contract will be effective until the necessary CUP is granted or until June 2, 2023, whichever is sooner. Staff will consider continuing the contract on a monthly basis depending on the need for such services. Per the agreed upon terms, CalOptima can terminate the contract at any time with or without cause. Consistent with CalOptima's practice, staff will monitor the performance of WPAA to ensure that the deliverables outlined in the contract are being achieved.

Totum Corporation Contract

To prepare for the necessary approvals and purchase of the sites, CalOptima identified the Totum Corporation (Totum) to provide conceptual design services with the goal of planning the desired Center and articulating spatial and aesthetic considerations. Totem is an architectural firm with experience in designing recuperative care centers and community living spaces.

In furtherance of the Board's discussion on June 2, 2022, CalOptima requests the Board of Directors' authorization to contract with Totum in order to produce a design proposal to quickly secure the necessary CUP from the City of Tustin.

CalOptima proposes a contract with Totum with a flat retainer payment of $6,250 in addition to hourly billable rates ranging from $45 per hour to $180 per hour, depending on the position of the Totum staff performing the billed task. Maximum payment for services delivered under the contract will be no more than $25,000, not including any additional reimbursements which are capped at $1,500. Per the agreed upon terms, CalOptima may terminate the contract at any time with or without cause. Consistent with CalOptima's practice, staff will monitor the performance of Totum to ensure that the deliverables outlined in the contract are being achieved.

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Fiscal Impact

WPAA Contract: The contract period includes one (1) month in FY 2021-22 and eleven (11) months in FY 2022-23.

- FY 2021-22: Administrative expenses related to the contract for the period of June 3, 2022, through June 30, 2022, is an unbudgeted item. Unspent administrative funds in the FY 2021-22 Operating Budget will fund up to $7,500 for this period.

- FY 2022-23: Funding for the recommended action of up to $82,500 is included in the Government Affairs budget under the FY 2022-23 Operating Budget approved by the Board on June 2, 2022. The net fiscal impact is budget neutral to CalOptima.

Totum Contract: Funding for the recommended action of up to $26,500 is included in the Operations Management budget under the FY 2022-23 Operating Budget approved by the Board on June 2, 2022. The net fiscal impact is budget neutral to CalOptima.

Rationale for Recommendation

Facilitating the approval and design of CalOptima's Community Living and PACE Center in the City of Tustin is necessary to address the urgent need for short-term housing and related support services for Orange County's older adult unhoused population and fully realize the goals of the California Advancing and Innovating Medi-Cal (CalAIM) initiative.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Entities Covered by this Recommended Board Action
2. Contract No. 22-10953 with Whittingham Public Affairs Advisors

/s/ Michael Hunn *07/28/2022*
Authorized Signature **Date**

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Attachment to the August 4, 2022 Board of Directors Meeting – Agenda Item 7

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Totum Corporation	15130 Ventura Blvd., Suite A	Sherman Oaks	CA	91403
Whittingham Public Affairs Advisors	31441 Santa Margarita Pkwy., Suite A181	Rancho Santa Margarita	CA	92688

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CONTRACT NO. 22-10953
BETWEEN
ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY, dba
ORANGE PREVENTION & TREATMENT INTEGRATED MEDICAL ASSISTANCE, dba
CALOPTIMA
And
WHITTINGHAM PUBLIC AFFAIRS ADVISORS
(CONTRACTOR)

THIS CONTRACT ("Contract") is made and entered into as of June 03, 2022 ("Effective Date"), by and between the Orange County Health Authority, dba CalOptima, a public agency, hereinafter referred to as "CalOptima" and Whittingham Public Affairs Advisors, hereinafter referred to as "CONTRACTOR." CalOptima and CONTRACTOR shall be referred to herein collectively as the "Parties" or individually as a "Party."

RECITALS

A. CalOptima desires to retain a contractor to provide Public Affairs and Advocacy Services, as described in the Scope of Work; and

B. CONTRACTOR provides such services; and

C. CONTRACTOR represents and warrants that it has the requisite personnel and experience and is capable of performing such services; and

D. CONTRACTOR desires to perform these services for CalOptima; and

E. CalOptima and CONTRACTOR desire to enter into this Contract on the terms and conditions set forth herein below.

NOW, THEREFORE, in consideration of their mutual and respective promises, and subject to the terms and conditions hereinafter set forth, the Parties agree as follows:

1. Documents Constituting Contract. This Contract shall include the following documents ("Contract Documents"), in the order of descending precedence: (i) this Contract, inclusive of all its exhibits and attachments, and any amendments thereto. Any new terms and conditions attached to CONTRACTOR's best and final offer, proposal, invoices, or request for payment, shall not be incorporated into the Contract Documents or be binding upon CalOptima unless expressly accepted by CalOptima in writing. All documents attached to this Contract and/or referenced herein as a "Contract Document" are incorporated into this Contract by this reference, with the same force and effect as if set forth herein in their entirety. Changes hereto shall not be binding upon CalOptima except when specifically confirmed in writing by an authorized representative of CalOptima and issued in accordance with Section 17, Modifications, herein. In the event of any conflict of provisions among the documents constituting the Contract, the provisions shall prevail in the above-referenced descending order of precedence.

2. Statement of Work.

2.1 CONTRACTOR shall perform the work necessary to complete, in a manner satisfactory to CalOptima, and if applicable, to the Centers for Medicare and Medicaid Services ("CMS"), the California Department of Health Care Services ("DHCS"), and/or the California Department of Managed Health Care ("DMHC"), as applicable, the services set forth in Exhibit A entitled "Scope of Work," which is attached hereto and incorporated herein by this reference.

2.2 CONTRACTOR shall provide the personnel listed below to perform the above-specified services, which persons are hereby designated as key personnel under this Contract. No person named in this Section 2, or his/her successor approved by CalOptima, shall be removed or replaced by CONTRACTOR, nor shall his/her agreed-upon function or level of commitment hereunder be changed without the prior written consent of CalOptima.

Name	Function/Title
Peter Whittingham	Founder & CEO

3. Insurance.

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

3.1.1 Required Insurance:

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

3.1.1.2 Per Occurrence: $1,000,000

3.1.1.3 Personal Advertising Injury: $1,000,000

3.1.1.4 Products Completed Operations: $2,000,000

3.1.1.5 General Aggregate: $2,000,000

3.1.2 Commercial Automobile Liability covering any auto, whether owned, leased, hired, or rented, on an ISO form CA 0001 or equivalent in the amount of $1,000,000 combined single limit for bodily injury or property damage.

3.1.3 Workers' Compensation and Employers' Liability Policy written in accordance with the laws of the State of California ("State") and providing coverage for all of CONTRACTOR's employees:

3.1.3.1 This policy must provide statutory coverage for Workers' Compensation.

3.1.3.2 This policy must also provide coverage for $1,000,000 Employers' Liability for each employee, each accident, and in the general aggregate.

3.1.4 Professional Liability insurance covering the CONTRACTOR's professional errors and omissions with the following minimum limits of insurance:

3.1.4.1 Per occurrence: $1,000,000

3.1.4.2 General aggregate: $2,000,000

3.1.5 Commercial crime policy covering employee theft and dishonesty, forgery and alteration, money orders and counterfeit currency, credit card fraud, wire transfer fraud, and theft of client property, with the following minimum limits of $1,000,000 per occurrence:

3.1.5.1 Cyber and Privacy Liability insurance with the following minimum limits of insurance covering claims involving privacy violations, information theft, damage to or destruction of electronic information, intentional and/or unintentional release of private information, alteration of electronic information, extortion and network security. Such coverage is required only if any products and/or services related to information technology (including hardware and/or software) are provided to Insured and for claims involving any professional

services for which CONTRACTOR is engaged with Insured for such length of time as necessary to cover any and all claims.

a) Privacy and Network Liability: $1,000,000

b) Internet Media Liability: $1,000,000

c) Business Interruption & Expense: $1,000,000

d) Data Extortion: $1,000,000

e) Regulatory Proceeding: $1,000,000

f) Data Breach Notification & Credit Monitoring: $1,000,000

3.2 Prior to commencement of any work hereunder, CONTRACTOR shall furnish to CalOptima's Purchasing Department additional insured endorsements and also broker-issued Certificate(s) of Insurance showing the required insurance coverages for CONTRACTOR, and further providing that:

Certificate Requirements:

3.2.1 CalOptima's officers, officials, directors, employees, agents, and volunteers are to be covered as additional insureds with respect to liability arising out of work or operations performed by or on behalf of CONTRACTOR including materials, parts, or equipment furnished in connection with such work or operations. This provision applies to CONTRACTOR's General Liability and Auto Liability policies and must be on ISO form CG 20 10 or equivalent.

3.2.2 For any claims related to this Contract, the CONTRACTOR's insurance coverage shall be primary insurance as respects to CalOptima, its officers, officials, directors, employees, agents, and volunteers. This provision applies to the CONTRACTOR's General Liability, Auto Liability and Workers' Compensation and Employers' Liability policies.

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

3.2.4 Insurance is to be placed with insurers with a current A.M. Best rating of no less than A-VII, unless otherwise acceptable to CalOptima.

3.2.5 CONTRACTOR shall furnish CalOptima with original certificates and amendatory endorsements affecting coverage required by this section. All certificates and endorsements are to be received and approved by CalOptima before work commences. CalOptima reserves the right to require complete, certified copies of all required insurance policies, including endorsements affecting the coverage required by these specifications, at any time.

3.2.6 Any deductibles or self-insured retentions must be declared to and approved by CalOptima. CalOptima may require the CONTRACTOR to purchase coverage with a lower deductible or retention or provide proof of ability to pay losses and related

investigations, claim administration, and defense expenses within the retention or deductible.

3.2.7 All deductibles and retentions that the aforementioned policies contain are the responsibility of the CONTRACTOR and in no way shall CalOptima be responsible for payment of the deductibles/retentions.

3.2.8 If CONTRACTOR maintains higher limits than the minimums required above, CalOptima requires and shall be entitled to coverage for the higher limits maintained by CONTRACTOR. Any available insurance proceeds in excess of the specified minimum limits of insurance and coverage shall be available to CalOptima.

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

3.3 If CONTRACTOR fails or refuses to maintain or produce proof of the insurance required by this Section 3, CalOptima shall have the right, at its election, to terminate forthwith this Contract. Such termination shall not affect CONTRACTOR'S right to be paid for its time and materials expended prior to notification of termination. CONTRACTOR waives the right to receive compensation and agrees to indemnify CalOptima for any work performed prior to approval of insurance by CalOptima

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

3.5 CONTRACTOR shall require each of its subcontractors who perform services related to this Contract, if any, to maintain insurance coverage that meets all of the requirements set forth herein.

3.6 "Occurrence," as used herein, means any event or related exposure to conditions that result in bodily injury or property damage.

4. Indemnification.

4.1 To the fullest extent permitted by law, CONTRACTOR agrees to and shall save, defend, indemnify, and hold harmless CalOptima and its respective officers, directors, agents, volunteers, consultants and employees (individually and collectively referred to as "Indemnified Parties") from and against any liability whatsoever, based or asserted upon any services of the CONTRACTOR, its officers, employees, subcontractors, agents, or representatives (individually and collectively referred to as "Indemnitors") arising out of or in any way relating to this Contract, including but not limited to property damage, bodily injury, or death or any other element of any kind or nature whatsoever arising from the performance of Indemnitors under this Contract. CONTRACTOR shall defend the Indemnified Parties in any claim or action based upon any such alleged acts or omissions, at its sole expense, which shall include all costs and fees, including, but not limited to, attorneys' fees, cost of investigation, defense, and settlement or awards. CalOptima may make all reasonable decisions with respect to its representation in any legal proceeding.

4.2 CONTRACTOR's obligation to indemnify hereunder is in addition to any liability CONTRACTOR may have to CalOptima for a breach by CONTRACTOR of any of the provisions of this Contract. Under no circumstances shall the insurance requirements and limits set forth in this Contract be construed to limit CONTRACTOR's indemnification and duty to defend obligation or other liability hereunder. The terms of this Contract are contractual and the result of negotiation between the Parties hereto. Accordingly, any rule of construction of contracts (including, without limitation, California Civil Code Section 1654) that ambiguities are to be construed against the drafting party, shall not be employed in the interpretation of this Contract.

4.3 CONTRACTOR's duty to defend herein is wholly independent of and separate from the duty to indemnify and such duty to defend shall exist regardless of any ultimate liability of CONTRACTOR, save and except Claims arising through the sole negligence or sole willful misconduct of CalOptima.

4.4 It is expressly understood and agreed that the foregoing provisions are intended to be as broad and inclusive as permitted by the law of the State of California and that CONTRACTOR's indemnification and duty to defend obligation hereunder shall survive the expiration or earlier termination of this Contract until such time as action against the Indemnified Parties for such matter indemnified hereunder is fully and finally barred by the applicable statute of limitations, including, but not limited to, those set forth under the California Government Claims Act (Cal. Gov. Code §900 et seq.).

4.5 The terms of this Section shall survive the termination of this Contract.

5. Independent Contractor. CalOptima and CONTRACTOR agree that CONTRACTOR, which term shall include any and all subcontractors, and any agents or employees of the CONTRACTOR, in performance of this Contract, shall act in an independent capacity, and not as officers or employees of CalOptima. CONTRACTOR's relationship with CalOptima in the performance of this Contract is that of an independent contractor. CONTRACTOR's personnel performing services under this Contract shall be at all times under CONTRACTOR's exclusive direction and control and shall be employees of CONTRACTOR and not employees of CalOptima. CONTRACTOR shall pay all wages, salaries and other amounts due its employees in connection with this Contract and shall be responsible for all reports and obligations respecting them, such as social security, income tax withholding, unemployment compensation, workers' compensation, and similar matters. At CONTRACTOR's expense as described herein, CONTRACTOR agrees to defend, indemnify, and hold harmless CalOptima, its officers, agents, employees, members, subsidiaries, joint venture partners, and predecessors and successors in interest from and against any claim, action, proceeding, liability, loss, damage, cost, or expense, including, without limitation, attorneys' fees as provided herein arising out of CONTRACTOR's alleged failure to pay, when due, all such taxes and obligations (collectively referred to for purposes of this paragraph as "Employment Claim(s)"). CONTRACTOR shall pay to CalOptima any expenses or charges relating to or arising from any such Employment Claim(s) as they are incurred by CalOptima.

6. Assignments; Subcontracts.

6.1 Except as specifically permitted hereunder, CONTRACTOR may not assign, transfer, delegate or subcontract any interest herein, either in whole or in part, without the prior written consent of CalOptima, which consent may be withheld in its sole and absolute discretion. In the event CalOptima provides such prior written consent, CONTRACTOR acknowledges and agrees that such assignment, transfer, delegation, or subcontract may additionally be subject to the prior written approval of DHCS. Any assignment, transfer, delegation, or subcontract made without CalOptima's express written consent shall be deemed void.

6.2 For purposes of this Section and this Contract, assignment is: (1) the change of more than twenty-five percent (25%) of the ownership or equity interest in CONTRACTOR (whether in a single transaction or in a series of transactions); (2) the change of more than twenty-five percent (25%) of the directors or trustees of CONTRACTOR (whether in a single transaction or in a series of transactions); (3) the merger, reorganization, or consolidation of CONTRACTOR with another entity with respect to which CONTRACTOR is not the surviving entity; and/or (4) a change in the management of CONTRACTOR from management by persons appointed, elected or otherwise selected by the governing body of CONTRACTOR (e.g. the Board of Directors) to a third-party management person, company, group, team or other entity.

6.3 In the event that CONTRACTOR is allowed to subcontract for services under this Contract, and does so subcontract, then CONTRACTOR shall, upon request, provide copies of such subcontracts to CalOptima or DHCS.

7. Non-Exclusive Relationship. It is understood by the parties that this is a non-exclusive relationship between CalOptima and CONTRACTOR. CalOptima shall have the right to have any of the services that are the subject of this Contract performed by CalOptima personnel or enter into contractual arrangements with one or more contractors who can provide CalOptima with similar or like services.

8. Compliance with Applicable Law and Policies. CONTRACTOR warrants that, in the performance of this Contract, it shall, at its own expense, observe and comply with all applicable federal, state, and local laws, and CalOptima policies relating to services under the Contract that are in effect when this Contract is signed, or which may come into effect during the term of this Contract.

9. Nondiscrimination Clause Compliance.

9.1 During the performance of this Contract, CONTRACTOR and its subcontractor(s) shall not unlawfully discriminate, harass, or allow harassment, against any employee or applicant for employment because of sex, race, color, ancestry, religious creed, national origin, physical disability, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), mental disability, medical condition (including cancer), age (over 40), marital status, and the use of family and medical care leave and pregnancy disability leave. CONTRACTOR and subcontractor(s) shall ensure that the evaluation and treatment of their employees and applicants for employment are free from discrimination and harassment. CONTRACTOR and subcontractor(s) shall comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900 et seq. and the applicable regulations promulgated thereunder Title 2, CCR, Section 7285.0 et seq.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code, Section 12990 (a-f), set forth in Chapter 5 of Division 4, Title 2, CCR are incorporated into this Contract by reference and made a part hereof as if set forth in full. CONTRACTOR and its subcontractor(s) shall give notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement. CONTRACTOR shall also fully comply with the following, to the extent applicable to the services provided by CONTRACTOR under this Contract: Title VI of the Civil Rights Act of 1964, 42 USC Section 2000d (race, color, national origin); Section 504 of the Rehabilitation Act of 1973 (29 USC §794) (nondiscrimination under Federal grants and programs); Title 45 CFR Part 84 (nondiscrimination on the basis of handicap in programs or activities receiving Federal financial assistance); Title 28 CFR Part 36 (nondiscrimination on the basis of disability by public accommodations and in commercial facilities); Title IX of the Education Amendments of 1973 (regarding education programs and activities); Title 45 CFR Part 91 and the Age Discrimination Act of 1975 (nondiscrimination based on age); as well as California Government Code Section 11135 (ethnic group identification, religion, age, sex, color, physical or mental handicap); California Civil Code Section 51 (all types of arbitrary discrimination); and all rules and regulations promulgated pursuant thereto.

9.2 CONTRACTOR shall include the nondiscrimination and compliance provisions of Section 9 in all subcontracts under this Contract.

10. Prohibited Interest.

10.1 CONTRACTOR shall comply with all applicable federal, state, and local laws and regulations pertaining to conflict-of-interest laws, including but not limited to CalOptima's Conflict of Interest Code, the California Political Reform Act (Government Code Section 81000 et seq.) and Government Code Section 1090 et seq. (collectively, the "Conflict of Interest Laws").

10.2 CONTRACTOR covenants that, for the term of the Contract, no director, officer, or employee of CalOptima during his tenure has any interest, direct or indirect, in this Contract or the proceeds thereof. CONTRACTOR further covenants that, for the term of this Contract, and consistent with the provisions of Title 22 California Code of Regulations (CCR) Section 53600(f), no state officer or state employee shall be employed in a management or contractor position by CONTRACTOR within one year after the state office or state employee has terminated state employment.

10.3 No employee, officer or agent of CalOptima shall participate in the selection, award or administration of an agreement, or in any decision that may have foreseeable impact on CONTRACTOR if a conflict of interest, real or implied, exists. Such a conflict arises when any of the following has a financial or other interest in the firm selected for award:

10.3.1 A CalOptima employee, officer or agent;

10.3.2 Any member of the employee, officer or agent's immediate family;

10.3.3 The employee, officer or agent's domestic or business partner; or

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

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

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

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

11.1 All officers and owners who own greater than 5% of the CONTRACTOR; and

11.2 All stockholders owning greater than 5% of any stock issued by CONTRACTOR.

11.3 All creditors of CONTRACTOR's business if such interest is over 5%.

12. Equal Opportunity.

12.1 CONTRACTOR and its subcontractors will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. CONTRACTOR and its subcontractors will take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Such action shall include, but not be limited to the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. CONTRACTOR and its subcontractors agree

to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the Federal Government or Department of Health Care Services ("DHCS"), setting forth the provisions of the Equal Opportunity clause, Section 503 of the Rehabilitation Act of 1973, and the affirmative action clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212). Such notices shall state CONTRACTOR and its subcontractors' obligation under the law to take affirmative action to employ and advance in employment qualified applicants without discrimination based on their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era and the rights of applicants and employees.

12.2 CONTRACTOR and its subcontractors will, in all solicitations or advancements for employees placed by or on behalf of CONTRACTOR and its subcontractors, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era.

12.3 CONTRACTOR and its subcontractors will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the Federal Government or the State, advising the labor union or workers' representative of CONTRACTOR and its subcontractors' commitments under the provisions herein and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

12.4 CONTRACTOR and its subcontractors will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212) and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and of the rules, regulations, and relevant orders of the Secretary of Labor.

12.5 CONTRACTOR and its subcontractors will furnish all information and reports required by Federal Executive Order No. 11246, as amended, including by Executive Order 11375, "Amending Executive Order No. 11246, Relating to Equal Employment Opportunity," and as supplemented by regulation at 41 CFR part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and the Rehabilitation Act of 1973, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to its books, records, and accounts by the State and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

12.6 In the event of CONTRACTOR and its subcontractors' noncompliance with the requirements of the provisions herein or with any federal rules, regulations, or orders which are referenced herein, this Contract may be cancelled, terminated, or suspended in whole or in part, and CONTRACTOR and its subcontractors may be declared ineligible for further federal and state contracts, in accordance with procedures authorized in Federal Executive Order No. 11246, as amended, and such other sanctions may be imposed and remedies invoked as provided in Federal Executive Order No. 11246 as amended, including by Executive Order 11375, "Amending Executive Order No. 11246 Relating to Equal Employment Opportunity," and as supplemented by regulation at 41 CFR part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

12.7 CONTRACTOR and its subcontractors will include the provisions of this section in every subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor, issued pursuant to Federal Executive Order No. 11246, as amended, including by Executive Order 11375, "Amending Executive Order No. 11246 Relating to Equal Employment Opportunity," and as supplemented by regulation at 41 CFR part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or Section 503 of the Rehabilitation Act of 1973 or (38 U.S.C. 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each subcontractor or CONTRACTOR. CONTRACTOR and its subcontractors will take such action with respect to any subcontract or purchase order as the Director of the Office of Federal Contract Compliance Programs or DHCS may direct as a means of enforcing such provisions, including sanctions for noncompliance; provided, however, that in the event CONTRACTOR and its subcontractors become involved in, or are threatened with litigation by a subcontractor or contractor as a result of such direction by DHCS, CONTRACTOR and its subcontractors may request in writing to DHCS, who, in turn, may request the United States to enter into such litigation to protect the interests of the State and of the United States.

13. Standard of Performance; Warranties.

13.1 CONTRACTOR agrees to perform all work under this Contract with the requisite skill and diligence consistent with professional standards for the industry and type of work performed under this Contract, and pursuant to the governing rules and regulations of the industry.

13.2 In the event that CONTRACTOR is allowed to subcontract for services under this Contract, and does so subcontract, then CONTRACTOR represents and warrants that any individual or entity acting as a subcontractor to this Contract has the appropriate skill and expertise to perform the subcontracted work.

13.3 CONTRACTOR expressly warrants that all material and work will conform to applicable specifications, drawings, description and samples, including, without limitation, CalOptima's designs, drawings, and specifications, and will be merchantable, of good workmanship and material, and free from defect. CONTRACTOR further warrants that all material covered by this Contract, if any, which is the product of CONTRACTOR will be new and unused unless otherwise specified and shall be fit and sufficient for the purpose intended by CalOptima, as disclosed to CONTRACTOR, CONTRACTOR shall promptly make whatever adjustments or corrections that may be necessary to cure any defects, including repairs of any damage to other parts of the system resulting from such defects. CalOptima shall give notice to CONTRACTOR of any observed defects. In the event that CONTRACTOR fails to make adjustments, repairs, corrections, or other work made necessary by such defects, CalOptima may do so and charge CONTRACTOR the costs incurred.

13.4 CONTRACTOR's warranties, together with its service guarantees, must run to CalOptima and its customers or users of the material and services, and must not be deemed exclusive. CalOptima's inspection, approval, acceptance, use of and payment for all or any part of the material and services must in no way affect its warranty rights whether or not a breach of warranty had become evident in time.

13.5 CONTRACTOR's obligations under this Section are in addition to CONTRACTOR's other express or implied warranties and other obligations under this Contract or state law, and in no way diminish any other rights that CalOptima may have against CONTRACTOR for faulty materials, equipment or work. CalOptima rejects any disclaimer by CONTRACTOR of any warranty, standard, implied or express, unless specifically agreed to in writing by both parties.

13.6 Any CalOptima property damaged by CONTRACTOR, its subcontractor(s), or by the personnel of either, will be subject to repair or replacement by CONTRACTOR at no cost to CalOptima.

14. Compensation.

14.1 Payment.

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

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

14.1.3 CONTRACTOR's requests for payments and reimbursements must comply with the requirements set forth in Exhibit B. CalOptima will not make payment for work that fails to meet the standards of performance as set forth in the Contract and Exhibit A, Scope of Work that may be reasonably expected by CalOptima. **CALOPTIMA SHALL NOT PAY ANY FEES, EXPENSES OR COSTS WHATSOEVER INCURRED BY CONTRACTOR IN RENDERING ADDITIONAL SERVICES NOT AUTHORIZED IN WRITING UNDER THIS CONTRACT.**

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

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

14.2 Contractor Travel Policy. CONTRACTOR is not entitled to any reimbursement for travel, meals, accommodations, or other similar expenses under this Contract.

15. Term. This Contract shall commence on June 03, 2022 and shall continue in full force and effect through June 02, 2023, unless earlier terminated as provided in this Contract.

16. Termination.

16.1 Termination without Cause. CalOptima may terminate this Contract at any time, in whole or in part, for its convenience and without cause, by giving CONTRACTOR thirty (30) days written notice hereof. Upon termination, CalOptima may pay CONTRACTOR its allowable cost incurred for services satisfactorily performed and accepted by CalOptima as of the date of termination. Thereafter, CONTRACTOR shall have no further claims against CalOptima under this Contract.

16.2 Termination for Unavailability of Funds. In recognition that CalOptima is a governmental entity, and its operations and budgets are determined on an annual basis, CalOptima shall have the right to terminate this Contract as follows:

16.2.1 CalOptima may terminate this Contract if it does not receive funding from the State of California or the federal government, as applicable, for any fiscal year.

16.2.2 In the event of Termination for Unavailability of Funds, as provided in this Section, CalOptima agrees to promptly pay CONTRACTOR all fees and other charges due and payable for services satisfactorily performed and accepted by CalOptima as of the termination date. CONTRACTOR shall not be entitled to payment for any other items, including, without limitation, lost or anticipated profit on work not performed, administrative costs, attorneys' fees, or consultants' fees.

16.2.3 In the event of Termination for Unavailability of Funds, as provided in this Section, and funds are received by CalOptima from the State of California within one-hundred twenty (120) days of the date of termination, then CalOptima shall promptly notify CONTRACTOR in writing and CalOptima shall have the right to reinstate this Contract for that period for which funds are received by CalOptima or the unexpired term of this Contract as of the date of termination, whichever period is shorter in duration. Notwithstanding the foregoing, CalOptima may only reinstate this Contract two (2) times during the Term of this Contract.

16.3 Termination for Default. Subject to a ten (10) day cure period, CalOptima may terminate this Contract for CONTRACTOR's default, or if a federal or state proceeding for the relief of debtors is undertaken by or against CONTRACTOR, or if CONTRACTOR makes an assignment for the benefit of creditors as defined in Section 6, or if CONTRACTOR breaches any term(s) or violates any provision(s) of this Contract and does not cure such breach or violation within ten (10) days after written notice thereof by CalOptima. In the event of Termination for Default, as provided by this Section, CONTRACTOR shall be liable for any and all reasonable costs incurred by CalOptima as a result of such default, including, but not limited to, reprocurement costs of the same or similar services defaulted by CONTRACTOR under this Contract.

16.4 Notwithstanding the foregoing, CalOptima may terminate this Contract immediately upon CONTRACTOR's breach of Section 3, (Insurance), Section 10, (Prohibited Interest), or Section 24, (Confidentiality).

16.5 Effect of Termination. Upon expiration or receipt of a termination notice under this Section:

16.5.1 CONTRACTOR shall promptly discontinue all services (unless the notice directs otherwise) and deliver or otherwise make available to CALOPTIMA all documents, reports, software programs and any other products, data and such other materials, equipment, and information, including but not limited to confidential information, or equipment provided by CalOptima, as may have been accumulated by CONTRACTOR in performing this Contract, whether completed or in process. If CONTRACTOR personnel were granted access to CalOptima's premises and issued a badge or access card, such badge or access card shall be returned prior to departure. Failure to return any

information or equipment, badge or access card, is considered a material breach of this Contract and CalOptima's privacy and security rules.

16.5.2 CalOptima may take over the services and may award another party a contract to complete the services under this Contract.

16.5.3 CalOptima may withhold from payment any sum that it determines to be owed to CalOptima by CONTRACTOR, or as necessary to protect CalOptima against loss due to outstanding liens or claims of former lien holders.

17. Modifications. CalOptima reserves the right to modify the Contract at any time should such modification be required by CMS or applicable law or regulation. Modifications shall be executed only by a written amendment to the Contract, signed by CalOptima and CONTRACTOR. Execution of amendments shall be contingent upon CONTRACTOR's notification to CalOptima, and CalOptima's approval, of any increase or decrease in the price of this Contract or in the time required for its performance.

18. Verification of CalOptima Costs by Government. Until the expiration of ten (10) years after the later of furnishing of any service pursuant to this Contract or completion of any audit, or longer as required by applicable regulations, CONTRACTOR will make available, upon written request of the Secretary of Health and Human Services or the Comptroller General of the United States or any of their duly authorized representatives, or the California Department of Health Care Services, or the California Department of Managed Health Care, or the Department of Justice, or the Bureau of Medical Fraud, copies of this Contract and any financial statements, books, documents, records, patient care documentation, and other records or data of CONTRACTOR that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under this Contract, or as are otherwise necessary to certify the nature and extent of costs incurred by CalOptima for such services. This provision shall also apply to any agreement between a subcontractor and an organization related to the subcontractor by control or common ownership. CONTRACTOR further agrees that regulating entities have the right to inspect, evaluate and audit any pertinent information and to facilitate the review of the items referenced herein, to make available its premises, physical facilities and equipment, records related to Medicare enrollees, and any additional relevant information that regulating entities may require. CONTRACTOR further agrees and acknowledges that this provision will be included in any and all agreements with CONTRACTOR's subcontractors.

19. Confidential Material.

19.1 During the term of this Contract, either Party may have access to confidential material or information ("Confidential Information") belonging to the other Party or the other Party's customers, vendors, or partners. "Confidential Information" shall include without limitation the disclosing Party's computer programs and codes, business plans, customer/member lists and information, financial records, partnership arrangements and licensing plans or other information, materials, records, writings or data that is marked confidential or that due to its character and nature, a reasonable person under like circumstances would treat as confidential. Confidential Information will be used only for the purposes of this Contract and related internal administrative purposes. Each Party agrees to protect the other's Confidential Information at all times and in the same manner as each protects the confidentiality of its own confidential materials, but in no event with less than a reasonable standard of care.

19.2 For the purposes of this Section 19, "Confidential Information" does not include information which: (i) is already known to the other Party at the time of disclosure; (ii) is or becomes publicly known through no wrongful act or failure of the receiving Party; (iii) is independently developed without use or benefit of the other's Confidential Information or proprietary information; (iv) is received from a third party which is not under and does not thereby breach an obligation of confidentiality; or (v) is a public record, not exempt from disclosure pursuant to California Public Records Act, Government Code Section 6250 et seq., applicable provisions of California Welfare

and Institutions Code or other state or federal laws, regardless of whether such information is marked as confidential or proprietary.

19.3 Disclosure of the Confidential Information will be restricted to the receiving Party's employees, consultants, suppliers or agents on a "need to know" basis in connection with the services performed under this Contract, who are bound by confidentiality obligations no less stringent than these prior to any disclosure. The receiving Party may disclose Confidential Information pursuant to legal, judicial, or administrative proceeding or otherwise as required by law; providing that the receiving Party shall give reasonable prior notice, if not prohibited by applicable law, to the disclosing Party and shall assist the disclosing Party, at the disclosing Party's expense, to obtain protective or other appropriate confidentiality orders, and further provided that a required disclosure of Confidential Information or proprietary information to an agency or Court does not relieve the receiving Party of its confidentiality obligations with respect to any other party.

19.4 Except as to the confidentiality of trade secrets, these confidentiality restrictions and obligations will terminate five (5) years after the expiration or termination of the Contract, unless the law requires a longer period. Upon written request of the disclosing Party, the receiving Party shall promptly return to the disclosing Party all documents, notes and other tangible materials representing the disclosing Party's Confidential Information or Proprietary Information and all copies thereof. This obligation to return materials or copies thereof does not extend to automatically generated computer backup or archival copies generated in the ordinary course of the receiving Party's information systems procedures, provided that the receiving Party shall make no further use of such copies.

19.5 For the purposes of this Section only, "Confidential Information" does not include protected health information or individually identifiable information, as defined by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other privacy statutes or regulations. The access use and disclosure of Protected Health Information is referenced below in Section 24, and shall be governed by a Business Associate Protected Health Information Disclosure Agreement, which shall be executed by the parties if CONTRACTOR will create, receive, maintain, use, or transmit Protected Health Information in performing services under this Contract.

20. Record Ownership and Retention.

20.1 The originals of all letters, documents, reports, software programs and any other products and data prepared or generated for the purposes of this Contract shall be delivered to and become the property of CalOptima at no cost to CalOptima and in a form accessible for CalOptima's use. Copies may be made for CONTRACTOR's records but shall not be furnished to others without written authorization from CalOptima. Such deliverables shall become the sole property of CalOptima and all rights in copyright therein shall be retained by CalOptima. CalOptima's ownership of these documents includes use of reproduction or reuse of, and all incidental rights. CONTRACTOR shall provide all deliverables within a reasonable amount of time upon CalOptima's request, but in no event shall such time exceed thirty (30) calendar days unless otherwise specified by CalOptima.

20.2 CONTRACTOR hereby assigns to CalOptima all of its rights in all materials prepared by or on behalf of CalOptima under this Contract ("Works"), and this Contract shall be deemed a transfer to CalOptima of the sole and exclusive copyright of any copyrightable subject matter CONTRACTOR created in these Works. CONTRACTOR agrees to cause its agents and employees to execute any documents necessary to secure or perfect CalOptima's legal rights and worldwide ownership in such materials, including, but not limited to, documents relating to patent, trademark and copyright applications. Upon CalOptima's request, CONTRACTOR will return or transfer all property and materials, including the Works, in CONTRACTOR's possession or control belonging to CalOptima.

20.3 Notwithstanding the foregoing, CONTRACTOR's intellectual property ("CONTRACTOR IP") that preexists this Contract shall remain the sole and exclusive property of CONTRACTOR. CONTRACTOR shall not incorporate any CONTRACTOR IP into the Works that would limit CalOptima's use of the Works without CalOptima's written approval. To the extent that CONTRACTOR incorporates any CONTRACTOR IP into the Works, CONTRACTOR hereby grants to CalOptima a non-exclusive, irrevocable, perpetual, worldwide, royalty-free license to use and reproduce the CONTRACTOR IP to the extent required to fully utilize the Works.

20.4 CONTRACTOR acknowledges and agrees that, notwithstanding any provision herein to the contrary, CalOptima's Intellectual Property ("CalOptima IP") in the information, documents and other materials provided to CONTRACTOR shall remain the sole and exclusive property of CalOptima. Any information, documents or materials provided by CalOptima to CONTRACTOR pursuant to this Contract and all copies thereof (including without limitation CalOptima IP, Proprietary Information and Confidential Information, as these terms are defined in Section 19) shall upon the earlier of CalOptima's request or the expiration or termination of this Contract be returned to CalOptima.

20.5 For purposes of this Section, Intellectual Property shall mean patents, copyrights, trademarks, trade secrets, and other proprietary information.

21. Patent and Copyright Infringement. In lieu of any other warranty by CalOptima or CONTRACTOR against infringement, statutory or otherwise, it is agreed that CONTRACTOR shall indemnify, hold harmless and defend, at its expense, any suit against CalOptima based on a claim that any item furnished under this Contract, or the normal use or sale thereof, infringes on any United States letters patent, patent, trademark, copyright, or other intellectual property right, and shall pay costs and damages finally awarded in any such suit, provided that CONTRACTOR is notified in writing of the suit and given authority, information, and assistance at CONTRACTOR's expense for the defense of the suit. CONTRACTOR, at no expense to CalOptima, shall obtain for CalOptima the right to use and sell said item, or shall substitute an equivalent item acceptable to CalOptima and extend this patent indemnity thereto.

22. Names and Marks. Neither Party shall use the name, logo or other proprietary mark of the other in any press release, advertising, promotional, marketing or similar publicly disseminated material without first submitting such material to the other Party and obtaining the other Party's express written approval of the material and consent to such use.

23. Business Associate Protected Health Information Disclosure Agreement. This Contract does not require or permit CONTRACTOR to create, receive, maintain, use, or transmit Protected Health Information. As such, no Business Associate Agreement is required for this Contract.

24. Confidentiality of Member Information.

24.1 CONTRACTOR and its employees, agents, or subcontractors shall protect from unauthorized disclosure, the names and other identifying information concerning persons either receiving services pursuant to this Contract, or persons whose names or identifying information become available or are disclosed to CONTRACTOR, its employees, agents, or subcontractors as a result of services performed under this Contract, except for statistical information not identifying any such person. CONTRACTOR and its employees, agents, or subcontractors shall not use such identifying information for any purpose other than carrying out CONTRACTOR's obligations under this Contract. CONTRACTOR and its employees, agents, or subcontractors shall promptly transmit to CalOptima all requests for disclosure of such identifying information not emanating from the Member. CONTRACTOR shall not disclose, except as otherwise specifically permitted by this Contract or authorized by the Member, any such identifying information to anyone other than DHCS or CalOptima without prior written authorization from CalOptima. For purposes of this provision, identity shall include, but not be limited to, name, identifying number, symbol, or

other identifying particular assigned to the individual, such as finger or voice print or a photograph.

24.2 Names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted thereunder. For the purpose of this Contract, all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to Members shall be protected by CONTRACTOR from unauthorized disclosure. CONTRACTOR may release Medical Records in accordance with applicable law pertaining to the release of this type of information. CONTRACTOR is not required to report requests for Medical Records made in accordance with applicable law. With respect to any identifiable information concerning a Member under this Contract that is obtained by CONTRACTOR or its subcontractors, CONTRACTOR:

24.2.1 Will not use any such information for any purpose other than carrying out the express terms of this Contract;

24.2.2 Will promptly transmit to CalOptima all requests for disclosure of such information, except requests for Medical Records in accordance with applicable law;

24.2.3 Will not disclose, except as otherwise specifically permitted by this Contract, any such information to any party other than DHCS or CalOptima without CalOptima's prior written authorization specifying that the information is releasable under Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted there under; and

24.2.4 Will, at the termination of this Contract, return all such information to CalOptima or maintain such information according to written procedures sent to the CONTRACTOR by CalOptima for this purpose.

24.3 CONTRACTOR agrees to complete a CalOptima Medi-Cal Data Access Agreement, which is attached hereto as Exhibit D and incorporated herein by this reference. All materials covered under this Medi-Cal Data Access Agreement shall be designated confidential, to the extent permitted by California law.

25. Medicare Advantage Program. Medicare Advantage Program requirements are not applicable under this Contract.

26. Time is of the Essence. Time is of the essence in performance of this Contract.

27. CalOptima Designee. The Chief Executive Officer of CalOptima, or his designee, shall have the authority to act for and exercise any of the rights of CalOptima, as set forth in this Contract, subsequent to and in accordance with the authority granted by the Board of Directors.

28. Omissions. In the event that either party hereto discovers any material omission in the provisions of this Contract which such party believes is essential to the successful performance of this Contract, the party may so inform the other party in writing, and the parties hereto shall thereafter promptly negotiate in good faith with respect to such matters for the purpose of making such reasonable adjustments, as may be necessary to perform the objectives of this Contract.

29. Choice of Law. This Contract shall be governed by and construed in accordance with all laws of the State of California. In the event any party institutes legal proceedings to enforce or interpret this Contract, venue and jurisdiction shall be in the County of Orange, California.

30. Force Majeure. When satisfactory evidence of a cause beyond a party's control is presented to the other party, and nonperformance is unforeseeable, beyond the control, and not due to the fault of the party not performing, a party shall be excused from performing its obligations under this Contract during the time and to the extent that it is prevented from performing by such cause, including, but not limited to, any incidence of fire, flood, acts of God, commandeering of material, products, plants or facilities by the federal, state or local government, or a material act or omission by the other party.

31. Notices. All notices required or permitted under this Contract and all communications regarding the interpretation of the terms of this Contract, or changes thereto, shall be in writing and shall be sent by registered or certified mail, postage prepaid, return receipt requested, or by any other overnight delivery service which delivers to the noticed destination and provides proof of delivery to the sender. All notices shall be effective when first received at the following addresses set forth below. Any party whose address changes shall notify the other party in writing.

To CONTRACTOR:	To CalOptima:
Whittingham Public Affairs Advisors	CalOptima
31441 Santa Margarita Parkway, Suite A181	505 City Parkway West
Rancho Santa Margarita, CA 92688	Orange, CA 92868
Attn: Peter Whittingham	Attention: Ryan Prest

32. Notice of Labor Disputes. Whenever CONTRACTOR has knowledge that any actual or potential labor dispute may delay this Contract, CONTRACTOR shall immediately notify and submit all relevant information to CalOptima. CONTRACTOR shall insert the substance of this entire clause in any subcontract hereunder as to which a labor dispute may delay this Contract.

33. Unavoidable Delays.

33.1 If the delivery of services under this Contract should be unavoidably delayed, CalOptima's Purchasing Department shall extend the time for completion of the Contract for the determined number of days of excusable delay. A delay is unavoidable only if the delay was not reasonably expected to occur in connection with, or during CONTRACTOR's performance, and was not caused directly or substantially by acts, omissions, negligence, or mistakes of CONTRACTOR, CONTRACTOR's subcontractors, or their agents, and was substantial and in fact caused CONTRACTOR to miss delivery dates and could not adequately have been guarded against by contractual or legal means. Delays caused by CalOptima will be sufficient justification for delay of services, and CONTRACTOR shall be allowed a day-for-day extension.

33.2 CONTRACTOR shall notify CalOptima's Purchasing Department as soon as CONTRACTOR has, or should have, knowledge that an event has occurred that will delay deliveries. Within five (5) working days, CONTRACTOR shall confirm such notice in writing, furnishing as much detail as is available.

33.3 CONTRACTOR agrees to supply, as soon as such data is available, any reasonable proof that is required by CalOptima's Purchasing Department to make a decision on any request for extension. CalOptima's Purchasing Department shall examine the request and any documents supplied by CONTRACTOR and shall determine if CONTRACTOR is entitled to an extension and the duration of such extension. CalOptima's Purchasing Department shall notify CONTRACTOR of this decision in writing. It is expressly understood and agreed that CONTRACTOR shall not be entitled to damages or compensation and shall not be reimbursed for losses on account of delays resulting from any cause under this provision.

34. No Liability of County of Orange. As required under Ordinance No. 3896 of the County of Orange, State of California, as amended, the parties hereto acknowledge and agree that the obligations of CalOptima

under this Contract are solely the obligations of CalOptima, and the County of Orange, State of California, shall have no obligation or liability therefor.

35. Attorneys' Fees. Should either party to this Contract institute any action or proceeding to enforce or interpret this Contract or any provision hereof, or for damages by reason of any alleged breach of this Contract, otherwise arising under this Contract, or for a declaration of rights hereunder, the prevailing party in any such action or proceeding shall be entitled to receive from the other party all costs and expenses, including, without limitation, reasonable attorneys' fees incurred by the prevailing party in such action or proceeding.

36. Entire Agreement. This Contract, including all exhibits and documents incorporated by reference and all Contract Documents referenced in Section 1 herein, contains the entire agreement between CONTRACTOR and CalOptima with respect to the subject matter of this Contract, and it supersedes all prior written or oral and all or contemporaneous oral agreements, representations, understandings, discussions, negotiations and commitments between CONTRACTOR and CalOptima, whether express or implied, with respect to the subject matter of this Contract.

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

38. Waiver. No delay or failure by either party hereto to exercise any right or power accruing upon noncompliance or default by the other party with respect to any of the terms of this Contract shall impair such right or power or be construed to be a waiver thereof. A waiver by either of the parties hereto of a breach of any of the covenants, conditions or agreements to be performed by the other shall not be construed to be a waiver of any succeeding breach thereof, or of any other covenant, condition, or agreement herein contained. Any information delivered, exchanged, or otherwise provided hereunder shall be delivered, exchanged or otherwise provided in a manner that does not constitute a waiver of immunity or privilege under applicable law.

39. California Public Records Act. As a local public agency, CalOptima is subject to the California Public Records Act (California Government Code Sections 6250 et seq.) (the "Public Records Act"). CONTRACTOR hereby acknowledges that any materials, documents, data, or similar items are subject to disclosure upon public request, unless they are exempt from disclosure under the provisions of the Public Records Act. CalOptima may be required to reveal certain information believed to be proprietary or confidential by CONTRACTOR pursuant to the Public Records Act. In the event that CONTRACTOR discloses information that it believes to be proprietary or confidential to CalOptima, it shall mark such information as "Confidential," "Proprietary," or "Restricted" or other similar marking. Unless CONTRACTOR marks its materials as "Confidential," "Proprietary," or "Restricted," and also notifies CalOptima in writing that CONTRACTOR has so marked each piece of material, then CalOptima will not be responsible to take any actions to protect any CONTRACTOR's materials under the Public Records Act that are not so marked. In the event CalOptima receives a request under the Public Records Act that potentially encompasses CONTRACTOR materials that have been properly marked, CalOptima will provide CONTRACTOR with notice thereof to allow CONTRACTOR to take actions it deems appropriate to prevent disclosure of the marked material. CONTRACTOR agrees to defend, indemnify, and hold harmless CalOptima, its officers, agents, employees, members, subsidiaries, joint venture partners, and predecessors and successors in interest from and against any claim, action, proceeding, liability, loss, damage, cost, or expense, including, without limitation, attorneys' fees, and any costs awarded to the person or entity that sought the CONTRACTOR marked material, arising out of or related to CalOptima's failure to produce or provide the CONTRACTOR marked material (collectively referred to for purposes of this Section as "Public Records Act Claim(s)"). CONTRACTOR shall pay to CalOptima any expenses or charges relating to or arising from any such Public Record Act Claim(s) as they are incurred by CalOptima.

40. Audit Disclosure. Pursuant to California Government Code Section 8546.7, if this Contract is over ten thousand dollars ($10,000), it is subject to examination and audit of the State Auditor, at the request of CalOptima, or as part of any audit of CalOptima, for a period of three (3) years after final payment under

this Contract. In addition to and notwithstanding any other right of access or inspection that may be otherwise set forth in this Contract or its attachments, CONTRACTOR agrees that, during the term of this Contract and for a period of three (3) years after its termination, CalOptima shall have access to and the right to examine any directly pertinent books, documents, invoices, and records of CONTRACTOR relating to services provided under this Contract. Where another right of access or inspection in this Contract provides for a period of greater than three (3) years, nothing herein shall be construed to shorten that time period.

41. Debarment and Suspension Certification.

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

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

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

41.2.2 Have not within a three-year period preceding this Contract been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

41.2.3 Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in Paragraph 41.2.2 herein;

41.2.4 Have not within a three-year period preceding this Contract had one or more public transactions (Federal, State or local) terminated for cause or default;

41.2.5 Have not and shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under Federal regulations (i.e., 48 CFR 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State; and

41.2.6 Will include a clause entitled, "Debarment and Suspension Certification'' that essentially sets forth the provisions herein, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

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

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

41.5 If the CONTRACTOR knowingly violates this certification, in addition to other remedies available to the Federal Government, CalOptima may terminate this Contract for cause or default.

42. Survival. The following provisions of this Contract shall survive termination or expiration of this Contract: Prohibited Interest, Warranties, Compensation, Confidentiality, Indemnification, Duty to Defend, Ownership of Records and Documents, Record Retention, Audit Disclosure, California Public Records Act, Patent and Copyright Infringement, Governing Law, and this Section.

43. Severability. If any section, subsection or provision of this Contract, or any Contract Documents incorporated into this Contract, or the application of such section, subsection or provision, is held invalid or unenforceable by any court of competent jurisdiction, the remainder of this Contract, other than that to which it is held invalid, shall not be affected thereby.

44. Third Party Beneficiaries. There are no intended third-party beneficiaries of this Contract. Nothing in this Contract shall be construed as conferring any rights on any other persons.

45. Successors and Assigns. Except as otherwise expressly provided in this Contract, this Contract will be binding on, and will inure to the benefit of, the successors and permitted assigns of the Parties to this Contract. Nothing in this Contract is intended to confer upon any Party other than the Parties hereto or their respective successors and permitted assigns any rights or obligations under or by reason of this Contract, except as expressly provided in this Contract.

46. Authority to Execute. The persons executing this Contract on behalf of the Parties warrant that they are duly authorized to execute this Contract and that by executing this Contract the Parties are formally bound.

47. Counterparts. This Contract may be executed and delivered in one or more counterparts, each of which shall be deemed an original, but all of which together will constitute one and the same instrument.

[Remainder of page left intentionally blank. Signatures on following page]

IN WITNESS WHEREOF, these Parties have, by their duly authorized representatives, executed this Contract No. 22-10953 on the day and year last shown below, retroactively agreeing that this Contract is effective as of June 03, 2022.

Whittingham Public Affairs Advisors	CalOptima
By: [signature]	By: DocuSigned by: Nancy Huang D22E3B87032946F...
Print Name: Peter Whittingham	Print Name: Nancy Huang
Title: CEO	Title: CFO, CalOptima
Date: June 21, 2022	Date: 06/23/2022
By:	By:
Print Name:	Print Name:
Title:	Title:
Date:	Date:

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

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Exhibit A

SCOPE OF WORK

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

Services of Consultant
CONTRACTOR agrees to provide to CalOptima, as requested by CalOptima, the following advice and consulting services:

- Representing CalOptima's interests related to CalOptima's project in the City of Tustin, California (Tustin), through government affairs, strategic guidance, public relations and community outreach and engagement.
- Regularly consulting with CalOptima's leadership on CalOptima's program goals, and provide strategic and tactical recommendations at its request, as well as strategic planning and political analysis.

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

Deliverables

- Provide a written monthly report that describes the nature and extent of the services or actions taken on behalf of CalOptima. The services or actions shall include a summary of the meetings CONTRACTOR had along with the issues discussed.

Exhibit B

PAYMENT

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

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

C. CONTRACTOR shall submit to CalOptima, to the attention of Accounts Payable, accountspayable@caloptima.org, an invoice at the conclusion of every month for the Services performed during the prior thirty (30) days. Each invoice shall cite Contract No. 22-10953; specify the number of hours worked; the specific dates the hours were worked; the description of work performed; the time period covered by the invoice and the amount of payment requested; and be accompanied by a progress report. CalOptima shall remit payment within thirty (30) days of receipt and approval of each invoice.

D. Notwithstanding any provisions of this Contract to the contrary, CalOptima and CONTRACTOR mutually agree that CalOptima's maximum cumulative payment obligation hereunder for work performed and/or products received on Exhibit A of this Contract shall not exceed Seven Thousand Five Hundred Dollars ($7,500.00) per month and Ninety Thousand Dollars ($90,000.00) per year, including all amounts payable to CONTRACTOR for its direct labor and expenses, overhead costs, fixed fee, subcontracts, leases, materials, and costs arising from or due to termination of this Contract. These fees are fixed for the duration of the Contract. CONTRACTOR agrees to extend these fees to CalOptima for a period of one year after Contract termination. CalOptima shall not pay CONTRACTOR for time spent traveling.

Exhibit B-1

Not applicable for this Contract

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Exhibit C

Not applicable for this Contract

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Exhibit D

MEDI-CAL DATA ACCESS AGREEMENT

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

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

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

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

By: _____ Date: JAN 21, 2022

Print Name: PETER WHITTINGHAM

Title: CEO

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Exhibit E

Not applicable for this Contract

Exhibit F

Not applicable for this Contract

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Exhibit G

Not applicable for this Contract

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Exhibit H

Not applicable for this Contract

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Exhibit 1

Officer, Owner, Shareholder, and Creditor Information

Contractor's Business Name: Whittingham Public Affairs Advisors

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

Business Address: 31441 Santa Margarita Parkway, Suite A-181

City: Rancho Santa Margarita State: CA Zip: 92688

Business Phone: (949) 280-9181 Email: : peter@whittinghampaa.com

President: Peter Whittingham Contact Person: Same

Person(s) Signing Contract & Title: : Peter Whittingham

*Please provide names of owners, officers, stockholders, and creditors of Contractor's business if such interest is over 5%.

Name	Officer Title or Ownership/Creditorship %

BY SIGNING BELOW, THE UNDERSIGNED HEREBY CERTIFIES THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF HIS OR HER KNOWLEDGE AND BELIEF.

Authorized Signature — June 21, 2022 Date

Peter Whittingham, CEO
Name and Title

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Exhibit J

Not applicable for this Contract

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Exhibit K

Not applicable for this Contract

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Exhibit L

Not applicable for this Contract

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 4, 2022
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

8. Authorize and Direct Execution of Amendments to CalOptima's Primary Agreement with the California Department of Health Care Services

Contacts

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

Recommended Actions

1. Authorize and direct the Chairman of the Board of Directors to execute an amendment to the Primary Agreement between the California Department of Health Care Services (DHCS) and CalOptima related to the 2022-B contract amendment for calendar year (CY) 2022.
2. Authorize and direct the Chairman of the Board of Directors to execute an amendment to the Primary Agreement between the DHCS and CalOptima related to the 2022-C contract amendment for CY 2022.

Background

As a County Organized Health System (COHS), CalOptima contracts with DHCS to provide health care services to Medi-Cal beneficiaries in Orange County. In December 2016, CalOptima entered into a new four (4)-year agreement with the DHCS for the provision of Medi-Cal services. Amendments to this agreement are summarized in the attached appendix, including Amendment 54, which extends the Primary Agreement to December 31, 2022. The Primary Agreement contains among other terms and conditions, the payment rates CalOptima receives from DHCS to provide health care services.

Discussion

Calendar Year (CY) 2022-B and CY 2022-C Contract Amendment to the Primary Agreement (January 1, 2022 through December 31, 2022)

On March 16, 2022, DHCS provided managed care plans (MCPs) with a draft version of the CY 2022-B contract amendment and notified MCPs that they will submit the amendment to the Centers for Medicare & Medicaid Services (CMS) at the end of September 2022. On May 5, 2022, DHCS provided MCPs with a draft version of the CY 2022-C contract amendment and notified MCPs that they will submit the amendment to the CMS. Both amendments will bring MCP agreements, including CalOptima's, into alignment with requirements effective January 1, 2022.

The amendments contain notable language changes, and it is worth noting that DHCS has generally already implemented the requirements of the CY 2022-B and CY 2022-C amendments by issuing sub-regulatory guidance such as All Plan Letters (APLs). Simultaneously, DHCS has been working with CMS to formalize the requirements in DHCS's agreements with MCPs, including CalOptima. DHCS's implementation of these requirements via sub-regulatory guidance prior to the formal inclusion of the requirements in MCP agreements is largely due to the lengthy CMS review process. While the

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contractual obligations are retroactive, CalOptima staff has implemented the required operational changes and other contractual requirements by following the DHCS APL guidance.

Please note that staff received Board authority during the August 2021 Board of Directors meeting to incorporate various provisions included in the CY 2022-B amendment into CalOptima's Primary Agreement with the DHCS. These provisions include Enhanced Care Management and Community Supports and updated Exhibit G: Health Insurance Portability and Accountability Act (HIPAA) requirements. These previous Board authorities are included as Attachments 4 and 5 with this COBAR.

The amendments do not contain any rate changes or otherwise set any rates. Staff has received finalized CY 2022 rates from the DHCS and received authority to execute that amendment during the March 2022 Board of Directors meeting. To date, DHCS has only shared boilerplate amendments with CalOptima and has noted that certain provisions of the boilerplate will be absent in the MCP-specific amendments that are ultimately provided for signature, as appropriate. If the final amendments are not consistent with staff's understanding as presented in this document, or if it includes substantive and unexpected language changes, staff will return to the Board of Directors for subsequent consideration.

Fiscal Impact
The recommended action to execute CY 2022-B and CY 2022-C contract amendments to the Primary Agreement with DHCS is expected to be budget neutral to CalOptima. Staff projects that estimated Medi-Cal revenue based on CY 2022 rates included the Fiscal Year 2022-23 Operating Budget approved by the Board of Directors on June 2, 2022, will be sufficient to cover anticipated member medical costs.

Rationale for Recommendation
CalOptima's execution of the CY 2022 amendments to its Primary Agreement with DHCS is necessary for the continued operation of CalOptima's Medi-Cal program.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Appendix summary of amendments to Primary Agreements with DHCS
2. 2022-B Final MCP Draft 3.11.22
3. Additional CY 2022-B Contract Amendment Detail
4. COBAR_2022_CalAIM_Aid Codes + ECM ILOS
5. Authorize Execution of Amendments to CalOptima's Primary Agreement with DHCS Related to HIPAA
6. CY 2022-C Draft Amendment for Medi-Cal Managed Care Plan Review.5-4-22
7. Additional CY 2022-C Contract Amendment Detail

/s/ Michael Hunn *07/28/2022*
Authorized Signature **Date**

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APPENDIX TO AGENDA ITEM 8

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

Amendments to Primary Agreement	Board Approval
A-01 provided language changes related to Indian Health Services, home and community-based services, and addition of aid codes effective January 1, 2009.	October 26, 2009
A-02 provided rate changes that reflected implementation of the gross premiums tax authorized by AB 1422 (2009) for the period January 1, 2009, through June 30, 2009.	October 26, 2009
A-03 provided revised capitation rates for the period July 1, 2009, through June 30, 2010; and rate increases to reflect the gross premiums tax authorized by AB 1422 (2009) for the period July 1, 2009, through June 30, 2010.	January 7, 2010
A-04 included the necessary contract language to conform to AB X3 (2009), to eliminate nine (9) Medi-Cal optional benefits.	July 8, 2010
A-05 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, including rate increases to reflect the gross premium tax authorized by AB 1422 (2009), the hospital quality assurance fee (QAF) authorized by AB 1653 (2010), and adjustments for maximum allowable cost pharmacy pricing.	November 4, 2010
A-06 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, for funding for legislatively mandated rate adjustments to Long Term Care facilities effective August 1, 2010; and rate increases to reflect the gross premiums tax on the adjusted revenues for the period July 1, 2010, through June 30, 2011.	September 1, 2011
A-07 included a rate adjustment that reflected the extension of the supplemental funding to hospitals authorized in AB 1653 (2010), as well as an Intergovernmental Transfer (IGT) program for Non-Designated Public Hospitals (NDPHs) and Designated Public Hospitals (DPHs).	November 3, 2011
A-08 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, for funding related to the Intergovernmental Transfer (IGT) Agreement between CalOptima and the University of California, Irvine.	March 3, 2011
A-09 included contract language and supplemental capitation rates related to the addition of the Community Based Adult Services (CBAS) benefit in managed care plans.	June 7, 2012

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A-10 included contract language and capitation rates related to the transition of Healthy Families Program (HFP) subscribers into CalOptima's Medi-Cal program	December 6, 2012
A-11 provided capitation rates related to the transition of HFP subscribers into CalOptima's Medi-Cal program.	April 4, 2013
A-12 provided capitation rates for the period July 1, 2011 to June 30, 2012.	April 4, 2013
A-13 provided capitation rates for the period July 1, 2012 to June 30, 2013	June 6, 2013
A-14 extended the Primary Agreement until December 31, 2014	June 6, 2013
A-15 included contract language related to the mandatory enrollment of seniors and persons with disabilities, requirements related to the Balanced Budget Amendment of 1997 (BBA) and Health Insurance Portability and Accountability Act (HIPAA) Omnibus Rule	October 3, 2013
A-16 provided revised capitation rates for the period July 1, 2012, through June 30, 2013 and revised capitation rates for the period January 1, 2013, through June 30, 2014 for Phases 1, 2 and 3 transition of Healthy Families Program (HFP) children to the Medi-Cal program	November 7, 2013
A-17 included contract language related to implementation of the Affordable Care Act, expansion of Medi-Cal, the integration of the managed care mental health and substance use benefits and revised capitation rates for the period July 1, 2013 through June 30, 2014.	December 5, 2013
A-18 provided revised capitation rates for the period July 1, 2013, through June 30, 2014.	June 5, 2014
A-19 extended the Primary Agreement until December 31, 2015 and included language that incorporates provisions related to **Medicare Improvements for Patients and Providers Act** (MIPPA)-compliant contracts and eligibility criteria for Dual Eligible Special Needs Plans (D-SNPs)	August 7, 2014
A-20 provided revised capitation rates for the period July 1, 2012, through June 30, 2013, for funding related to the Intergovernmental Transfer (IGT) Agreement between CalOptima and the University of California, Irvine and Optional Targeted Low-Income Child Members	September 4, 2014
A-21 provided revised 2013-2014 capitation rates.	November 7, 2013
A-22 revised capitation rates for Fiscal Year (FY) 2013-14 and added an aid code to implement Express Lane/CalFresh Eligibility	November 6, 2014
A-23 revised ACA 1202 rates for January – June 2014, established base capitation rates for FY 2014-2015, added an aid code related to the OTLIC and AIM programs, and contained language revisions related to supplemental payments for coverage of Hepatitis C medications.	December 4, 2014
A-24 revises capitation rates to include SB 239 Hospital Quality Assurance Fees for the period January 1, 2014 to June 30, 2014.	May 7, 2015
A-25 extends the contract term to December 31, 2016. DHCS is obtaining a continuation of the services identified in the original agreement.	May 7, 2015

A-26 adjusts the 2013-2014 Intergovernmental Transfer (IGT) rates.	May 7, 2015
A-27 adjusts 2013-2014 capitation rates for Optional Expansion and SB 239.	May 7, 2015
A-28 incorporates language requirements and supplemental payments for BHT into primary agreement.	October 2, 2014
A-29 added optional expansion rates for January- June 2015; also added updates to MLR language.	April 2, 2015
A-30 incorporates language regarding Provider Preventable Conditions (PPC), determination of rates, and adjustments to 2014-2015 capitation rates with respect to Intergovernmental Transfer (IGT) Rate Range and Hospital Quality Assurance Fee (QAF).	December 1, 2016
A-31 extends the Primary Agreement with DHCS to December 31, 2020.	December 1, 2016
A-32 incorporates base rates for July 2015 to June 2016 with Behavioral Health Treatment (BHT) and Hepatitis–C supplemental payments, and Partial Dual/Medi-Cal only rates, and added aid codes 4U, and 2P–2U as covered aid codes.	February 2, 2017
A-33 incorporates base rates for July 2016 to June 2017.	February 2, 2017
A-34 incorporates revised Adult Optional Expansion rates for January 2015 to June 2015. These rates were revised to include the impact of the Hospital Quality Assurance Fee (HQAF) required by Senate Bill (SB) 239.	June 1, 2017
A–35 incorporates Managed Long–Term Services and Supports (MLTSS) into CalOptima's Primary Agreement with the DHCS.	March 6, 2014 February 2, 2017
A–36 incorporates revised base rates for July 2015 to June 2016.	December 7, 2017
A–37 incorporates revised base rates for July 2016 to June 2017.	February 7, 2019
A–38 incorporates full dual rates for Calendar Year (CY) 2015	August 1, 2019
A–39 incorporates full dual rates for Calendar Year (CY) 2016	August 1, 2019
A-40 incorporates Final Rule contract language.	June 1, 2017 February 6, 2020
A-41 incorporates base rates for July 2017 to June 2018, Transportation, American Indian Health Program, Mental Health Parity, CCI updates and Adult Expansion Risk Corridor language for SFY 2017-18.	December 7, 2017 June 7, 2018 February 6, 2020
A-42 incorporated revised base rates for July 2017 to June 2018, directed payments language and mental health parity documentation requirements.	August 1, 2019
A–43 incorporates revises Hospital Quality Assurance Fee (HQAF) rates for January 1, 2017 to June 30, 2017.	August 1, 2019
A-44 incorporates full dual rates for Calendar Year (CY) 2017.	August 1, 2019
A–45 incorporates the new requirements of the 2018 Final Rule Amendment, Behavioral Health Treatment (BHT) and State Fiscal Year (SFY) 2018 – 19 capitation rates	June 7, 2018 August 1, 2019 August 6, 2020
A-46 incorporates full dual rates for Calendar Year (CY) 2018.	August 1, 2019
A-47 incorporates full dual rates for Calendar Year (CY) 2019.	October 1, 2020

A-48 incorporates new Bridge Period, Health Homes Program (HHP) and Whole Child Model (WCM) language and adds 2019 – 2020 capitation rates	June 7, 2018 October 1, 2020 February 4, 2021
A-49 extends the Primary Agreement with DHCS to December 31, 2021	November 5, 2020
A-50 incorporates full dual rates for Calendar Year (CY) 2020.	February 4, 2021
A-51 incorporates full dual rates for Calendar Year (CY) 2021.	February 4, 2021
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-57 incorporates Calendar Year (CY) 2022 risk mitigation language.	March 3, 2022
A-58 incorporates the COVID Vaccination Incentive Program.	March 3, 2022

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

Amendments to Secondary Agreement	Board Approval
A-01 implemented rate amendments to conform to rate amendments contained in the Primary Agreement with DHCS (08-85214).	July 8, 2010
A-02 implemented rate adjustments to reflect a decrease in the statewide average cost for Sensitive Services for the rate period July 1, 2010 through June 30, 2011.	August 4, 2011
A-03 extended the term of the Secondary Agreement to December 31, 2014.	June 6, 2013
A-04 incorporates rates for the periods July 1, 2011 through June 30, 2012, and July 1, 2012 through June 30, 2013 as well as extends the current term of the Secondary Agreement to December 31, 2015	January 5, 2012 (FY 11-12 and FY 12-13 rates) May 1, 2014 (term extension)
A-05 incorporates rates for the periods July 1, 2013 through June 30, 2014, and July 1, 2014 through June 30, 2015. For the period July 1, 2014 through June 30, 2015, Amendment A-05 also adds funding for the Medi-Cal expansion population for services provided through the Secondary Agreement.	December 4, 2014
A-06 incorporates rates for the period July 1, 2015 onward. A-06 also extends the term of the Secondary Agreement to December 31, 2016.	May 7, 2015 (term extension) Ratification of rates requested April 7, 2016
A-07 extends the Secondary Agreement with the DHCS to December 31, 2020.	December 1, 2016

A–08 incorporates Adult & Family/Optional Targeted Low–Income Child and Adult Expansion rates for July 2016 to June 2017 and July 2017 to June 2018.	December 6, 2018
A-10 extends the Secondary Agreement with DHCS to December 31, 2021	November 5, 2020
A-12 extends the Secondary Agreement with DHCS to December 31, 2022.	October 7, 2021

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

Amendments to Agreement 16-93274	Board Approval
A-01 extends the Agreement 16-93274 with DHCS to December 31, 2018.	August 3, 2017
A–02 extends the Agreement 16–93274 with DHCS to December 31, 2019	June 7, 2018
A–03 extends the Agreement 16–93274 with DHCS to December 31, 2020	May 2, 2019
A–04 extends the Agreement 16–93274 with DHCS to December 31, 2021	June 4, 2020
A–05 extends the Agreement 16–93274 with DHCS to December 31, 2023.	June 3, 2021

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

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

Two-Plan CCI
2022-B Amendment includes:
MIS, Transplant Carve-in, MSSP Carve-out, Telehealth, Vision, MMCE Phase I, No PCP for Members with OHC, ECM/Community Supports +STCs, HHP Carve-out, Indemnification, State Hearings, Rx Carve-out, Program Data, ARPA, and Exhibit G + 2022 Rates.

IV. Exhibit A, Attachment 3, MANAGEMENT INFORMATION SYSTEM, is amended to read:

1. Management Information System (MIS) Capability

A. Contractor's Management and Information System (MIS) **shall be fully compliant with 42 CFR section 438.242 requirements and** shall 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. All data related to this Contract shall be available to DHCS and to the Centers for Medicare and Medicaid Services (CMS) upon request. Contractor shall have and maintain a MIS that provides, at a minimum:

5) Provider Network information, ~~and~~

6) **Program Data, and**

7) Financial information as specified in Exhibit A, Attachment 1, Provision 8. Administrative Duties/Responsibilities.

2. Encounter Data Reporting

A. Contractor shall maintain a MIS that collects and reports Encounter Data to DHCS**, including allowed amounts and paid amounts as required,** in compliance with 42 CFR **section** 438.242, and pursuant to applicable DHCS All Plan Letters (APL).

5. Participation in the State Drug Rebate Program

A. Contractor shall 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 **set forth** in **42 USC** ~~S~~**s**ection ~~1927~~**1396r-8**(k)(2)~~ of the Social Security Act~~.

2) All outpatient drug Encounter Data shall include, at a minimum, the total number of units of each dosage form, strength, and package size, by National Drug Code, for each ~~claim, including~~ eligible Physician ~~A~~**a**dministered ~~D~~**d**rug

Commented [A1]: Rx only

Commented [A2R1]: Plans have already reviewed RX language as of 2/4/2021.

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claims.

7. Program Data Reporting

A. Contractor must maintain a MIS that consumes and transmits Program Data to DHCS in accordance with all applicable DHCS APLs.

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

C. Contractor must require all Network Providers, Subcontractors, and Out-of-Network Providers to submit Program Data to Contractor to meet Contractor's administrative functions and the requirements set forth in this Contract. Contractor must have mechanisms, including edit and reporting systems sufficient to ensure Program Data is complete, accurate, and timely, as defined in State and federal law and all applicable DHCS APLs, prior to submission to DHCS. Contractor must ensure the completeness, accuracy, and timeliness of all Network Provider, Subcontractor, and Out-of-Network Provider Program Data regardless of contracting arrangements.

D. Contractor must submit complete, accurate, and timely Program Data within ten (10) 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, and Out-of-Network

Providers must comply with this Provision for submission of Program Data to Contractor.

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

F. If DHCS finds deficiencies regarding the completeness, accuracy, 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 the 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.

V. Exhibit A, Attachment 4, QUALITY IMPROVEMENT SYSTEM, is amended to read:

4. Quality Improvement Committee

Commented [A3]: Add numbering only for COHS only. Derived from HPSM.

A. Contractor shall implement and maintain a Quality Improvement Committee (QIC) designated by, and accountable to, the governing body; the Medical Director or a physician designee shall actively participate on the committee. Contractor must ensure that Subcontractors and Network Providers, who are representative of the composition of the Provider Network including but not limited to Network Providers who provide health care services to Seniors and Persons with Disabilities or chronic conditions (such as asthma, diabetes, congestive heart failure), actively participate on the committee or medical sub-committee that reports to QIC.

B. The committee shall meet at least quarterly but as frequently as necessary to demonstrate follow-up on all findings and required actions. The activities, findings, recommendations, and actions of the committee shall be reported to the governing body in writing on a scheduled basis.

C. Contractor shall maintain minutes of committee meetings and minutes shall be submitted to DHCS quarterly. Contractor shall maintain a process to ensure rules of confidentiality are maintained

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in quality improvement discussions as well as avoidance of conflict of interest on the part of committee members.

12. Credentialing and Recredentialing

Contractor shall implement, and maintain written policies and procedures concerning the initial credentialing, recredentialing, recertification, and reappointment of Network Providers, developed by the Department in accordance with 42 CFR 438.214 and APL 19-004, and including but not limited to: Primary Care Physicians (PCP); Specialists; Providers for acute, behavioral health, and substance use disorders; and MLTSS Providers as appropriate per the requirements in Exhibit A, Attachment 21, Managed Long Term Services and Supports, Provision 4, Provider Network. Contractor shall ensure those policies and procedures are reviewed and approved by the governing body, or designee. Contractor shall ensure that the responsibility for recommendations regarding credentialing decisions will rest with a credentialing committee or other peer review body.

Commented [A4]: Applies to CCI only

VI. Exhibit A, Attachment 5, UTILIZATION MANAGEMENT, is amended to read:

1. Utilization Management Program

Contractor shall develop, implement, and continuously update and improve, a Utilization Management (UM) program that ensures appropriate processes are used to review and approve the provision of Medically Necessary Covered Services. Contractor is responsible to ensure that the UM program includes:

These activities shall be done in accordance with Health and Safety Code ~~S~~**S**ections 1363.5 and ~~1367.01~~**1367.1,** and ~~Title 28, CCR, Section 1300.70(b)(2)(H) & (c)~~ **28 CCR 1300.70(a)(3) and (c)**.

2. Prior Authorization~~s~~ and Review Procedures

Commented [A5]: Rx only

Commented [A6R5]: Plans have already reviewed RX language as of 2/4/2021.

Contractor shall ensure that its Prior Authorization, concurrent review, and retrospective review procedures meet the following minimum requirements:

C. Qualified health care professionals supervise **the** review **of medical** decisions, including service reductions, and a qualified

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~~p~~**P**hysician will review all denials that are made, whole or in part, on the basis of Medical Necessity. For purposes of this ~~p~~**P**rovision, a qualified ~~p~~**P**hysician or Contractor's pharmacist may approve, defer, modify, or deny Prior Authorization for pharmaceutical services, provided that such determinations are made under the auspices of and pursuant to criteria established by Contractor's medical director, in collaboration with ~~Contractor's Pharmacy and~~ Therapeutics Committee ~~(PTC)~~ or its equivalent.

1) Contractor is not responsible for the review of Prior Authorizations billed on a pharmacy claim by an outpatient pharmacy for the following:

a) Physician administered drugs;

b) Medical supplies;

c) Enteral nutritional products; and

d) Covered outpatient drug claims.

2) Contactor must still review Prior Authorizations billed on a medical claim for Physician administered drugs, medical supplies, enteral nutritional products, and covered outpatient drugs.

3. Timeframes for Medical Authorization

Commented [A7]: Rx only

Commented [A8R7]: Plans have already reviewed RX language as of 2/4/2021.

~~F. Pharmaceuticals: For all covered outpatient drug Prior Authorization requests, provide notice by telephone, fax, email or other electronic communication within 24 hours of receipt of the request, and in emergency situations dispense at least a 72-hour supply of the covered outpatient drug, in accordance with Welfare and Institutions Code, Section 14185, 42 CFR 438.3(s)(6), and Section 1927(d)(5)(A) of the Social Security Act or any respective future amendments thereto.~~

~~G~~**F**. Routine authorizations: As expeditiously as the Member's condition requires but within five (5) ~~w~~**W**orking ~~d~~**D**ays from receipt of the information reasonably necessary to render a decision (these are requests for specialty service, cost control purposes, out-of-Network not otherwise exempt from Prior Authorization) in

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accordance with Health and Safety Code~~,~~ S**s**ection 1367.01~~,~~ or any future amendments thereto, but, no longer than 14 calendar days from the receipt of the request. The decision may be deferred and the time limit extended an additional 14 calendar days only where the Member or the Member's Provider requests an extension, or ~~the~~ Contractor can provide justification upon request by the State for the need for additional information and how it is in the Member's interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.

~~H~~**G**. Expedited authorizations: Contractor must make expedited authorization decisions for service requests where a Member's Provider indicates, or Contractor, Subcontractor, or Network Provider determines that, following the standard timeframe for Prior Authorizations could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function, Contractor must make an expedited authorization decision and provide notice as expeditiously as the Member's health condition requires and not later than 72**-**hours after receipt of the request for services **in accordance with 42 CFR section 438.210(d)**. Contractor may extend the 72**-**hour~~s~~' time period by up to 14 calendar days if the Member requests an extension, or if Contractor justifies, to the satisfaction of DHCS upon request, a need for additional information and how the extension is in the Member's interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.

~~I~~**H**. Hospice i**I**npatient ~~c~~**C**are: 24-hour response.

~~J~~**I**. Therapeutic Enteral Formula for Medical Conditions in Infants and Children: -Timeframes for medical authorization of Medically Necessary therapeutic enteral formulas for infants and children and the equipment/and supplies necessary for delivery of these special foods are set forth in PL 14-003, ~~Welfare and Institutions~~ **W&I** Code ~~S~~**s**ection 14103.6**.** and Health and Safety Code ~~S~~**s**ection 1367.01.

4. Review of Utilization Data

Contractor shall include within the UM program mechanisms to detect both under- and over-utilization of health care services. Contractor's internal reporting mechanisms used to detect Member utilization patterns shall be reported to DHCS **must be reported to DHCS no later than 30**

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calendar days after the beginning of each calendar year and upon request.

VII. Exhibit A, Attachment 6, PROVIDER NETWORK, is amended to read:

Commented [A9]: Rx only

Commented [A10R9]: Plans have already reviewed RX language as of 2/4/2021.

2. Network Composition

Contractor shall ensure and monitor an appropriate Provider Network within its Service Area in compliance with W&I Code ~~S~~**s**ection 14197, and if necessary to ensure compliance with Network adequacy requirements in this Contract, attempt to contract with Providers in adjoining counties outside of Contractor's Service Area. Contractor's Network must include, but not be limited to, adult and pediatric PCPs, OB/GYN, adult and pediatric behavioral health Providers, adult and pediatric Specialists, ~~professional,~~ Allied Health Personnel, supportive paramedical personnel, hospitals, ~~pharmacies~~ and an adequate number of accessible inpatient facilities and service sites. In addition, Contractor shall ensure and monitor MLTSS Providers, American Indian Health Service Programs, Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and Freestanding Birthing Centers (FBCs), where available. Contractor shall submit assurances to DHCS regarding its Network composition in accordance with 42 CFR **section** 438.207.

6. Specialists

Contractor shall maintain an adequate Network that includes adult and pediatric Specialists, and at a minimum, core Specialists as described in ~~Welfare and Institutions~~ **W&I** Code~~, S~~ **s**ection 14197(h)(2), within their Network to accommodate the need for specialty care in accordance with ~~Title~~ 22 CCR ~~S~~**s**ection 53853(a), and ~~Welfare and Institutions~~ **W&I** Code, ~~S~~**s**ections 14182(c)(2) and 14087.3.

8. Time or Distance Standards

A. Contractor shall meet time or distance standards for adult and pediatric PCPs, adult and pediatric core Specialists, OB/GYN primary and specialty care, adult and pediatric outpatient mental health Providers, **and** hospitals~~, and pharmacies~~ based on county population density and as required by W&I Code ~~S~~**s**ection 14197. For MLTSS, Contractor shall adhere to timely access standards in accordance with W&I Code ~~S~~**s**ection 14197.

Commented [A11]: This applies to all COHS CCI/CMC plans, except for PHP.

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Two-Plan CCI
2022-B Amendment includes:
MIS, Transplant Carve-in, MSSP Carve-out, Telehealth, Vision, MMCE Phase I, No PCP for Members with OHC, ECM/Community Supports +STCs, HHP Carve-out, Indemnification, State Hearings, Rx Carve-out, Program Data, ARPA, and Exhibit G + 2022 Rates.

VIII. Exhibit A, Attachment 7, PROVIDER RELATIONS, Provision 4, is amended to read:

4. Contractor's Provider Manual

Contractor shall issue a provider manual to Network Provider that includes information and updates regarding Medi-Cal services, policies and procedures, statutes, regulations, telephone access, special requirements, and the Member Grievance, Appeal, and State ~~Fair~~ Hearing process. Contractor's ~~p~~**P**rovider ~~m~~**M**anual shall include the following Member rights information:

A. Member's right to a State ~~Fair~~ Hearing, how to obtain a Hearing, and representation rules at a **State** Hearing;

E. Member's right to request continuation of benefits during an Appeal or State ~~Fair~~ Hearing.

IX. Exhibit A, Attachment 8, PROVIDER COMPENSATION ARRANGEMENTS, is amended to read:

16. Organ and Bone Marrow Transplants

In accordance with W&I Code section 14184.201(c), and for applicable dates of service, Contractor shall 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 Medi-Cal 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 Code section 14184.102(d).

X. Exhibit A, Attachment 9, ACCESS AND AVAILABILITY, is amended to read:

2. Existing ~~Patient~~ Member-Physician Relationships

Contractor shall ensure that no Traditional or Safety-Net Provider, upon entry into Contractor's Network, suffers any disruption of existing

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~~patient~~**Member** ~~p~~**P**hysician relationships, to the maximum extent possible.

10. Changes in Availability or Location of Covered Services

Commented [A12]: Technical updates in numbering only.

~~1~~**A**. Contractor must provide notification to DHCS immediately upon discovery of a Provider initiated termination, or at least 60 calendar days before making any Significant Change in the availability or location of services to be provided under this Contract if it affects more than 2,000 Members or affects Contractor's ability to meet Network adequacy standards in accordance with APL 21-003. In the event of an emergency or other unforeseeable circumstances, Contractor must notify DHCS of the change in the availability or location of as soon as possible.

~~2~~**B**. Contractor must provide notification to DHCS immediately or within ten (10) calendar days of learning of a Provider's exclusionary status from any database or list included in APL 21-003.

13. Cultural and Linguistic Program

Contractor shall have a Cultural and Linguistic Services Program that incorporates the requirements of Title 22 CCR Section 53876. Contractor shall monitor, evaluate, and take effective action to address any needed improvement in the delivery of culturally and linguistically appropriate services. Contractor shall review and update their cultural and linguistic services consistent with the population needs assessment (PNA) requirements stipulated below.

C. Population Needs Assessment (PNA)

Contractor shall conduct a PNA, as specified below, to identify the health education and cultural and linguistic needs of its' Members; and utilize the findings for continuous development and improvement of contractually required health education and cultural linguistic programs and services. Contractor must use multiple reliable data sources, methodologies, techniques, and tools to conduct the PNA.

1) Contractor shall conduct an initial PNA within 12 months from the commencement of operations within a Service Area and at least ~~every five (5) years from the commencement of operations~~ **annually** thereafter. For Contracts existing at the

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time this provision becomes effective, the next PNA will be required at a time within ~~the~~ five (5) year**s** ~~period~~ from the effective date of this provision, to be determined by DHCS.

2) Contractor shall submit a PNA ~~Summary R~~**r**eport to the DHCS ~~within six (6) months of the completion of each PNA. The summary report~~ **that** must include:

~~3) Contractor shall annually update the PNA summary report, including a current update on the information required in item 2) b) above. Contractor shall maintain, and have available for DHCS review, the PNA summary report updates.~~

~~4~~**3**) Contractor shall demonstrate that PNA ~~and summary~~ report findings and conclusions in item 2) b) above are utilized for continuous development of its health education and cultural and linguistic services program. Contractor must maintain documentation of program priorities, target populations, and program goals/objectives as they are revised to meet the identified and changing needs of the Member population.

14. Linguistic Services

Commented [A13]: Rx only

Commented [A14R13]: Plans have already reviewed RX language as of 2/4/2021.

D. Key points of contact include:

1) Medical care settings: telephone, advice and urgent care transactions, and outpatient encounters with health care Providers ~~including pharmacists~~.

16. Out-of-Network Providers

C. For newly enrolled ~~SPD~~ beneficiaries who request continued access, Contractor shall provide continued access for up to 12 months to an Out-of-Network Provider with whom they have an ongoing relationship if there are no quality of care issues with the Provider and the Provider will accept Contractor or Medi-Cal FFS rates, whichever is higher, in accordance with W~~-&-~~I Code **section** 14182(b)(13) and (14). An ongoing relationship shall be determined by ~~the~~ Contractor identifying a link between a newly enrolled SPD beneficiary and an Out-of-Network Provider using FFS utilization data provided by DHCS.

Two-Plan CCI
2022-B Amendment includes:
MIS, Transplant Carve-in, MSSP Carve-out, Telehealth, Vision, MMCE Phase I, No PCP for Members with OHC, ECM/Community Supports +STCs, HHP Carve-out, Indemnification, State Hearings, Rx Carve-out, Program Data, ARPA, and Exhibit G + 2022 Rates.

XI. Exhibit A, Attachment 10, SCOPE OF SERVICES, is amended to read:

1. Covered Services

C. Except as set forth in Attachment 3.1.B.1 (effective 1/1/2006) of the California Medicaid State Plan or as otherwise authorized by ~~Welfare and Institutions~~ **W&I** Code ~~S~~**s**ection 14133.23, effective January 1, 2006, ~~drug benefits~~ for Full Benefit Dual Eligible Members who are eligible for drug benefits under Part D of Title XVIII of the Social Security Act (42 USC ~~S~~**s**ection 1395w-101 et seq)**, Part D-eligible drugs** are not a Covered Service under this Contract. Consequently, effective January 1, 2006, the capitation rates shall not include reimbursement for such drug benefits and existing capitation rates shall be adjusted accordingly, even if the adjustment results in a change of less than one **(1)** percent of cost to Contractor. Additionally, Contractor shall comply with all applicable provisions of the Medicare Prescription Drug Improvement and Modernization Act of 2003, 42 USC ~~S~~**s**ection 1395(x) et seq.

5. Services for Members under Twenty-One (21) Years of Age

Contractor shall cover and ensure the provision of all screening, preventive and Medically Necessary diagnostic and treatment services for Members under 21 years of age required under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services benefit described in 42 USC Section 1396d(r), and W&I Code ~~S~~**s**ection 14132(v). The EPSDT benefit includes all Medically Necessary health care, diagnostic services, treatments and other measures listed in 42 USC Section 1396d(a), whether or not covered under the State Plan. All EPSDT services are Covered Services, unless excluded under this Contract.

E. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services

1) For Members under the age of 21 years, Contractor shall provide or arrange and pay for all Medically Necessary EPSDT services, including all Medicaid services listed in 42 USC Section 1396(a), whether or not covered under the State Plan, unless expressly excluded in this Contract.

Commented [A15]: Flag for GMC and COHS only – there is duplicative language in Exhibit E, Attachment 1, Definitions – Covered Services - Q for COHS and U for GMC that will be removed as it currently exists here.

This language in GMC is listed under Ex E, Attach 1, Definitions, Covered Services U. – *Remove this language from U. in Covered Services definition in GMC and edit as appropriate in GMC in A, 10, 1. C. as existing language lives in both areas of the contract for GMC.*

This language in COHS is listed in Ex E, Attach 1, Definitions, Covered Services Q. – *Remove this language from T. in Covered Services definition in COHS and add into COHS as a new* **C** in a, 10, 1. **C.** and change existing C. in COHS from ~~C.~~ to **D.**

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Covered Services shall include without limitation, in-home nursing provided by home health agencies or individual nurse providers, as required by APL 20-012, care coordination, case management, and Targeted Case Management (TCM) services as defined in Attachment 11, Provision ~~3~~**1** of this Contract. If Members under age 21 are not eligible for or accepted for Medically Necessary TCM services by a Regional Center or local government health program, Contractor shall ensure the Members' access to comparable services under the EPSDT benefit in accordance with APL 19-010.

2) Contractor shall arrange for any Medically Necessary treatment identified at a preventative screening or other visit identifying the need for treatment, either directly or through referral to appropriate agencies, organizations, or individuals, as required by 42 U.S.C. section 1396a(a)(43)(C). Contractor shall ensure that all Medically Necessary services 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 treatment, whether or not the services are Covered Services under this Contract. Without limitation, Contractor shall identify available Providers, including if necessary Out-of-Network Providers and individuals eligible to enroll as Medi-Cal Providers, to ensure the timely provision of Medically Necessary services. Contractor shall provide appointment scheduling assistance and necessary transportation, including Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT), to and from medical appointments for Medically Necessary services, including all services through the Medi-Cal program, whether or not they are Covered Services under this Contract.

3) Covered Services do not include California Children's Services (CCS) pursuant to Exhibit A, Attachment 11, Provision ~~9~~**7**, regarding CCS, or mental health services pursuant to Exhibit A, Attachment 11, Provision ~~6~~**4** (subject to Provision 8 below), regarding Specialty Mental Health Services. Contractor shall ensure that the case management

Commented [A16]: This would apply to all non WCM plans. Those with WCM would not have this language in their contracts.

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for Medically Necessary services authorized by CCS or county mental health agencies under this paragraph is equivalent to that provided by Contractor for Covered Services for Members under the age 21 under this Contract and shall, if indicated or upon the Member's request provide additional care coordination and case management services as necessary to meet the Member's medical needs.

G. 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 (1) year of age or younger and is receiving inpatient hospital services in an intensive care unit as required in W&I Code section 14132(ae).

7. Pregnant Women

C. Referral to Specialists

Contractor ~~shall~~ **must** ensure that pregnant ~~women~~ **Members** ~~at high risk of a poor pregnancy outcome~~ are referred to **medically** appropriate Specialists**,** including**, as appropriate,** perinatologists**, Freestanding Birthing Centers, Certified Nurse Midwives,** and **Licensed Midwives. In addition, Contractor must ensure that postpartum Members** have access to genetic screening with appropriate referrals. Contractor ~~shall~~ **must** also ensure that appropriate hospitals are available within the ~~Provider~~ Network to provide necessary high-risk pregnancy services.

8. Services for All Members

A. Health Education

11) Contractor shall cover and ensure provision of comprehensive case management including coordination of care services as described in Exhibit A, Attachment ~~11~~**22**.

B. The Health Information Form (HIF)/Member Evaluation Tool (MET)

Contractor shall use data from a Health Information Form

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(HIF)/Member Evaluation Tool (MET) to help identify newly enrolled Members who may need expedited services. In accordance with 42 CFR **section** 438.208(b), Contractor shall, at a minimum, comply with the following:

2) Within 90 days of each new Member's effective date of enrollment:

b) Conduct an initial screening of the Member's needs as identified in the HIF/METs received. To meet this requirement, Contractor may build upon any existing screening process currently used to meet requirements in Exhibit A, Attachment 10, Scope of Services, or Exhibit A, Attachment 11, Case Management and **External** Coordination of Care.

D. Vision Care - Lenses

Contractor shall cover and ensure the provision of eye examinations and prescriptions for corrective lenses as appropriate for all Members. Contractor~~'s~~ **must** ~~responsibility to~~ 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** ~~shall be limited to Medi-Cal covered optical/optical lab services~~. Contractor shall cover the cost of the eye examination and dispensing of the lenses fabricated by PIA ~~and specialty lenses, including lenses that exceed PIA ranges for qualifying Members as described in W & I Code, Section 14131.10~~. 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 lens material, fabrication and dispensing of lenses not available through PIA.**

E. ~~Mental Health and Substance Use Disorder~~ **Behavioral Health** Services

1) Contractor shall cover mild to moderate Outpatient Mental Health Services that are within the scope of practice of Primary Care Providers and mental health care Providers. **Contractor shall refer Members needing Specialty Mental Health Services to the county mental health plan.**

Commented [A17]: Does not go into Kaiser Sacramento or PHP Solano contract

Contractor's policies and procedures shall define and describe what services are to be provided by Primary Care Providers **and mental health care Providers**. ~~In addition, Contractor shall cover and ensure the provision of psychotherapeutic drugs prescribed by its Primary Care Providers or other mental health care professionals, except those specifically excluded in this Contract as stipulated below.~~

Commented [A18]: Does not go into Kaiser Sacramento or PHP Solano contract

2) Contractor shall cover and pay for all Medically Necessary Mental Health Covered Services for the Member, including the following services:

a) Emergency room professional services as described in ~~Title~~ 22 CCR S**s**ection 53855~~, except services provided by psychiatrists, psychologists, licensed clinical social workers, marriage, family and child counselors, or other specialty mental health Providers~~. **This includes all professional, physical, mental, and substance use disorder 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. Emergency Services includes Facility and professional services and facility charges claimed by emergency departments.**

e) All NEMT services, as provided for in ~~Title~~ 22 CCR ~~S~~**s**ection 51323, required by Members to access Medi-Cal covered mental health and substance use disorder services**. NEMT services are subject to a written prescription and Prior Authorization**. These services include outpatient opioid detoxification, tobacco cessation, and Alcohol Misuse Screening and Counseling (AMSC) services, and are subject to a written prescription by Contractor's mental health or substance use disorder Provider within Contractor's mental health and substance use disorder Provider Network. **The Physician Certification Statement form must be completed**

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by a Member's Provider to request NEMT.

g) All Medically Necessary Medi-Cal covered psychotherapeutic drugs **not otherwise excluded under this Contract, when administered in the outpatient setting as part of medical services** ~~for Members not otherwise excluded under this Contract~~.

i. This includes reimbursement for **all Medically Necessary Medi-Cal** covered psychotherapeutic drugs ~~prescribed~~ **not otherwise excluded under this Contract, when administered in the outpatient setting as part of medical services** by Out-of-Network ~~psychiatrists~~ **Providers** ~~for Members~~.

~~ii. Contractor may require that covered prescriptions written by Out-of-Network psychiatrists be filled by pharmacies in Contractor's Provider Network.~~

~~iii~~ **ii**. Reimbursement to pharmacies for ~~those~~ psychotherapeutic drugs **billed on a pharmacy claim** ~~listed in the Medi-Cal Provider Manual, MCP: Two-Plan Model, Capitated/Noncapitated Drugs section, which lists excluded psychiatric drugs,~~ shall be ~~reimbursed~~ **provided** through the Medi-Cal FFS program~~, whether these drugs are provided by a pharmacy contracting with Contractor or by an out-of-Network pharmacy Provider~~.~~-~~ To qualify for reimbursement under this provision, a pharmacy must be enrolled as a Medi-Cal Provider in the Medi-Cal FFS program.

3) Contractor shall develop and implement a written internal policy and procedure to ensure that Members who need Specialty Mental Health Services ~~(services outside the scope of practice of Primary Care Providers)~~ are referred to and are provided mental health services by an appropriate Medi-Cal FFS mental health Provider or

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to the county mental health plan for Specialty Mental Health Services in accordance with Exhibit A, Attachment 11, Case Management and **External** Coordination of Care, Provision ~~6~~**4**. Specialty Mental Health.

~~F. Tuberculosis (TB)~~

~~1) TB screening, diagnosis, treatment and follow-up are covered under this Contract. Contractor shall provide TB care and treatment in compliance with the guidelines recommended by American Thoracic Society and the Centers for Disease Control and Prevention.~~

~~2) Contractor shall coordinate with Local Health Departments in the provision of direct observed therapy as required in Exhibit A, Attachment 11, Case Management and Coordination of Care, Provision 16. Direct Observed Therapy (DOT) for Treatment of Tuberculosis (TB) and Attachment 12, Local Health Department Coordination.~~

~~G~~ **F**. Pharmaceutical Services ~~and Provision of Prescribed Drugs~~

~~1) Contractor shall cover and ensure the provision of all prescribed drugs and Medically Necessary pharmaceutical services. Contractor shall provide pharmaceutical services and Prescription Drugs in accordance with all federal and State laws and regulations including, but not limited to Title 22 CCR Sections 53214 and 53854, Title 16, Sections 1707.1, 1707.2, and 1707.3, 42 CFR 438.3(s), and Sections 1927(d)(5) and 1927(k)(2) of the Social Security Act. Prior authorization requirements for pharmacy services and provision of prescribed drugs must be clearly described in the Member Services Guide and Contractor's provider manual.~~

~~2) At a minimum, Contractor shall arrange for pharmaceutical services to be available during regular business hours.~~

~~3) Contractor shall ensure access to at least a 72-hour supply of a covered outpatient drug in an emergency situation. Contractor shall meet this requirement by doing all of the following:~~

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~~a) Having written policies and procedures, including, if applicable, written policies and procedures of Contractor's Network hospitals' policies and procedures related to emergency medication dispensing, which describe the method(s) that are used to ensure that the emergency medication dispensing requirements are met, including, if applicable, specific language in Network hospital subcontracts. Written policies and procedures must describe how Contractor and/or Contractor's Network hospitals will monitor compliance with the requirements. Compliance monitoring does not require verification of receipt of medications for each and every ER visit made by Members to an emergency room which does not result in hospitalization.~~

~~b) Providing the Member, in all cases, access to at least a 72-hour supply of Medically Necessary drugs. This requirement can be met by providing a 72-hour supply of the drug to the Member, or provision of an initial dose of medication and a prescription for additional medication, which together cover the Member for the 72-hour period. Contractor's policies and procedures can describe other methods for ensuring compliance with the 72-hour requirement.~~

~~c) Having a mechanism in place for informing Members of this requirement and of their right to submit a Grievance if they do not receive Medically Necessary medications in emergency situations.~~

~~d) Having a procedure for investigating and resolving Grievances related to the failure of Contractor to provide Medically Necessary medications in emergency situations.~~

~~e) Having policies and procedures and Grievance and Appeal logs available for inspection during any State audit or monitoring visit, upon request.~~

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4) Continuity of Care

Contractor must maintain policies and procedures outlining continuity of care in compliance with the provisions of Welfare and Institutions Code 14185(b), and Health and Safety Code 1367.22. All newly enrolled Members shall be maintained on their current drug therapy, including non-formulary drugs without Prior Authorization until the Member is evaluated or re-evaluated by a Network Provider.

5) Formulary Requirements

Contractor shall post current formulary drug lists on Contractor's website in a machine readable file and format, and make a printed version available to Members upon request pursuant to 42 CFR 438.10(i). Contractor's drug formulary must meet the following requirements:

a) Contractor shall submit to DHCS a complete formulary for review and approval, prior to use. Contractor shall also submit an annual formulary to DHCS for review and approval. Contractor may use the formulary as published until DHCS notifies Contractor of approval or of required changes. In addition to the annual formulary submission, Contractor shall submit any changes to its formulary to DHCS as File and Use. DHCS may request an updated or current formulary at any time.

b) Contractor's formulary shall be comparable to the Medi-Cal FFS contract drugs list (CDL), except for drugs carved out through specific contract agreements. Comparable means that:

i. Every therapeutic category or class listed on the Medi-Cal FFS CDL shall be represented by at least one (1) drug on Contractor's formulary within six (6) months of its inclusion. Therapeutic category or class is defined by the American Hospital Formulary Service pharmacologic therapeutic classification system to include all tiers of United States

~~Pharmacopeia.~~

~~ii. If Contractor places Prior Authorization requirements on all drugs within the same therapeutic category, and one (1) such drug is available on the Medi-Cal FFS CDL without treatment authorization request requirements, Contractor shall submit the following for all drugs of that same mechanism of action:~~

~~a. Clinical rationale for such an action.~~

~~b. Criteria used to decide on the Prior Authorization request and/or how the approval criteria for the formulary option(s) differs from the non-formulary options.~~

~~iii. A drug not listed on the formulary must be available by Prior Authorization if deemed Medically Necessary.~~

~~iv. All drugs listed on the Medi-Cal FFS list need not be included in Contractor's formulary.~~

~~6) Contractor shall implement and maintain a process to ensure that its formulary is reviewed and updated no less than quarterly by Contractor's PTC. The PTC must include the following:~~

~~a) A majority of members who are practicing Physicians and/or practicing pharmacists;~~

~~b) Contractor's Pharmacist as a voting member;~~

~~c) At least one (1) practicing Physician and at least one (1) practicing pharmacist who are independent and free of conflict of interest from pharmaceutical manufacturers; and~~

~~d) At least one (1) practicing Physician and one (1) practicing pharmacist who are experts regarding care~~

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~~of elderly or disabled Members.~~

~~This review and update of Contractor's formulary must consider all drugs approved by the FDA and/or added to the Medi-Cal FFS CDL. Deletions to the formulary must be documented and justified.~~

~~7~~**1**) Drug Utilization Review (DUR)

Contractor shall develop and implement **an** effective DUR~~s~~ and treatment outcome processes**,** as directed in APL 17-008 and APL 19-012 **(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~~s should be comparable to such programs administered by the State,~~ must meet or exceed the requirements described in 42 CFR 438.3(s) **and**~~, Section 1927(g) of the Social Security Act, 42 CFR 456, Subpart K,~~ **42 USC section 1396r-8(g), 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~~, and implement:~~**.**

~~i. Safety edit on the prescription's days' supply, early refills, duplicate fills, and quantity limitations on opioids and a claims review automated process that indicates the number of fills of opioids in excess of limitations identified by the Department;~~

~~ii. Safety edits on the maximum daily morphine equivalent for treatment of pain, and a claims review automated process that indicates when a Member is prescribed the morphine milligram equivalent for such treatment in excess of any limitation that may be identified by the Department;~~

b) Contractor's DUR must implement:

~~iii~~ **i**. A **retrospective** claims review automated process that monitors when a Member is concurrently prescribed opioids and benzodiazepines or opioids and antipsychotics;

~~iv~~ **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) and superseding the requirements of APL 19-012**; **and**

~~v~~ **iii**. Fraud and abuse identification processes for potential fraud or abuse of controlled substances by Members, Providers, and pharmacies~~;~~**.**

~~b~~**c**) Contractor shall annually submit to DHCS a detailed report ~~in a format specified by DHCS~~ on their DUR Program activities **in a format specified by DHCS**.

~~c) Contractor's process should also ensure that DURs are appropriately conducted and that pharmacy service and drug utilization Encounter Data are provided to DHCS on a monthly basis.~~

~~8) Reimbursement to pharmacies for those drugs for the treatment of HIV/AIDS listed in the Medi-Cal Provider Manual, MCP: Two-Plan Model, shall be reimbursed through the Medi-Cal FFS program, whether these drugs are provided by a pharmacy contracting with Contractor or by an out-of-Network pharmacy Provider. To qualify for reimbursement under this provision, a pharmacy must be enrolled as a Medi-Cal Provider in the Medi-Cal FFS program.~~

~~9~~**2**) Contractor shall not impose QTL or NQTL more stringently ~~on~~ **for** mental health and substance use disorder drugs ~~as compared to~~ **than for** medical/surgical drugs prescriptions in accordance with 42

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CFR **section** 438.900 et. seq.

~~H~~ **G**. Transportation

Commented [A21]: Rx only

Commented [A22R21]: Plans have already reviewed RX language as of 2/4/2021.

Contractor shall cover transportation services as required in this Contract and directed in APL 17-010 to ensure Members have access to all Medically Necessary services.

2) Contractor shall cover NEMT services ~~required by~~ **necessary for** Members to access Medi-Cal services **covered under this Contract and pharmacy services**, ~~as provided for in Title 22 CCR Section 51323,~~ subject to **a Prior Authorization when required, in accordance with 22 CCR section 51323. In addition,** Contractor's Physician Certification Statement form ~~being~~ **must be** completed by the Member's Provider **to request NEMT services**.

Contractor must cover NEMT services necessary for Members to access pharmacy services for all prescriptions that are prescribed by the Member's Provider(s) and authorized under Medi-Cal Rx.

Contractor shall refer and coordinate NEMT for **all other** Medi-Cal services not covered in this Contract.

3) As provided for in W~~-~~&~~-~~I Code ~~S~~**s**ection 14132(ad), Contractor shall authorize all NMT for Members to obtain Medically Necessary Covered Services in accordance with the requirements and guidelines set forth in APL 17-010. Nothing in this Provision should be construed to prohibit ~~the~~ Contractor from developing policies and procedures ~~which~~ **that** may include Prior Authorization requirements 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, ~~s~~**S**pecialty ~~m~~**M**ental ~~h~~**H**ealth **Services**, substance use disorder, dental, **pharmacy, pharmaceutical services,** and any other benefits delivered through Medi-Cal FFS.

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H. 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, including Centers of Excellence.**

2) **Contractor must refer Members identified as potential organ 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 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.**

3) **Contractor must refer Members under 21 years of age and identified as a potential organ transplant candidate to the local CCS Program for eligibility if necessary.**

Commented [A23]: This language does not apply to WCM contracts.

4) **Contractor must refer Members under 21 years of age to the appropriate CCS-approved Special Care Center that meets criteria set forth by DHCS within 72 hours of receiving the referral from the Member's PCP or Specialist identifying the Member as a transplant candidate. If the CCS-approved Special Care Center considers the Member to be a suitable transplant candidate, Contractor is required to approve the Prior Authorization request.**

Commented [A24]: This language only applies to WCM contracts.

5) **For Members under 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 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.

6) 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 removal, and all Medically Necessary services related to organ removal including complications, transportation, and prescriptions not covered by and billable to Medi-Cal Rx.

7) Contractor must ensure coordination of care between all Providers, organ 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.

8) Contractor must ensure the provision of Discharge Planning as defined in this Contract for Members and living donors.

9) Contractor must cover all readmissions and other health care costs related to any complications the Member or the living donor experiences from the organ transplant.

10) Contractor must authorize all Medically Necessary Physician administered drugs billed on a medical claim needed for the Member receiving an organ transplant, such as anti-rejection medication, and any other Medically Necessary drugs not covered by Medi-Cal Rx.

XII. Exhibit A, Attachment 11, CASE MANAGEMENT AND COORDINATION OF CARE, is amended to read:

Commented [A25]: Provisions 1 & 2 struck out here and moving into new Attachment 22

Exhibit A, Attachment 11, CASE MANAGEMENT AND EXTERNAL COORDINATION OF CARE

~~1. Comprehensive Case Management Including Coordination of Care Services~~

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~~Contractor shall ensure the provision of Comprehensive Medical Case Management to each Member.~~

~~Contractor shall maintain procedures for monitoring the coordination of care provided to Members, including but not limited to all Medically Necessary services delivered both within and outside Contractor's Provider Network. These services are provided through either Basic or Complex Case Management activities based on the medical needs of the Member.~~

~~A. Basic Case Management Services are provided by the Primary Care Provider, in collaboration with Contractor, and shall include:~~

~~1) Initial Health Assessment (IHA);~~

~~2) Individual Health Education Behavioral Assessment (IHEBA);~~

~~3) Identification of appropriate Providers and facilities (such as medical, rehabilitation, and support services) to meet Member care needs;~~

~~4) Direct communication between the Provider and Member/family;~~

~~5) Member and family education, including healthy lifestyle changes when warranted; and~~

~~6) Coordination of carved-out and linked services, and referral to appropriate community resources and other agencies.~~

~~B. Complex Case Management Services are provided by Contractor, in collaboration with the Primary Care Provider, and shall include, at a minimum:~~

~~1) Basic Case Management Services~~

~~2) Management of acute or chronic illness, including emotional and social support issues by a multidisciplinary case management team~~

3) Intense coordination of resources to ensure member regains optimal health or improved functionality

4) With Member and PCP input, development of care plans specific to individual needs, and updating of these plans at least annually

C. Contractor shall develop methods to identify Members who may benefit from complex case management services, using utilization data, the HIF/MET, clinical data, and any other available data, as well as self and physician referrals. Complex case management services for SPD beneficiaries must include the concepts of Person-Centered Planning.

D. Person-Centered Planning for SPD Beneficiaries

1) Upon the enrollment of a SPD beneficiary, Contractor shall provide, or ensure the provision of, Person-Centered Planning and treatment approaches that are collaborative and responsive to the SPD beneficiary's continuing health care needs.

2) Person-Centered Planning shall include identifying each SPD beneficiary's preferences and choices regarding treatments and services, and abilities.

3) Contractor shall allow or ensure the participation of the SPD beneficiary, and any family, friends, and professionals of their choosing, to participate fully in any discussion or decisions regarding treatments and services.

4) Contractor shall ensure that SPD beneficiaries receive all necessary information regarding treatment and services so that they may make an informed choice.

2. Discharge Planning and Care Coordination

Contractor shall 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 shall 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 patient and/or caregiver. Minimum criteria for a discharge planning checklist must include:~~

~~A. Documentation of pre-admission status, including living arrangements, physical and mental function, social support, Durable Medical Equipment (DME), and other services received.~~

~~B. Documentation of pre-discharge factors, including an understanding of the medical condition by the SPD beneficiary or a representative of the SPD Member as applicable, physical and mental function, financial resources, and social supports.~~

~~C. Services needed after discharge, type of placement preferred by the SPD Member or representative of the SPD Member and hospital/institution, type of placement agreed to by the SPD Member or representative of the SPD Member, specific agency/home recommended by the hospital, specific agency/home agreed to by the SPD Member or representative of the SPD Member, and pre-discharge counseling recommended.~~

~~D. Summary of the nature and outcome SPD Member or representative of the SPD Member involvement in the discharge planning process, anticipated problems in implementing post-discharge plans, and further action contemplated by the hospital/institution.~~

~~3~~1. Targeted Case Management Services

~~4~~ 2. Disease Management Program

~~5~~3. Out-of-Network Case Management and Coordination of Care

~~6~~4. Specialty Mental Health

~~7~~5. Alcohol and Substance Use Disorder Treatment Services

~~8~~6. Services for Children with Special Health Care Needs

~~9~~7. California Children's Services (CCS)

~~10~~8. Services for Persons with Developmental Disabilities

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~~11~~9. Early Intervention Services

~~12~~10. Local Education Agency Services

~~13~~11. School Linked CHDP Services

~~14~~12. Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS)

~~15~~13. Dental

Commented [A26]: Rx only

Commented [A27R26]: Plans have already reviewed RX language as of 2/4/2021.

Contractor shall cover and ensure that dental screenings~~/~~ **and** oral health assessments for all Members are included as a part of the IHA. ~~-~~For Members under 21 years of age, Contractor is responsible for ensuring that a dental screening~~/~~ **or** oral health assessment shall be performed as part of every periodic assessment, with annual dental referrals made with the eruption of the child's first tooth or at 12 months of age, whichever occurs first. ~~-~~Contractor shall ensure that Members are referred to appropriate Medi-Cal dental Providers. Contractor shall provide Medically Necessary Federally Required Adult Dental Services (FRADs) and fluoride varnish, 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.

Contractor shall ensure the provision of covered medical services related to dental services that are not provided by dentists or dental anesthetists. Covered medical services include: ~~contractually covered Prescription Drugs;~~ laboratory services~~;~~, and~~,~~ pre-admission physical examinations required for admission to an out-patient 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 medical services required in support of dental procedures.

If ~~the~~ Contractor requires Prior Authorization for these services, Contractor shall develop and publish the procedures for obtaining Prior Authorization to ensure that services for the Member are not delayed. ~~-~~Contractor shall submit such procedures to DHCS for review and approval.

~~16~~14. Direct Observed Therapy (DOT) for Treatment of Tuberculosis (TB)

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~~17~~15. Women, Infants, and Children (WIC) Supplemental Nutrition Program

~~18~~16. Excluded Services Requiring Member Disenrollment

Commented [A28]: This does not apply to COHS as it's already covered in COHS.

Contractor shall continue to cover and ensure that all Medically Necessary services are provided to Members who must disenroll ~~and receive major organ transplants through the Medi-Cal FFS program~~ until the date of disenrollment is effective.

~~A. Major Organ Transplants~~

Commented [A29]: MOT excluded language removal only applies to GMC, Regional and TP. Does not apply to COHS as it's already covered.

Commented [A30]: MOT excluded language removal only applies to GMC, Regional and TP. Does not apply to COHS as it's already covered.

~~Except for kidney transplants, major organ transplant procedures that are Medi-Cal FFS benefits are not covered under the Contract. When a Member is identified as a potential major organ transplant candidate, Contractor shall refer the Member to a Medi-Cal approved transplant center. If the transplant center physician considers the Member to be a suitable candidate, the Contractor shall submit a Prior authorization Request to either the San Francisco Medi-Cal Field Office (for adults) or the CCS Program (for children) for approval. Contractor shall initiate disenrollment of the Member when all of the following has occurred: referral of the Member to the organ transplant facility; the facility's evaluation has concurred that the Member is a candidate for major organ transplant and, the major organ transplant is authorized by either DHCS' Medi-Cal Field Office (for adults) or the CCS Program (for children).~~

~~B. Contractor shall continue to provide all Medically Necessary Covered Services until the Member has been disenrolled. Upon the disenrollment effective date, Contractor shall ensure continuity of care by transferring all of the Member's medical documentation to the transplant physician. The effective date of the disenrollment will be retroactive to the beginning of the month in which the Member was approved as a major organ transplant candidate. The request for reimbursement for services in the month during which the transplant is approved are to be sent by the Provider directly to the Medi-Cal FFS fiscal intermediary. The Capitation Payment for the Member will be recovered from Contractor by DHCS.~~

~~C. If the Member is evaluated and determined not to be a candidate for a major organ transplant or DHCS denies authorization for a~~

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~~transplant, the Member will not be disenrolled. Contractor shall cover the cost of the evaluation performed by the Medi-Cal approved transplant center.~~

~~19~~17. Immunization Registry Reporting

~~20~~18. Erectile Dysfunction (ED) Drugs and Other ED Therapies

~~21~~19. Waiver Programs

XIII. Exhibit A, Attachment 12, LOCAL HEALTH DEPARTMENT COORDINATION, is amended to read:

2. Network Provider Agreements, Subcontractor Agreements or Memoranda of Understanding

If reimbursement is to be provided for services rendered by the following programs or agencies, Contractor shall execute Network Provider Agreements and Subcontractor Agreements, as appropriate, with the LHD or agency as stipulated in Provision 1 above. If no reimbursement is to be made, Contractor or agency shall negotiate in good faith and execute a Memorandum of Understanding (MOU) for services provided by these programs and agencies.

J. Multipurpose Senior Service Program (MSSP)

3. County Mental Health Plan Coordination

A. Contractor shall negotiate in good faith and execute a MOU with the county mental health plan (MHP) in accordance with ~~Welfare and Institutions~~ **W&I** Code ~~S~~**s**ection 14715. -The MOU shall specify, consistent with this Contract, the respective responsibilities of Contractor and the MHP in delivering Medically Necessary Covered Services and Specialty Mental Health Services to Members. The MOU shall address:

3) Protocols for the delivery of mental health services within the Primary Care Provider's **and mental health care Providers** scope of practice;

Commented [A31]: Does not go into Kaiser Sacramento or PHP Solano contract

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5) Procedures for the delivery of Medically Necessary Covered Services to Members who require Specialty Mental Health Services, including:

a) ~~Pharmaceutical services and~~ Prescription Drugs **when administered in an outpatient setting and not otherwise excluded under this Contract**;

Commented [A32]: Rx only

Commented [A33R32]: Plans have already reviewed RX language as of 2/4/2021.

4. Any MOU that Contractor enters into with the county IHSS office and IHSS Public Authority shall be submitted to DHCS for prior approval at least 60 calendar days prior to the effective date of the MOU. DHCS shall acknowledge in writing the receipt of any material sent to DHCS by Contractor for approval within five (5) ~~w~~**W**orking ~~d~~**D**ays of receipt.

~~1)~~**A.** These MOUs shall not become effective until written approval is provided by DHCS and the California Department of Social Services (CDSS) or by operation of law where DHCS has acknowledged receipt of the proposed MOU, and has neither approved nor rejected the proposed MOU within 60 calendar days of receipt.

~~2)~~**B.** Any new or updated MOU that makes a material change to the MOU must be re-submitted to DHCS. Previous MOU approval shall be valid only until such time as the new or amended MOU is approved by DHCS and CDSS.

5. Any MOU that Contractor enters into with MSSP Provider(s) shall be submitted to DHCS for prior approval at least 60 calendar days prior to the effective date of the MOU. DHCS shall acknowledge in writing the receipt of any material sent to DHCS by Contractor for approval within five (5) Working Days of receipt.

A. These MOUs shall not become effective until written approval is provided by DHCS and the California Department of Aging (CDA) or by operation of law where DHCS has acknowledged receipt of the proposed MOU, and has neither approved nor rejected the proposed MOU within 60 calendar days of receipt.

B. Any new or updated MOU that makes a material change to the MOU must be re-submitted to DHCS. Previous MOU approval shall be valid only until such time as the new or amended MOU is approved by DHCS and CDA.

C. Contractor's MOUs with MSSP sites shall provisions for data

sharing while following HIPAA regulations for health care operations. At a minimum, MOU data sharing requirements shall include:

1) MSSP sites sharing initial health and psychosocial assessments;

2) MSSP sites sharing initial level of care determinations;

3) MSSP sites sharing initial care plan;

4) MSSP sites sharing any re-assessments;

5) MSSP sites notifying Contractor of Member terminating from MSSP;

6) Contractor sharing current durable medical equipment authorizations;

7) Contractor sharing hospitalization information;

8) Contractor sharing medication list; and

9) Contractor sharing health risk assessment.

~~5~~6. MOU Monthly Reports

XIV. Exhibit A, Attachment 13, MEMBER SERVICES, is amended to read:

1. Members Rights and Responsibilities

A. Member Rights and Responsibilities

Contractor shall develop, implement and maintain written policies that address the Member's rights and responsibilities and shall communicate these to its Members, Providers, Subcontractors, and, upon request, Potential Enrollees.

1) Contractor's written policies regarding Member rights shall include the following:

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p) To receive a copy of his or her ~~m~~**M**edical ~~r~~**R**ecords, and request that they be amended or corrected, as specified in 45 CFR ~~§~~**sections** 164.524 and 164.526.

3. Written Member Information

E. Provider Directory

Commented [A34]: Rx only

6) Provider directories shall be compliant with 42 CFR **section** 438.10(h) and Health and Safety Code **section** 1367.27, and shall include the following information for PCPs, Specialists, hospitals, ~~pharmacies,~~ behavioral health Providers, MLTSS Providers as appropriate, **ECM Providers, Community Supports Providers,** and any ~~other~~ Providers contracted for Medi-Cal Covered Services:

a) The ~~P~~**p**rovider or site's name and any group affiliation, NPI number, address, telephone number, and, if applicable, web site URL for each service location, and provider specialty as appropriate;

e) The ~~P~~**p**rovider's cultural and linguistic capabilities, including whether non-English languages and American Sign Language are offered either by the ~~P~~**p**rovider or a skilled medical interpreter at the ~~P~~**p**rovider's facility, and if the ~~P~~**p**rovider has completed cultural competence training;

f) The telephone number to call after normal business hours; ~~and~~

g) Identification of ~~P~~**p**roviders or sites that are not available to all or new Members~~.~~**; and**

h) The link to the Medi-Cal Rx Pharmacy Locator, which can be found on the dedicated Medi-Cal Rx website described in APL 21-018.

F. Contractor shall provide each Member, or family unit, a Member Services Guide/EOC that constitutes a fair disclosure of the provisions of, and the right to obtain, available and accessible covered health care services. DHCS shall provide Contractor with a

template for the Member Services Guide/EOC prior to distribution to Members. Contractor shall submit a complete Member Services Guide/EOC to DHCS for review and approval prior to implementing. Contractor shall ensure that the Member Services Guide/EOC includes the following information:

1) The plan name, address, toll-free telephone number(s) for Member services**, Medi-Cal Rx telephone number(s) and website information,** and any other Contractor staff providing services directly to Members, and ~~s~~**S**ervice ~~a~~**A**rea covered ~~by the health plan~~ **under this Contract**.

16) Information on the Member's right to the Medi-Cal State ~~Fair~~ Hearing process, the method for obtaining a Hearing, the timeframe to request a Hearing, and the rules that govern representation in a Hearing. Include information on the circumstances under which an expedited State ~~Fair~~ Hearing is possible and information regarding assistance in completing the request pursuant to ~~Title~~ 22 CCR ~~S~~**s**ection 53452, when a health care service requested by the Member or Provider has been denied, deferred or modified. Information on State ~~Fair~~ Hearings shall also include information on the timelines which govern a Member's right to a State ~~Fair~~ Hearing, pursuant to ~~Welfare and Institutions~~ **W&I** Code ~~S~~**s**ection §10951 and the State of California Department of Social Services' Public Inquiry and Response Unit toll-free telephone number (1-800-952-5253) to request a State ~~Fair~~ Hearing. Information shall include that services previously authorized by ~~the~~ Contractor will continue while the State ~~Fair~~ Hearing is being resolved if the Member requests a Hearing in the specified timeframe.

25) An explanation of the expedited disenrollment process for Members qualifying under conditions specified under ~~Title~~ 22 CCR ~~S~~**s**ection 53889(j)**,** which includes children receiving services under the Foster Care or Adoption Assistance Programs; Members with special health care needs, including, but not limited to major organ transplants; and Members already enrolled in another Medi-Cal, Medicare or commercial managed care plan.

~~31) Contractor's drug formulary information notice. Pursuant to~~

Commented [A35]: 31) – 36) – Rx only

Commented [A36R35]: Plans have already reviewed RX language as of 2/4/2021.

~~California Health and Safety Code, Section 1363.01, and 42 CFR 438.10(d)(6) and (i), the drug formulary information notice shall: (1) be in an easily understood language and format; (2) include an explanation of what a formulary is, which medications are covered, both generic and name brand, what tier each medication is on, how the plan decides which Prescription Drugs are included or excluded from the formulary, and how often the formulary is updated; (3) indicate that the drug formulary is available on Contractor's website in a machine readable file, available in a hard copy, and provide the telephone number for requesting this information; and (4) indicate that the presence of a drug on the plan's formulary does not guarantee that a Member will be prescribed that drug by his or her prescribing Provider for a particular medical condition.~~

3~~2~~**1**) Policies and procedures regarding a Members' right to formulate advance directives. -This information shall include the Member's right to be informed by ~~the~~ Contractor of State law regarding advance directives, and to receive information from ~~the~~ Contractor regarding any changes to that law. -The information shall reflect changes in State law regarding advance directives as soon as possible, but no later than 90 calendar days after the effective date of change.

3~~3~~**2**) Instructions on how a Member can view online, or request a copy of, Contractor's non-proprietary clinical and administrative policies and procedures.

3~~4~~**3**) That oral interpreter services are available for any language spoken by the Member, and written translations of Member materials are available in the identified threshold languages, both free of charge, with instruction on how to access these services.

3~~5~~**4**) That Auxiliary Aids and services are available upon request and at no cost for Members with disabilities, and how to access these services.

3~~6~~**5**) Information on how to report suspected fraud or abuse.

3~~7~~**6**) Any other information determined by DHCS to be essential

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for the proper receipt of Covered Services.

5. Primary Care Provider Selection

A. Contractor shall 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 ~~Primary Care Physician~~ **PCP**.

1) Comprehensive OHC refers to:

a) Members with the OHC Code indicator C, H, F, K, or P as listed in the 834 file, or,

b) 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.

~~1~~**2**) Contractor shall provide each new Member an opportunity to select a ~~Primary Care Physician~~ **PCP** within the first 30 calendar days of enrollment.

~~2~~**3**) Contractor may allow Members to select a clinic that provides ~~p~~**P**rimary ~~c~~**C**are **services for a PCP**.

~~3~~**4**) If ~~the~~ Contractor's ~~Provider~~ Network includes Nurse Practitioners, Certified Nurse Midwives, or Physician Assistants, the Member may select a Nurse Practitioner, Certified Nurse Midwife, or Physician Assistant within 30 calendar days of enrollment to provide Primary Care services in accordance with ~~Title~~ 22 CCR ~~S~~**s**ection 53853(a)(4).

~~4~~**5**) Contractor shall provide a mechanism for SPD beneficiaries to select a Specialist or clinic that meets DHCS Network Provider Agreement requirements as stated in Attachment 6 of this Contract as a ~~Primary Care Physician~~ **PCP** if the Specialist or clinic agrees to serve as a Primary Care Provider and is qualified to treat the required range of conditions of the SPD beneficiary, per W&I Code ~~S~~**s**ection 14182 (b)(11).

~~5~~**6**) Contractor shall ensure that Members are allowed to change a

Commented [A37]: COHS reads:

5. Primary Care Provider Selection

A. Contractor shall implement and maintain DHCS approved procedures to ensure that each new Member has an appropriate and available ~~Primary Care Physician~~ **PCP.** Contractor shall provide each new Member an opportunity to select a PCP within the first 30 calendar days of enrollment. Contractor may allow Members to select a clinic that provides Primary Care services **for a PCP**. If ~~the~~ Contractor's ~~Provider~~ Network includes nurse practitioners, certified nurse midwives, or physician assistants, in accordance with Title 22 CCR Sections 51240 and 51241, the Member may select a nurse practitioner, certified nurse midwife, or physician assistant within 30 calendar days of enrollment to provide Primary Care services. Contractor shall ensure that Members are allowed to change a PCP, nurse practitioner, certified nurse midwife, or physician assistant, upon request, by selecting a different Primary Care Provider from Contractor's Network.

~~Primary Care Physician~~ **PCP**, Nurse Practitioner, Certified Nurse Midwife or Physician Assistant, upon request, by selecting a different Primary Care Provider from Contractor's Network.

B. Members who transition out of comprehensive OHC must have an appropriate and available PCP assigned within 30 days of Enrollment with Contractor.

~~B~~**C**. Contractor shall disclose to affected Members any reasons for which their selection or change in ~~Primary Care Physician~~ **PCP** could not be made.

~~C~~**D**. Contractor shall ensure that Members with an established relationship with a Network Provider, who have expressed a desire to continue their patient/Network Provider relationship, are assigned to that Network Provider without disruption in their care.

~~D~~**E**. Contractor shall ensure that Members may choose Traditional and Safety-Net Providers as their Primary Care Provider, and that American Indian Members may choose an American Indian Health Care Provider within Contractor's Network as their Primary Care Provider.

~~E~~**F**. Contractor shall not be obligated to require Full Benefit Dual Eligible Members to select a Medi-Cal Primary Care Provider. Nothing in this section shall be construed to require Contractor to pay for services that would otherwise be paid for by Medicare.

6. Primary Care Provider Assignment

A. If the Member does not select a Primary Care Provider within 30 calendar days of the effective date of enrollment, Contractor shall assign that Member to a Primary Care Provider and notify the Member and the assigned Primary Care Provider no later than 40 calendar days after the Member's ~~e~~**E**nrollment. Contractor shall ensure that adverse selection does not occur during the assignment process of Members to Providers. If, at any time, a Member notifies the Contractor of a Primary Care Provider or Subcontracting Health Plan choice, such choice shall override the Member assignment **or selection of** ~~to~~ a Primary Care Provider or Subcontracting Health Plan.

Commented [A38]: This is in COHS and GMC Provision 7.A, does not apply to TP.

Commented [A39]: This language only in COHS and GMC, not in TP.

B. If a Member does not select a Primary Care Provider within 30 calendar days of the effective date of enrollment, Contractor shall use utilization data or other data sources provided by DHCS, including electronic data, to

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establish existing Provider relationships for the purpose of Primary Care Provider assignment, including a Specialist or clinic for a **PCP assignment for a** SPD beneficiary if a preference for either has been indicated. Contractor shall comply with all federal and State privacy laws in the provision and use of this data.

C. Contractor shall notify the Primary Care Provider that a Member has ~~selected or~~ been assigned **or selected** to the Provider within ten (10) calendar days from when selection or assignment is completed by the Member or ~~the~~ Contractor, respectively.

E. Submit policies and procedures for Member assignment to a ~~Primary Care Physician~~ **PCP**. Include the use of FFS utilization data and other data in linking an ~~APD~~**SPD** beneficiary to a PCP.

Commented [A40]: This is in COHS Provision 7.E, does not apply to TP or GMC.

F. Contractor shall provide any Member utilization data received from DHCS to the Primary Care Provider or Subcontractor to which a Member has been assigned **to or has selected** for the coordination of the Members care. To the extent the Provider is not equipped to receive the data, Contractor shall make it available to the Primary Care Provider or Subcontractor.

Commented [A41]: In GMC, numbered as F. In COHS, numbered as G.

7. Denial, Deferral, or Modification of Prior Authorization Requests

D. Contractor shall provide for a written notification to the Member and the Member's representative on a standardized form informing the Member of all the following:

1) The Member's right to, and method of obtaining, a State ~~Fair~~ Hearing to contest Contractor's denial, deferral, delay or modification of a requested service.

2) The Member's right to represent himself/herself at the State ~~Fair~~ Hearing or to be represented by legal counsel, friend or other spokesperson.

XV. Exhibit A, Attachment 14, MEMBER GRIEVANCE AND APPEAL SYSTEM, is amended to read:

3. Grievance and Appeal Log and Quarterly Grievance and Appeal Report

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D. Contractor shall submit complete, accurate, and timely Grievance and Appeal data within ten (10) calendar days following the end of each month under this Contract or as otherwise agreed upon by DHCS, and in the format specified by DHCS **and as required in Exhibit A, Attachment 3, Provision 7, Program Data**. Contractor shall certify all Network data as set forth in 42 CFR **section** 438.606.

4. Notice of Action (NOA)

B. A written NOA shall be in a format and language that, at a minimum, meets the standards set forth in 42 CFR **section** 438.10 and Exhibit A, Attachment 13, **Member Services,** Provision 4**3**, Paragraph D, ~~Member Services,~~ and shall include all of the following:

4) The Member's right to request a State ~~Fair~~ Hearing after requesting an Appeal and receiving notice that Contractor is upholding its action, or after Contractor fails to send a resolution notice or extension in response to the Appeal within 30 calendar days;

5) Procedures for exercising the Member's rights to request an Appeal or a State ~~Fair~~ Hearing;

5. Appeal Process

Contractor shall have in place a process as required below to resolve Member requests for Appeals. Contractor may have only one **(1)** level of Appeal for Members. Upon request, Contractor shall assist Members in preparing their Appeal.

B. If Contractor fails to send a Member resolution notice within 30 calendar days, or fails to comply with the notice requirements of 42 CFR **section** 438.10, the Member is deemed to have exhausted

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Contractor's internal Appeal process and may request a State ~~Fair~~ Hearing. This is referred to as Deemed Exhaustion.

C. Contractor's NAR, at a minimum, must include the result and date of the Appeal resolution. For decisions not wholly in the Member's favor, Contractor, at a minimum, must include:

1) Member's right to request a State ~~Fair~~ Hearing;

2) How to request a State ~~Fair~~ Hearing;

3) Right to continue to receive benefits pending a State ~~Fair~~ Hearing;

H. If Contractor, at the Member's request, continues or reinstates the provision of Covered Services while an Appeal or State ~~Fair~~ Hearing is pending, those services must continue until:

1) The Member withdraws their request for an Appeal or a State ~~Fair~~ Hearing;

2) The Member fails to request a State ~~Fair~~ Hearing and continuation of Covered Services within **ten (**10**)** calendar days of when the NOA was sent; or

3) The State ~~Fair~~ Hearing decision is adverse to the Member.

7. State ~~Fair~~ Hearings and Independent Medical Reviews

A. State ~~Fair~~ Hearings

1) Members, or a Provider or authorized representative acting on behalf of a Member and with the Member's written consent, may request a State ~~Fair~~ Hearing:

b) If the Member is deemed to have exhausted the Appeals process due to Contractor's failure to comply with Appeal notice and timing requirements Contractor shall maintain documentation to demonstrate to the Department, why the extension is necessary, as stated in this Contract the Member may request a ~~Fair~~ **State** Hearing. In cases of such

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deemed exhaustion, Contractor must not request a dismissal of the ~~Fair~~ **State** Hearing based on a failure to exhaust Contractor's internal Appeal process.

2) Upon request, Contractor shall assist the Member with preparing for the State ~~Fair~~ Hearing and must provide the Member, upon request, with all documents, guidelines and clinical criteria Contractor relied on for its initial denial and anything Contractor considered during its internal Appeal process.

3) Contractor must provide its Statement of Position for the ~~Fair~~ **State** Hearing to the Member and to the Department of Social Services **(DSS)** at least two (2) ~~w~~**W**orking ~~d~~**D**ays before the hearing.

4) Contractor must ensure that an employee familiar with the facts of the case and Contractor's ~~bases~~ **basis** for upholding its Adverse Benefit Determination is available to participate in the ~~hearing~~ **State Hearing**. Contractor must ensure that it provides accurate contact information for Contractor's representative to ensure appearance at the ~~hearing~~ **State Hearing** via telephone or in person.

5) In cases where the State ~~Fair~~ 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 ~~Fair~~ 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 ~~Fair~~ Hearing must include Contractor as well as the Member and their representative or the representative of a deceased Member's estate.

8) Contractor shall notify Members that the State must reach its decision for a standard State ~~Fair~~ Hearing within 90 days of the date of the request. For an expedited State ~~Fair~~

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Hearing, the State must reach its decision within 72 hours of receipt of the expedited State ~~Fair~~ Hearing request. Contractor shall also comply with all other requirements as required by 42 ~~section~~ CFR **section** 438.410, W&I Code **section** 10951.5**, and as outlined in APL 21-001**.

B. Expedited State ~~Fair~~ Hearings

1) Within two (2) ~~w~~**W**orking ~~d~~**D**ays of being notified by DHCS or ~~the California Department of Social Services (C~~DSS~~)~~ that a Member has filed a request for State ~~Fair~~ Hearing which meets the criteria for expedited resolution, Contractor shall deliver directly to the designated/appropriate ~~C~~DSS 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 ~~Fair~~ Hearing. This includes, but is not necessarily limited to, copies of the relevant treatment authorization request and NOA, plus any pertinent Appeal resolution notice and all documents Contractor relied on for its denial, including clinical criteria and guidelines. If the NOAs or NARs are not in English, fully translated copies shall be transmitted to ~~C~~DSS along with copies of the original NOAs and NARs.

2) One **(1)** or more of Contractor's representatives with knowledge of the Member's condition and the reason(s) for the action, which is the subject of the expedited State ~~Fair~~ Hearing, shall be available by phone during the scheduled **State** Hearing.

C. Independent Medical Review (IMR)

2) An IMR must be requested by a Member. Contractor shall not require a Member to request an IMR before, or use one as a deterrent to, requesting a State ~~Fair~~ Hearing.

8. Continuation of Services Until Appeal and State ~~Fair~~ Hearing Rights Are Exhausted

A. Contractor shall automatically continue providing Covered Services while the Appeal and State ~~Fair~~ Hearing are pending if all of the following conditions are met:

B. If Contractor, at the Member's request, continues or reinstates the provision of Covered Services while an Appeal or State ~~Fair~~ Hearing is pending, those services must continue until:

1) The Member withdraws their request for an Appeal or a State ~~Fair~~ Hearing;

2) The Member fails to request a State ~~Fair~~ Hearing and continuation of Covered Services within **ten (**10**)** calendar days of when the NOA was sent; or

3) The final State ~~Fair~~ Hearing decision is adverse to the Member.

C. Contractor must pay for disputed services, until there is a final decision on the State Hearing, if the Member received the disputed services while the Appeal or State ~~Fair~~ Hearing was pending.

XVI. Exhibit A, Attachment 16, ENROLLMENTS AND DISENROLLMENTS, is amended to read:

1. Enrollment Program

Contractor shall cooperate with the DHCS Enrollment program and shall provide to DHCS' enrollment contractor a ~~list of Network Providers (~~provider directory~~)~~, linguistic capabilities of the Providers and other information deemed necessary by DHCS to assist Eligible Beneficiaries, and Potential Enrollees, in making an informed choice in health plans. The provider directory will be submitted every six (6) months and in accordance with PL 11-009.

3. Disenrollment

The enrollment contractor shall process a Member disenrollment under the following conditions, subject to approval by DHCS, in accordance with

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the provisions of ~~Title~~ 22 CCR ~~S~~**s**ection 53891:

A. Disenrollment of a Member is mandatory when:

3) Enrollment was in violation of ~~Title~~ 22 CCR ~~S~~**s**ection 53891(a)(2), or requirements of this Contract regarding Marketing, and DHCS or Member requests disenrollment.

4) Disenrollment is requested in accordance with ~~Welfare and Institutions~~**W&I** Code ~~S~~**s**ection 14303.1 regarding merger with other organizations, or **W&I Code section** 14303.2 regarding reorganizations or mergers with a parent or subsidiary corporation.

6) Disenrollment is based on the circumstances described in Exhibit A, Attachment 11, Provision 1~~7~~**6**, Excluded Services Requiring Member Disenrollment.

Commented [A42]: Only for CCI plans.

Such disenrollment shall become effective on the first day of the second month following receipt by DHCS of all documentation necessary, as determined by DHCS, to process the disenrollment, provided disenrollment was requested at least 30 calendar days prior to that date~~, except for disenrollment pursuant to Exhibit A, Attachment 11, Provision 18, regarding Major Organ Transplants, for which disenrollment shall be effective the beginning of the month in which the transplant is approved~~.

XVII. Exhibit A, Attachment 17, REPORTING REQUIREMENTS, is amended to read:

Contract Section	Requirement	Frequency
Exhibit A - SCOPE OF WORK		
Attachment 9 ACCESS AND AVAILABILITY		
13. Cultural and Linguistic Program C. Population Needs Assessment ~~4)~~	Population Needs Assessment ~~Summary~~ Report	~~Every 5 years~~ **Annually**
Attachment 10 SCOPE OF SERVICES		
~~8. Services for All Members G. Pharmaceutical Services and Provision of Prescribed Drugs 5)~~	~~Report of Changes to the Formulary~~	~~Annually~~

Commented [A43]: Rx only – plans have already reviewed RX language as of 2/4/2021.

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Contract Section	Requirement	Frequency
8. Services for All Members ~~G~~**F**. Pharmaceutical Services ~~and Provision of Prescribed Drugs~~ ~~7~~**1**)	Report of DUR Program Activities	Annually
Attachment 20 ~~MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS~~ BEHAVIORAL HEALTH SERVICES		
~~**Attachment 22 HEALTH HOMES PROGRAM**~~		
~~10. Required Reports for the Health Homes Program~~	~~Data Reports as determined by DHCS~~	~~Monthly~~

Commented [A44]: Only applies to those plans who have HHP in their contracts.

Commented [A45]: Only applies to those plans who have HHP in their contracts.

XVIII. Exhibit A, Attachment 18, IMPLEMENTATION PLAN AND DELIVERABLES, is amended to read:

5. Utilization Management (UM)

H. Submit policies and procedures for utilization management for organ and bone marrow transplant surgeries.

6. Provider Network

B. Submit policies and procedures describing how Contractor will monitor Provider to ~~patient~~ **Member** ratios to ensure they are within specified standards.

C. Submit policies and procedures regarding ~~p~~**P**hysician supervision of Non-Physician Medical Practitioners.

D. Submit policies and procedures for providing ~~e~~**E**mergency ~~s~~**S**ervices.

E. Submit a complete list of Specialists by type within Contractor's Network in accordance with ~~Welfare and Institutions~~ **W&I** Code ~~S~~**s**ection 14087.3.

8. Provider Compensation Arrangements

Commented [A46]: Rx only

Commented [A47R46]: Plans have already reviewed RX language as of 2/4/2021.

I. Submit policies and procedures regarding payment to non-

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contracting ~~e~~**E**mergency ~~s~~**S**ervices Providers. Include schedule of per diem rates and/or FFS rates for each of the following Provider types;

~~5) Pharmacies~~

9. Access and Availability

M. Submit a timeline and work plan for the development and performance of a ~~Group~~ **Population** Needs Assessment.

10. Scope of Services

D. Submit the plan's risk assessment tool to be used to comprehensively assess an SPD beneficiaries' current health risk and help develop individualized care management plans~~, as well as the Health Homes Program (HHP) assessment template~~.

Commented [A48]: Only applies to those plans who have HHP in their contracts.

L. Submit policies and procedures for the provision of:

~~4) Tuberculosis services~~

~~5~~**4**) NEMT/NMT

5) Organ and bone marrow transplant surgeries

~~M. Submit standards and guidelines for the provision of pharmaceutical services and prescribed drugs, including providing at least a 72-hour supply of a covered outpatient drug when prescribed in an emergency.~~

~~N. Submit a complete drug formulary.~~

~~O. Submit a process for review of drug formulary.~~

Commented [A49]: Rx only

Commented [A50R49]: Plans have already reviewed RX language as of 2/4/2021.

~~P~~**M**. Submit policies and procedures for conducting a Drug Utilization Review (DUR).

~~Q~~**N**. 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.

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O. Submit policies and procedures regarding the authorization of Medically Necessary Physician administered drugs billed on a medical claim needed for organ and bone marrow transplants.

11. Case Management Including External Coordination of Care

~~A. Submit procedures for monitoring the coordination of care provided to Members. Include procedures used to monitor the provision of Basic Case Management.~~

~~B. Submit procedures for administering and monitoring the provision of Complex Case Management to Members. Include procedures to identify members who may benefit from complex case management services, and for conducting care management for HHP Enrolled Members.~~

~~C. Submit policies and procedures for ensuring the provision of Person-Centered Planning for SPD beneficiaries as part of case management and coordination of care.~~

~~D. Submit policies and procedures for ensuring the provision of Discharge Planning, including discharge planning workflows for HHP Enrolled Members.~~

~~E. Submit policies and procedures for coordinating care of Members who are receiving services from a Targeted Case Management Provider.~~

~~F. Submit policies and procedures for the referral of Members under the age of 21 years that require complex case management services.~~

~~G~~**A**. Submit policies and procedures for administration of a disease management program, including procedures for identification and referral of Members eligible to participate in the disease management program.

~~H~~**B**. Submit policies and procedures for referral and coordination of care for Members in need of Specialty Mental Health Services from the county mental health plan or other community resources.

~~I~~**C**. Submit policies and procedures for resolving disputes between

Commented [A51]: A-F is being removed from Provision 11 and moved into new Provision 22.

Commented [A52]: Only applies to those plans who have HHP in their contracts.

Commented [A53]: Only applies to those plans who have HHP in their contracts.

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Contractor and the county mental health plan.

~~J~~**D**. Submit policies and procedures for identification, referral and coordination of care for Members requiring alcohol or substance use treatment services from both within and, if necessary, outside Contractor's Service Area.

~~K~~**E**. Submit a detailed description of Contractor's program for Children with Special Health Care Needs (CSHCN).

~~L~~**F**. Submit policies and procedures for identifying and referring children to the local CCS program.

~~M~~**G**. Submit policies and procedures for the identification, referral and coordination of care for Members with developmental disabilities in need of non-medical services from the local Regional Center and the DDS-administered Home and Community Based Waiver Program. Include the duties of the Regional Center Liaison.

~~N~~**H**. Submit policies and procedures for the identification, referral and coordination of care for Members at risk of developmental delay and eligible to receive services from the local Early Start Program.

~~O~~**I**. Submit policies and procedures for case management coordination of care of LEA services, including Primary Care Physician involvement in the development of the Member's Individual Education Plan or Individual Family Service Plan.

~~P~~**J**. Submit policies and procedures for case management coordination of care of Members who receive services through local school districts or school sites.

~~Q~~**K**. Submit a description of the cooperative arrangement Contractor has with the local school districts, including the Subcontracts or written protocols/guidelines, if applicable.

~~R~~**L**. Submit policies and procedures describing the cooperative arrangement that Contractor has regarding care for children in Foster Care.

~~S~~**M**. Submit policies and procedures for identification and referral of Members eligible to participate in the HIV/AIDS Home and Community Based Waiver Program.

~~T~~**O**. Submit policies and procedures for the provision of dental screening and covered medical services related to dental services.

~~U~~**P**. Submit policies and procedures for coordination of care and case management of Members with the LHD TB Control Officer.

~~V~~**Q**. Submit policies and procedures for the assessment and referral of Members with active TB and at risk of non-compliance with TB drug therapy to the LHD.

~~W~~**R**. Procedures to identify and refer eligible Members for WIC services.

~~X~~**S**. Submit policies and procedures for the assessment and subsequent disenrollment of Members eligible for **Waiver Program** ~~the following~~ services~~:~~**.**

~~1) Major organ transplants~~

~~2) Waiver Programs~~

~~Y. Submit policies and procedures for assessment of transitional needs of members into and out of Complex Case Management services:~~

~~1) At the request of PCP or Member~~

~~2) Achievement of targeted outcomes~~

~~3) Change of healthcare setting~~

~~4) Loss or change in benefits~~

~~5) Member non-compliance~~

13. Member Services

K. Submit policies and procedures for notifying **a** Primary Care Provider that a Member has selected or been assigned to the Provider within **seven (**7**)** ~~-~~days.

14. Member Grievance and Appeal System

D. Submit policies and procedures relating to Contractor's Appeals process. Include Contractor's responsibilities in expedited Appeals

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and State ~~Fair~~ Hearings.

19. ~~**Mental Health and Substance Use Disorder Benefits**~~ **Behavioral Health Services**

Commented [A54]: Title update only.

20. Managed Long-Term Services and Supports

Submit the following consistent with the requirements of Exhibit A, Attachment 21.

C. Submit policies and procedures for the provision of LTC~~, and the Multipurpose Senior Services Program (MSSP),~~ as **a** Covered Service~~s~~.

~~**22. Health Homes Program**~~

~~Submit the following consistent with the requirements of Exhibit A, Attachment 22.~~

~~A. Submit a report, in a format specified by DHCS, that includes the list of contracted Community-Based Care Management Entities (CB-CME) in Contractor's Network that have primary responsibility for Care Coordination, and the projected enrollment capacity of each CB-CME at the time of the Health Homes Program (HHP) implementation date.~~

~~B. Contractor shall submit a boilerplate of their CB-CME Subcontract that includes a Business Associate Agreement.~~

~~C. Submit policies and procedures describing how information is shared among the HHP Multi-Disciplinary Care Team.~~

~~D. Submit Health Action Plan (HAP) template.~~

~~E. Submit policies and procedures for conducting care transitions.~~

~~F. Submit policies and procedures for providing Individual Housing Transition Services and Individual Housing & Tenancy Sustaining Services, including how Contractor will identify and work with community resources to ensure seamless access to housing support services.~~

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~~G. Submit policies and procedures for engagement with HHP Enrolled Members, including Member information, Member services, and face-to-face engagement.~~

~~H. Submit Member information regarding HHP that will be provided to Members.~~

~~I. Submit policies and procedures for ensuring HHP Enrolled Members receive the appropriate services at the appropriate intensity level.~~

Commented [A55]: Only applies to those plans who have HHP in their contracts.

21. Case Management and Internal Coordination of Care

Submit the following consistent with the requirements of Exhibit A, Attachment 22.

A. Submit procedures for monitoring the coordination of care provided to Members. Include procedures used to monitor the provision of Basic Case Management.

B. Submit procedures for administering and monitoring the provision of Complex Case Management to Members. Include procedures to identify Members who may benefit from Complex Case Management services.

C. Submit policies and procedures for ensuring the provision of Person-Centered Planning for SPD beneficiaries as part of case management and internal coordination of care.

D. Submit policies and procedures for ensuring the provision of Discharge Planning.

E. Submit policies and procedures for coordinating care of Members who are receiving services from a Targeted Case Management Provider.

F. Submit policies and procedures for the referral of Members under the age of 21 years who require Complex Case Management services.

G. Submit policies and procedures for assessment of transitional needs of Members into and out of Complex Case Management

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services:

1) At the request of the PCP or Member

2) Achievement of targeted outcomes

3) Change of healthcare setting

4) Loss or change in benefits

5) Member non-compliance

H. Submit policies and procedures for coordinating care of Members who are receiving services from Enhanced Care Management Provider.

I. Submit policies and procedures for administering and monitoring the provision of Community Supports to Members. Include procedures to identify Members who may benefit from Community Supports.

~~21~~22. Budget Detail and Payment Provisions

~~22~~23. Program Terms and Conditions

XIX. Exhibit A, Attachment 20, ~~MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS~~ BEHAVIORAL HEALTH SERVICES, is amended to read:

1. Outpatient Mental Health Services Providers

B. The number of Outpatient Mental Health Services Providers available shall be sufficient to meet referral and appointment access standards for routine care and shall meet the Timely Access Regulation ~~per~~ **requirements set forth in** Health~~y~~ and Safety Code~~,~~ ~~S~~**s**ection 1367.03 **and**~~, Rule~~ **28 CCR section** 1300.67.2.2, in accordance with the requirements set forth in Exhibit A, Attachment 9, Access and Availability, Provision 4~~.~~**,** Access Standards.

4) Any time that a Member requires a Medically Necessary Outpatient Mental Health Service that is not available within

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the Provider Network, Contractor shall ensure access to Out-of-Network Providers and ~~Telehealth~~ mental health Providers **who can provide services via Telehealth** as necessary to meet access requirements.

2. Emergency Services

A. In addition to the requirements set forth in Exhibit A, Attachment 12, Local Health Department Coordination, Contractor shall have a Memorandum of Understanding (MOU) with the county mental health plan to refer Members in need of urgent and emergency care, including person-to-person telephone transfers, to the county crisis program during their call center hours. The MOU shall be executed in accordance with the requirements specified in Exhibit A, Attachment 10, Scope of Services, and Exhibit A, Attachment 11, Case Management and **External** Coordination of Care.

3. Provider Network Reports

A. In addition to the requirements set forth in Exhibit A, Attachment 6, Provider Network, Provision 11~~.~~**,** Provider Network Report, the Provider Network report shall identify the number of licensed mental health care Providers. The report shall include:

2) The percentage of Providers who deliver services through ~~the~~ Telehealth ~~method,~~ if applicable.

XX. Exhibit A, Attachment 21, MANAGED LONG-TERM SERVICES AND SUPPORTS, is amended to read:

~~**2. Quality Improvement System**~~

~~In addition to Exhibit A, Attachment 4, Quality Improvement System, Provision 12. Credentialing and Recredentialing, Contractor is not responsible for credentialing Multipurpose Senior Services Program (MSSP) Providers. Credentialing MSSP Providers is the responsibility of the California Department of Aging (CDA).~~

~~**3. Utilization Management**~~

~~Notwithstanding Exhibit A, Attachment 5, Utilization Management,~~

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~~Provision 2. Prior Authorizations and Review Procedures, Contractor shall not authorize MSSP services. Contractor shall refer Members who are potentially eligible for MSSP to MSSP Providers for authorization. Contractor shall collaborate and coordinate MSSP care management services with MSSP Providers.~~

~~4~~ 2. Provider Network

In addition to Exhibit A, Attachment 6, Provider Network, Contractor also agrees to the following:

A. Contractor shall ensure that every ~~contracted~~ Long Term Care (LTC) Provider ~~and MSSP site~~ within the Service Area approved by the California Department of Public Health (CDPH) ~~and CDA~~ as a qualified Provider is included in their Network, to the extent that the Provider remains licensed, certified, operating, and is willing to enter into a Network Provider Agreement with Contractor on mutually agreeable terms and meets the Contractor's credentialing and quality standards.

~~E. Any subcontract that Contractor enters into with a CDA qualified MSSP site, for either the provision of health care service or to perform an administrative function, shall be submitted to DHCS for prior approval at least 60 calendar days prior to the effective date of the contract. DHCS shall acknowledge in writing the receipt of any subcontract sent to DHCS by Contractor for approval within five (5) working days of receipt. These subcontracts shall not be effective until written approval is provided by DHCS and CDA or by operation of law where DHCS has acknowledged receipt of the proposed subcontract, and has neither approved nor rejected the proposed subcontract within 60 calendar days of receipt.~~

~~1) Contractor shall also submit a subcontract for MSSP to DHCS for approval even if the Subcontractor has been previously approved by DHCS and CDA for another program.~~

~~2) Any new or updated subcontract that makes a material change to the subcontract must be re-submitted to DHCS. Previous subcontract approval shall be valid only until such time as the new or amended subcontract is approved by DHCS and CDA.~~

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~~F. Subcontract amendments shall be submitted to DHCS for prior approval at least 30 calendar days before the effective date of any proposed changes governing compensation, services, or term. Proposed changes which are neither approved nor rejected by DHCS and CDA shall become effective by operation of law 30 calendar days after DHCS has acknowledged receipt or upon the date specified in the subcontract amendment, whichever is later.~~

~~5~~ 3. Provider Relations

~~6~~ 4. Provider Compensation Arrangements

In addition to Exhibit A, Attachment 8, Provider Compensation Arrangements, Contractor also agrees **that Skilled Nursing Facilities and Nursing Facilities (SNF/NF) claims are to be paid in accordance with W&I Code sections 14182.16 and 14186.3.**~~to the following:~~

~~A. Skilled Nursing Facilities and Nursing Facilities (SNF/NF) claims are to be paid in accordance with Welfare and Institutions (W&I) Code Sections 14182.16 and 14186.3.~~

~~B. MSSP invoices submitted by subcontracted MSSP sites for MSSP services are to be paid in a timely manner upon verification of the accuracy and validity of the services invoiced therein, and in accordance with Contractor's subcontract with the MSSP site.~~

~~C. For MSSP services, Contractor must follow the processes pursuant to W&I Code Section 14186.3 (b)(7)(A).~~

~~7~~ 5. Covered Services

Contractor shall provide MLTSS based on a Member's current assessment, conducted in accordance with the requirements of this Contract, and consistent with Person-Centered Planning. LTC, ~~and MSSP are~~ **is a** Covered Service~~s~~ under this Contract. In addition to Exhibit A, Attachment 10, Scope of Services, Contractor shall also cover ~~MSSP and~~ **Medically Necessary** LTC ~~in accordance with the following requirements:~~

~~A.~~ ~~Contractor shall cover Medically Necessary LTC~~ from the time of admission into an appropriate facility to either the Member's release from the facility or to the Member electing to receive hospice services.

~~1)~~**A.** Contractor shall ensure that Members in need of LTC are placed in a facility that provides the level of care most appropriate to the Member's medical needs. These health care facilities include SNF/NF, subacute facilities, and Intermediate Care Facilities.

~~2)~~**B.** Contractor shall base decisions on the appropriate level of care on the definitions set forth in ~~Title~~ 22 CCR Sections 51118, 51120, 51120.5, 51121, 51124.5, and the criteria for admission set forth in ~~Title~~ 22 CCR Sections 51335, 51335.5, and 51334 and related sections of the Manual of Criteria for Medi-Cal Authorization referenced in ~~Title~~ 22 CCR Section 51003(e).

~~3)~~**C.** Upon admission to an appropriate facility, Contractor shall assess the Member's health care needs and estimate the potential length of stay of the Member.

~~4)~~**D.** Contractor shall provide continuity of care for all Medically Necessary LTC services at non-contracting LTC facilities for those Full Benefit Dual Eligible Members, Partial Dual Eligible Members, and Medi-Cal Only Members residing in an LTC facility at the time of enrollment into Medi-Cal managed care. Contractor shall not require said Members residing in non-contracted facilities to relocate unless it is determined that relocation is Medically Necessary or if the non-contracted LTC facility does not meet the requirements set forth in Provision 8, Paragraph B of this Attachment.

~~B. Contractor shall cover MSSP in accordance with the eligibility determination as performed by the appropriate MSSP site, and ensure the provision of these services in accordance with the requirements set forth below in Provision 8. Coordination of Care.~~

~~1) Contractor shall not be required to determine Member eligibility to receive MSSP.~~

~~2) Contractor shall refer MSSP eligibility determination to the MSSP site for approval.~~

~~3) Contractor shall refer to the MSSP site for confirmation of Member eligibility and to verify if the Member has been enrolled in MSSP.~~

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~~C. Contractor shall continue to cover MSSP for 19 months after the commencement of MSSP as a managed care benefit.~~

~~8~~ 6. Coordination of Care

In addition to Exhibit A, Attachment 11, Case Management and **External** Coordination of Care, Contractor also agrees to the following:

F. Contractor shall retain and compile a copy of each assessment conducted on behalf of Full Benefit Dual Eligible and Partial Dual Eligible Members through MSSP, CBAS, and/or **receiving** LTC. Contractor shall review these assessments and determine if any further care coordination of services for the Member is appropriate.

H. Contractor shall ensure that coordination of care services for Partial Dual Eligible Members and Medi-Cal Only Members reflect a person-centered, outcome-based approach and shall:

5) Follow the requirements for Person-Centered Planning set forth for SPD Beneficiaries in this Contract as stated in Exhibit A, Attachment ~~11~~**22**, Case Management and **Internal** Coordination of Care, Provision ~~1~~**32**, ~~Comprehensive Case Management Including Coordination of Care Services~~ **Person-Centered Planning for Seniors and Persons with Disabilities (SPD) Beneficiaries**.

~~9~~ 7. Member Services

A. In addition to Exhibit A, Attachment 13, Member Services, Provision 3, Written Member Information, Contractor shall include in its ~~Network P~~**p**rovider ~~D~~**d**irectory ~~MSSP Provider sites and~~ all contracted LTC Network Providers.

~~10~~8. Required Reports for Managed Long Term Services and Supports

Contractor shall submit to DHCS the following reports:

D. In addition to the requirements set forth in Exhibit A, Attachment 14, Member Grievance and Appeal System, Provision 3. Grievance and Appeal Log and Quarterly Grievance and Appeal Report, Contractor shall also report to DHCS on a monthly basis the

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number and percentage of Grievances or Appeals that have been submitted in relation to a Member receiving LTC services. ~~Contractor shall not be responsible for reporting Grievances, Appeals, or resolutions related to a Member receiving MSSP if they were reported to the MSSP site.~~

~~11~~9. Risk Corridor

B. A Risk Corridor shall ~~also~~ be established for a period of 24 months, effective July 1, 2014 and ending on June 30, 2016 for Partial Dual Eligible Members and Medi-Cal Only Members, **as defined in Exhibit E, Definitions, of this Contract for the applicable period** and applies only to the provision of MLTSS**, MSSP, and IHSS** Covered Services ~~and IHSS~~ for Partial Dual Eligible Members and Medi-Cal Only Members.

~~12~~10. Capitation Rate Structure for Full Benefit Dual Eligible Members

B. Full Benefit Dual Eligible Members shall also be grouped into ~~four (4)~~ **distinct** Member mix categories representing differing levels of risk.

1) For applicable Rating Periods beginning prior to ~~Effective~~ January 1, 2**0**18, these categories are defined as follows:

~~1)~~**a)** Institutionalized: Members in LTC aid codes and/or residing in an LTC facility for 90 days or more;

b) HCBS High: Members identified as high utilizers of HCBS. These Members meet one (1) or more of the following criteria:

i) Members who receive CBAS; or

ii) Members who are clients of MSSP sites; or

iii) Members who receive IHSS and are classified under the IHSS program as "severely impaired"

c) HCBS Low: Members identified as low utilizers of HCBS. These Members are IHSS recipients and classified under the IHSS program as "not severely impaired"; and

d) Community Well: Members living in the community with no covered HCBS, who are not residents in LTC facilities, and who do not utilize CBAS, MSSP, or IHSS.

2) For Rating Periods within the period of January 1, 2018, through December 31, 2021, these categories are defined as follows:

a) Institutionalized: Members in LTC aid codes and/or residing in an LTC facility for 90 days or more;

~~2~~**b)** CBAS and MSSP: Members meet one (1) or more of the following criteria:

~~a)~~**i.** Members who receive CBAS; or

~~b)~~**ii.** Members who are clients of MSSP sites~~;~~

~~3~~**c**) IHSS Only (no CBAS or MSSP): Members who receive IHSS, but do not receive CBAS and are not clients of a MSSP site; and

~~4~~**d**) Community Well: Members living in the community with no covered HCBS, **who** are not residents in LTC facilities, and **who** do not utilize CBAS, MSSP, or IHSS ~~services~~.

3) For the Rating Period effective January 1, 2022, Member mix categories are defined as follows:

a) Institutionalized: Members in LTC aid codes and/or residing in an LTC facility for 90 days or more;

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b) CBAS: Members living in the community who utilize CBAS; and

c) Other Community: Members living in the community who are not in LTC aid codes, are not residing in a LTC facility for 90 days or more, and do not utilize CBAS.

C. The capitation rate**s** will utilize the following payment methodology**, subject to the phases described in Paragraph D of this Provision**:

1) DHCS shall ~~initially~~ pay ~~an estimated rate~~ **a blended rate** based on the assumed mix across the ~~three (3)~~ population segments **described in Paragraph A of this Provision** and **the** ~~four (4)~~ Member mix categories **described in Paragraph B of this Provision**. ~~This assumed mix is impacted by a DHCS assumption related to the percentage of Members who will opt out of Cal MediConnect.~~

2) **For applicable phases described in Paragraph D of this Provision,** DHCS shall recalculate the blended rate based on the actual Full Benefit Dual Eligible Member ~~distribution beginning no later than January 1, 2015 when actual Full Benefit Dual Eligible Member enrollment is known~~ **mix**. The final rate based on the actual ~~enrollment distribution~~ **Member mix** will incorporate the same base rates by population segment and Member mix category as the original ~~estimated~~ rate **described in Subparagraph 1) of this Paragraph**. DHCS shall retain the ability to group Members into the ~~three (3)~~ population segments and ~~four (4)~~ Member mix categories **described in Paragraphs A and B of this Provision**.

3) The final ~~Member mix~~ **blended rate** calculations will be completed ~~after the recalculation time frames,~~ either monthly, quarterly, or annually as referenced in each respective ~~P~~**p**hase identified in Paragraph D of this Provision.

4) Once DHCS has recalculated the **final** blended rate, there may be additional payments by DHCS to Contractor or a

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recoupment of Overpayment**s** from Contractor to DHCS.

D. The payment process will vary over three (3) distinct phases to address the stability of enrollment and to establish appropriate financial incentives for Contractor.

1) Phase I: The recalculation of the final **blended** rate will be applied monthly and retroactively to match Contractor's actual enrollment. This phase will continue through each county's phase-in enrollment period for a minimum of one (1) year and will end at the start of the following fiscal quarter. For example, if Contractor operates in a county with a 12-month phase-in that began enrollment in April 2014, this phase would last through the end of March 2015.

2) Phase II: This phase will be for one (1) fiscal quarter. The recalculation of the final **blended** rate will be prospectively applied at the start of the quarter. Weighting of the ~~three (3)~~ population segments and ~~four (4)~~ Member mix categories will be based on the month preceding the quarter enrollment snapshot, which will be available after the quarter ends and will be retroactively applied to that period. For example, if Contractor operates in a county with a 12-month phase-in that begins enrollment in April 2014, this Phase II would be applicable for the fiscal quarter of April 2015 through June 2015. Enrollment data from March 2015 would be utilized although the rate update would not occur until several months after the quarter to ensure data availability.

E. With the structure as described above, DHCS and its actuaries will establish actuarially sound capitation rates for this Contract for Full Benefit Dual Eligible Members eligible for MLTSS. These capitation rates will be consistent with 42 CFR **section** 438.6(b)(1) and reviewed by the CMS. ~~Capitation rates approved by CMS will serve as the baseline Medi-Cal costs.~~

~~F. DHCS and its actuaries will provide to CMS the underlying data for the capitation rate calculations associated with this Contract.~~

~~G. As allowed under the capitation rates for this Contract, DHCS and its actuaries will calculate a range of actuarially sound capitation rates, including lower bound and upper capitation rates.~~

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~~H~~**F**. Limited risk corridors will be applied as described for Contractor and be reconciled after application of any risk adjustment methodologies and any other adjustments.

XXI. Exhibit A, Attachment 22, HEALTH HOMES PROGRAM, removes the following language:

Commented [A56]: Only applies to those plans who have HHP in their contracts.

~~**Exhibit A, Attachment 22, HEALTH HOMES PROGRAM**~~

~~**1. Health Homes Program Compliance**~~

~~Contractor shall be responsible for the overall administration of the Health Homes Program (HHP). Contractor shall comply with all State and federal requirements related to HHP and all HHP requirements determined by DHCS, including but not limited to APL 18-XXX.~~

~~**2. Provider Network**~~

~~In addition to Exhibit A, Attachment 6, Provider Network, Contractor also agrees to the following:~~

~~A. Contractor shall maintain an adequate Network of Community-Based Care Management Entities (CB-CME) to HHP Enrolled Members.~~

~~B. Contractor shall select CB-CMEs in accordance with Welfare & Institutions Code, Section 14127.3(d)(1), and qualifications as defined by DHCS.~~

~~C. Contractor may subcontract with CB-CMEs, and any other necessary Providers or agencies, for the provision of HHP Services.~~

~~D. In addition to the requirements set forth in Exhibit A, Attachment 6, Provider Network, Provision 14, Subcontracts, Contractor shall ensure HHP Subcontracts also contain the following provisions:~~

~~1) Specification of the CB-CME duties and responsibilities, including engagement activities, as defined by DHCS.~~

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2) Business Associate Agreement (BAA) with a Subcontractor that allows for Network data sharing.

3) Specification of guidelines for information and data sharing including sharing from Contractor to CB-CME, sharing from CB-CME to Contractor, notification of emergency department visits, inpatient admissions and discharges, and patient history.

4) Subcontractor's agreement to complete HHP training required by Contractor and DHCS.

E. Contractor shall establish and maintain contractual relationships with organizations to provide HHP Services, including Individual Housing Transition Services and Individual Housing and Tenancy Sustaining Services, and contractual or non-contractual relationships to provide linkages to other support services, as needed.

F. As required in Exhibit A, Attachment 12, Provision 3, Contractor shall have a signed MOU with county mental health plans, and shall amend the MOU to incorporate HHP requirements in accordance with APL 13-018. Contractor shall ensure that the updated MOU is in place as of the implementation date for Members with serious mental illness conditions.

G. Contractor may use HHP funding to make payments to HHP Enrolled Members' Providers who are not included formally on the CB-CME's HHP Multi-Disciplinary Care Team, but who are responsible for coordinating with the CB-CME care manager to conduct case conferences and to provide input to the Health Action Plan (HAP).

H. Contractor shall ensure availability of Providers with experience working with people who are Chronically Homeless, pursuant to Welfare & Institutions Code, Section 14127.3(d)(1)(B).

I. Contractor shall ensure the establishment of HHP Multi-Disciplinary Care Teams, to provide HHP Services, as defined by DHCS.

J. Contractor shall ensure CB-CMEs fulfill CB-CME duties as defined by DHCS.

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K. Contractor shall maintain an aggregate minimum care manager ratio as defined by DHCS.

3. Provider Relations

A. Contractor shall ensure that staff who provide HHP Services complete required training, as determined by DHCS.

B. Contractor shall participate in the DHCS-operated learning collaborative.

4. Eligibility and Enrollment

A. Contractor shall enroll individuals in HHP based on the HHP eligibility criteria, as defined by DHCS.

B. Contractor shall accept referrals of Members potentially eligible for HHP from CB-CMEs, Providers or other non-Provider community entities, and care Providers, for confirmation of eligibility prior to enrollment in HHP.

C. Contractor shall ensure verbal or written consent is obtained from a Member to participate in HHP in accordance with legal requirements. Contractor shall ensure records of HHP Enrolled Member consents are maintained.

D. Contractor shall evaluate and attempt to engage individuals on the DHCS HHP Targeted Engagement List (TEL) in a manner determined by DHCS.

5. HHP Member Services

A. Contractor shall assign HHP Enrolled Members to CB-CMEs for the provision of HHP Services.

B. Contractor shall inform HHP Enrolled Members of their assigned CB-CME and the option to choose a different CB-CME.

C. Contractor shall maintain an HHP call line or other mechanism for Member inquiries and input.

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~~D. Contractor shall ensure the following HHP-specific information is available to the Contractor's customer service line and 24/7 nurse line staff, as applicable:~~

~~1) HHP eligibility criteria~~

~~2) HHP Provider information~~

~~3) Call center scripts related to HHP~~

~~E. In addition to the requirements in Exhibit A, Attachment 13, Member Services, Provision 4, Contractor shall provide Member information specific to HHP.~~

~~F. In addition to the requirements for a provider directory found in Exhibit A, Attachment 13, Member Services, Provision 4.E., Contractor shall ensure a directory of community services and supports is developed and maintained, and made available to all CB-CMEs and care coordinators.~~

~~G. Contractor shall submit all Member information developed for HHP by Contractor regarding the provision of HHP Services to DHCS for review. If Contractor is a Knox-Keene licensed plan, these materials shall be filed with DMHC for review, as applicable.~~

~~H. In addition to the requirements in Exhibit A, Attachment 9, Provision 14, Linguistic Services, Contractor shall ensure that services, communication, and information to HHP Enrolled Members meets health literacy, reading level, and trauma-informed care standards, and is culturally appropriate.~~

~~6. HHP Covered Services~~

~~A. Contractor shall provide and coordinate the following HHP Services informed by evidence-based clinical practice guidelines, where appropriate:~~

~~1) Comprehensive care management~~

~~2) Care coordination~~

~~3) Health promotion~~

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~~4) Comprehensive transitional care~~

~~5) Individual and family support services~~

~~6) Referral to community and social supports~~

~~B. Contractor shall ensure HHP specific elements are included in Contractor's HHP Enrolled Member assessment tools and processes, as determined by DHCS, for the purpose of completing a HAP.~~

~~C. Contractor shall ensure a HAP is completed for each HHP Enrolled Member within 90 days of HHP enrollment. The completed HAP shall include, as needed, an assessment and a plan to address needs relating to medical, social, economic, behavioral health, functional impairment, cultural and environmental factors affecting the health and health care choices available to HHP Enrolled Members.~~

~~D. Contractor shall ensure that appropriate HHP Services are provided to a HHP Enrolled Member at the appropriate intensity level, based on Member acuity or assigned risk group.~~

~~E. HHP Services shall be provided through in-person meetings where the HHP Enrolled Member lives, seeks care, or is accessible, whenever possible. If necessary, services may also be provided through various multi-mode communications including telephone, letters, mailings, and community outreach.~~

~~F. Contractor shall have a process to facilitate necessary follow-up services and ensure they are accessed within an appropriate amount of time. The process must include follow-up services for HHP Enrolled Members following a discharge from an acute care facility.~~

~~G. Contractor shall have a process in place with the CB-CME to discuss changes in patient circumstances or condition with the treating/authorizing Providers that serve the HHP Enrolled Member and make changes to the HAP in a timely manner.~~

~~H. Contractor shall develop and ensure the implementation of policies and procedures to support CB-CME coordination efforts to:~~

~~1) Maintain frequent, in-person contact between the HHP Enrolled Member and the care manager when delivering HHP Services, based on DHCS requirements.~~

~~2) Coordinate with behavioral health Providers to assess and coordinate services as part of the HHP coordination.~~

~~3) Provide HHP Enrolled Members who are Homeless or experiencing housing instability, with Individual Housing Transition Services and Individual Housing & Tenancy Sustaining Services that will attempt to link them to available permanent housing, and help them maintain housing.~~

~~I. Contractor shall develop requirements for communication and information flow regarding referrals, transitions, and care delivered outside the primary care site.~~

~~J. In addition to, Exhibit A, Attachment 12, Local Health Department Coordination, Contractor shall coordinate care planning for HHP Enrolled Members with the county Specialty Mental Health Plan and Providers, and Drug Medi-Cal Providers, as needed.~~

~~**7. Information Sharing**~~

~~A. Contractor shall develop and maintain a method to track and share HHP Enrolled Member information between CB-CME and Contractor and other Providers as warranted.~~

~~B. Contractor shall track and share data with CB-CMEs and other Providers regarding each HHP Enrolled Member's health history.~~

~~C. Contractor shall ensure HHP Enrolled Member assessments are available to the PCPs, mental health service providers, substance use disorder services providers, and the care managers for HHP Enrolled Members.~~

~~D. Contractor shall notify CB-CMEs of emergency department visits, and inpatient admissions and discharges.~~

~~E. Contractor shall establish and maintain a data-sharing agreement with other Providers, with whom Contractor shares HHP Enrolled Member health information, that is compliant with all federal and State laws and regulations.~~

~~**8. Quality Improvement System**~~

~~A. Contractor shall include HHP-specific elements in Contractor's current quality improvement system processes.~~

~~B. Contractor shall be responsible for oversight and regular auditing and monitoring activities to ensure that case conferences occur, the HAP is updated as health care events unfold, and all other HHP care management requirements are completed.~~

~~**9. Payment**~~

~~A. Contractor shall be paid an additional monthly payment for each HHP Enrolled Member who receives HHP Services, in accordance with Exhibit B, Provision 15.~~

~~B. Contractor shall provide at least one HHP Service to each HHP Enrolled Member during each quarter of the ongoing service delivery period to be eligible for payment.~~

~~**10. Required Reports for the Health Homes Program**~~

~~Contractor shall collect and report on data determined by DHCS in a format determined by DHCS.~~

XXII. Exhibit A, Attachment 22, CASE MANAGEMENT AND INTERNAL COORDINATION OF CARE, adds the following language:

Exhibit A, Attachment 22
CASE MANAGEMENT AND INTERNAL COORDINATION OF CARE

1. Comprehensive Case Management Including Coordination of Care Services

Contractor must ensure the provision of Comprehensive Medical Case Management to each Member.

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Contractor must maintain procedures for monitoring the coordination of care provided to Members, including but not limited to all Medically Necessary services delivered both within and outside Contractor's Provider Network. These services are provided through either Basic or Complex Case Management activities based on the medical needs of the Member.

A. Basic Case Management Services are provided by the Primary Care Provider, in collaboration with Contractor, and must include:

1) Initial Health Assessment (IHA);

2) Individual Health Education Behavioral Assessment (IHEBA);

3) Identification of appropriate Providers and Facilities (such as medical, rehabilitation, and support services) to meet Member care needs;

4) Direct communication between the Provider and Member/family;

5) Member and family education, including healthy lifestyle changes when warranted; and

6) Coordination of carved-out and linked services, and referral to appropriate community resources and other agencies.

B. Complex Case Management Services are provided by Contractor, in collaboration with the Primary Care Provider, and must include, at a minimum:

1) Basic Case Management Services;

2) Management of acute or chronic illness, including emotional and social support issues by a multidisciplinary case management team;

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3) Intense coordination of resources to ensure member regains optimal health or improved functionality; and

4) With Member and PCP input, development of care plans specific to individual needs, and updating of these plans at least annually.

C. Contractor must develop methods to identify Members who may benefit from Complex Case Management services, using utilization data, the HIF/MET, clinical data, and any other available data, as well as self and Physician referrals.

2. Contractor's Responsibilities for Administration of Enhanced Care Management (ECM)

A. Contractor must take a whole-person approach to offering ECM, ensuring that ECM addresses the clinical and non-clinical needs of high-need and high-cost Members in distinct Populations of Focus, as defined in Provision 3, Populations of Focus for ECM of this Attachment, through systematic coordination of services and Comprehensive Case Management. Contractor must ensure ECM is community-based, interdisciplinary, high-touch, and person-centered.

B. Contractor must ensure ECM is available throughout its Service Area.

C. Contractor must ensure ECM is offered primarily through in-person interaction where Members and their family members, guardians, authorized representatives, caregivers, and authorized support persons live, seek care, or prefer to access services in their local community. Contractor must ensure its ECM Providers focus on building relationships with Members, and in-person visits may be supplemented with secure teleconferencing and telehealth, when appropriate and with the Member's consent.

D. In situations where Contractor is performing ECM functions using Contractor's own staff, Contractor must follow the same requirements as an ECM Provider that is a Network Provider or Subcontractor.

E. In counties with operating Health Homes Program (HHP) and Whole Person Care (WPC) pilots, Contractor must enter into Subcontractor Agreements or Network Provider Agreements, as appropriate, with WPC Lead Entities and HHP Community-Based Care Management Entities (CB-CMEs) for the provision of ECM, as described in Provision 7, Member Identification for ECM of this Attachment.

F. Contractor must follow the appropriate processes to ensure Members who may benefit from ECM receive ECM as defined in this Contract.

G. Contractor must ensure ECM provided to each Member encompasses the ECM core service components described in Provision 12, Core Service Components of ECM of this Attachment.

H. Contractor must ensure a Member receiving ECM is not receiving duplicative services from other sources, including by not limited to county-specific Targeted Case Management (TCM) services administered by Local Governmental Agencies (LGAs).

I. For Members who are dually eligible for Medicare and Medi-Cal and enrolled in a Medicare Advantage Plan, including a Dual-Eligible Special Needs Plan (D-SNP), Contactor must coordinate with the Medicare Advantage Plan for the provision of ECM for those Members.

J. Contractor must develop Member-facing written material about ECM for use across its network of ECM Providers. The written material must be submitted for DHCS review and approval prior to use. This material must include the following:

1) Explain ECM and how a Member may request it;

2) Explain that ECM participation is voluntary and can be discontinued at any time;

3) Explain that the Member must authorize ECM-related data sharing;

4) Describe the process by which the Member may choose a different ECM Lead Care Manager or ECM Provider; and

5) Meet standards for culturally and linguistically appropriate communication outlined in Exhibit A, Attachment 9, Provision 13, Cultural and Linguistic Program and in Exhibit A, Attachment 13, Provision 3, Written Member Information.

3. Populations of Focus for ECM

A. Subject to the phase-in and Member transition requirements described in Provision 7, Member Identification for ECM of this Attachment.

B. Contractor must provide ECM to Members that meet the eligibility criteria for at least one (1) of the following Populations of Focus, as described in the ECM Policy Guide:

1) Members over the age of 21 who are:

a) Experiencing homelessness;

b) High utilizers;

c) Experiencing Serious Mental Illness (SMI) or Substance Use Disorder (SUD);

d) Transitioning from incarceration;

e) At risk for institutionalization who are eligible for Long-Term Care services; or

f) Nursing facility residents transitioning to the community.

2) Children who are:

a) Experiencing homelessness;

b) High utilizers;

c) Experiencing Serious Emotional Disturbance (SED) or identified to be at Clinical High Risk (CHR) for psychosis or experiencing a first episode of psychosis;

d) Enrolled in California Children's Services (CCS)/CCS Whole Child Model (WCM) with additional needs beyond the CCS qualifying condition;

e) Involved in, or with a history of involvement in, child welfare (including individuals involved in foster care ages 26 and under); or

f) Transitioning from incarceration.

C. Contractor may offer ECM to Members who do not meet Population of Focus criteria in full, but may benefit from ECM.

D. Contractor must follow all DHCS policies and guidance including All Plan Letters (APLs) and ECM Policy Guide that further defines the approach to ECM for each Population of Focus, including the eligibility criteria for each Population of Focus and the phase-in timeline for Populations of Focus.

E. To avoid duplication between existing care management and coordination approaches, Members are excluded from ECM while enrolled in the following programs:

1) 1915(c) waiver programs including:

a) Multipurpose Senior Services Program (MSSP);

b) Assisted Living Waiver (ALW);

c) Home and Community-Based Alternatives (HCBA) Waiver;

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d) Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) Waiver;

e) HCBS Waiver for Individuals with Developmental Disabilities (DD); and

f) Self-Determination Program for Individuals with intellectual and DD.

2) Fully integrated programs for Members dually eligible for Medicare and Medi-Cal including:

a) Cal MediConnect (CMC);

b) Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs); and

c) Program for All-Inclusive Care for the Elderly (PACE).

3) Family Mosaic Project

4) California Community Transitions (CCT) Money Follows the Person (MFTP)

5) Basic Case Management (BCM) or Complex Care Management (CCM)

4. ECM Providers

A. Contractor must ensure ECM is provided primarily through in-person interaction in settings that are most appropriate for the Member, such as where the Member lives, seeks care, or prefers to access services in their local community.

B. ECM Providers may include, but are not limited to, the following entities:

1) Counties;

2) County behavioral health Providers;

3) Primary Care Physician (PCP), Specialist, or Physician groups;

4) Federally Qualified Health Centers (FQHCs);

5) Community health centers;

6) Community-based organizations;

7) Hospitals or hospital-based Physician groups or clinics (including public hospitals and district or municipal public hospitals);

8) Rural Health Clinics (RHC) and American Indian Health Service (AIHS) Programs;

9) Local Health Departments (LHDs);

10) Behavioral health entities;

11) Community mental health centers;

12) SUD treatment Providers;

13) Community Health Workers;

14) Organizations serving individuals experiencing homelessness;

15) Organizations serving justice-involved individuals;

16) CCS Providers; and

17) Other qualified Providers or entities that are not listed above, as approved by DHCS.

C. For the Population of Focus for eligible individuals with SMI or SUD and the Population of Focus for eligible individuals with SED, Contractor must prioritize county behavioral health staff or behavioral health Providers to serve in the ECM Provider role, provided they agree and are able to coordinate all

services needed by those Populations of Focus, not just their behavioral health services.

D. Contractor must attempt to enter into a Subcontractor Agreement or Network Provider Agreement, as appropriate, with each AIHS Facility as set forth in 22 CCR sections 55110 through 55180 to provide ECM, when applicable, as described in Exhibit A, Attachment 8, Provision 7, Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC), and American Indian Health Service Programs, Paragraph C.

E. Contractor must ensure ECM Providers meet the requirements set forth in all applicable APLs including, but not limited to, the requirements regarding the use of a care management documentation system.

F. Care management documentation systems may include certified electronic health record technology, or other documentation tools that can:

1) Document Member goals and goal attainment status;

2) Develop and assign care team tasks;

3) Define and support Member care coordination and care management needs;

4) Gather information from other sources to identify Member needs and support care team coordination and communication; and

5) Support notifications regarding Member health status and transitions in care such as discharges from a hospital or LTC Facility, and housing status.

G. Contractor must also comply with requirements on data exchange pursuant to Provision 13, Data System Requirements and Data Sharing to Support ECM of this Attachment.

H. Contractor must ensure all ECM Providers for whom a State-level enrollment pathway exists enroll in Medi-Cal, pursuant to

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relevant APLs, including APL 19-004. If APL 19-004 does not apply to an ECM Provider, Contractor must have a process for verifying qualifications and experience of ECM Providers, which must extend to individuals employed by or delivering services on behalf of the ECM Provider. Contractor must ensure that all ECM Providers meet the capabilities and standards required to be an ECM Provider.

I. Contractor must not require eligible ECM Providers to be National Committee for Quality Assurance (NCQA) certified or accredited as a condition of entering into a Subcontractor Agreement or Network Provider Agreement, as appropriate.

5. ECM Provider Capacity

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

B. Contractor must ensure sufficient ECM Provider capacity to meet the needs of all ECM Populations of Focus.

C. Contractor must meet DHCS' requirements regarding ECM Provider capacity separately from general Network adequacy; ECM Provider capacity does not alter the general Network adequacy provisions in Exhibit A, Attachment 6, Provider Network.

D. Contractor must report on its ECM Provider capacity to DHCS initially in its ECM MOC Template as referenced in Provision 6, ECM Model of Care (MOC) of this Attachment, and on an ongoing basis pursuant to DHCS reporting requirements in a form and manner specified by DHCS.

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

F. If Contractor is unable to provide sufficient capacity to meet the needs of all ECM Populations of Focus through Subcontractor Agreements or Network Provider Agreements,

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as appropriate, with community-based ECM Providers, Contractor may submit a written request to DHCS for an exception that authorizes Contractor to use Contractor's own personnel for ECM. Any such request must be submitted in accordance with DHCS guidelines and must meet at least one (1) of the following criteria:

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

2) There is a justified quality of care concern with one (1) or more of the otherwise qualified ECM Providers;

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

4) ECM Providers are unwilling to contract;

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

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

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

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

H. Contractor's failure to provide network capacity that meets the needs of all ECM Populations of Focus in a community-based manner may result in imposition of corrective action

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proceedings, and may result in sanctions pursuant to Exhibit E, Attachment 2, Program Terms and Conditions, Provision 16, Sanctions.

6. ECM Model of Care (MOC)

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

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

C. Contractor may collaborate with other Medi-Cal Managed Care Health Plans within the same county on the development of its ECM MOC.

Commented [A57]: This language does not apply to COHS and San Benito.

D. Contractor must submit its ECM MOC for DHCS review and approval. Contractor must also submit any significant changes to its ECM MOC for DHCS review and approval at least 60 calendar days in advance of any occurrence of changes or updates, in accordance with DHCS policies and guidance, including all applicable APLs. Significant changes may include, but are not limited to, changes to Contractor's approach to administer or deliver ECM services, approved policies and procedures, and Subcontractor Agreement or Network Provider Agreement boilerplates, as appropriate.

7. Member Identification for ECM

A. Contractor must promote continuity from the HHP and WPC pilots to ECM.

B. Contractor must authorize ECM for Members in HHP and WPC pilot counties, following the DHCS implementation schedule.

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C. To ensure continuity between HHP and ECM, Contractor must:

1) Automatically authorize ECM for all Members of ECM Populations of Focus who are enrolled in or are in the process of being enrolled in HHP; and

2) Ensure that each Member automatically authorized for ECM under this Provision is assessed within six (6) months, or other timeframes provided by DHCS in guidance for specific transitioning subpopulations, to determine the most appropriate level of services for the Member, to confirm whether ECM or a lower level of care coordination best meets the Member's needs.

D. To ensure continuity between WPC Pilots and ECM, Contractor must:

1) Automatically authorize all Members enrolled in a WPC pilot who are identified by the WPC Lead Entity as belonging to an ECM Population of Focus; and

2) Ensure each Member automatically authorized under this Provision is assessed within six (6) months, or other timeframes provided by DHCS in guidance for specific transitioning subpopulations, to determine the most appropriate level of services for the Member, to confirm whether ECM or a lower level of care coordination best meets the Member's needs.

E. Contractor must enter into a Subcontractor Agreement or Network Provider Agreement, as appropriate, with each WPC Lead Entity or HHP CB-CME to provide Members with ongoing care coordination previously provided in HHP and WPC pilot counties, except under the permissible exceptions set forth in Paragraph F below.

F. Contractor must submit to DHCS for prior approval any requests for exceptions to the Subcontractor Agreement or Network Provider Agreement requirement with a WPC Lead Entity or HHP CB-CME as an ECM Provider. Permissible exceptions to the Subcontractor Agreement or Network

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Provider Agreement requirement, include, but are not limited to:

1) There is a justified quality of care concern with the ECM Provider(s);

2) Contractor and ECM Provider(s) are unable to agree on contracted rates;

3) ECM Provider(s) is/are unwilling to contract;

4) ECM Provider(s) is/are unresponsive to multiple attempts to contract;

5) ECM Provider(s) is/are unable to comply with the Medi-Cal enrollment process or vetting by Contractor; or

6) For ECM Provider(s) without a State-level pathway to Medi-Cal enrollment, ECM Provider(s) is/are unable to comply with Contractor processes for vetting qualifications and experience.

G. Contractor must proactively identify Members who may benefit from ECM and who meet the eligibility criteria for the ECM Populations of Focus, as described in Provision 3, Populations of Focus for ECM of this Attachment.

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

1) Members' health care utilization;

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

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

4) Long-term services and supports (LTSS) needs.

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

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

a) Enrollment data;

b) Encounter Data;

c) Utilization/claims data;

d) Pharmacy data;

e) Laboratory data;

f) Screening or assessment data;

g) Clinical information on physical and behavioral health;

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

i) Risk stratification information for Members under 21 years of age in Contractor's Whole Child Model (WCM) program;

Commented [A58]: This only applies to the COHS plans that have WCM and should not be included in non-COHS plan amendments.

j) Information about Social Drivers of Health, including standardized assessment tools including Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences (PRAPARE) and International Classification of Diseases, Tenth Revision (ICD-10) codes;

k) Results from any available Adverse Childhood Experience (ACE) screening; and

l) Other cross-sector data and information, including housing, social services, foster care,

criminal justice history, and other information relevant to the ECM Populations of Focus such as Homeless Management Information System (HMIS), and available data from the education system.

2) Receipt of requests from ECM Providers and other Providers or community-based entities.

a) Contractor must accept requests for ECM on behalf of Members from:

i. ECM Providers;

ii. Social service or other Providers; and

iii. Community-based entities, including those contracted to provide Community Supports, as described in Provision 20, Community Supports Providers of this Attachment.

b) Contractor must designate an email and dedicated phone number that is widely available by which referrals can be made.

c) Contractor must directly engage with Network Providers, Subcontractors, and county agencies to inform these entities of ECM, the ECM Populations of Focus, and how to request ECM for Members.

d) Contractor must encourage ECM Providers to identify Members who meet the criteria for the ECM Populations of Focus, and must develop a process for receiving and responding to requests from ECM Providers.

3) Requests from Members.

Contractor must have a process for allowing Members to request ECM and for Members' parents, family members, legal guardians, authorized representatives, caregivers, and authorized support persons to request ECM on a Member's behalf. Contractor must provide information to Members regarding the Member initiated ECM request and approval process.

8. Authorizing Members for ECM

A. Contractor must authorize ECM for each eligible Member identified through any of the pathways described in Provision 7, Member Identification for ECM of this Attachment.

B. Contractor must develop policies and procedures that explain how it will authorize ECM for eligible Members in an equitable and non-discriminatory manner.

C. For requests from Providers and other external entities, Members, Member's parent, family member, legal guardian, authorized representative, caregiver, or authorized support person:

1) Contractor must ensure that authorization or a decision to not authorize ECM occurs as soon as possible and in accordance with Exhibit A, Attachment 5, Provision 3, Timeframes for Medical Authorization and APL 21-011;

2) If Contractor does not authorize ECM, Contractor must ensure the Member and the requesting individual or entity who requested ECM on a Member's behalf, as applicable, are informed of the Member's right to an Appeal and the Appeals process by way of the Notice of Action (NOA) as described in Exhibit A, Attachment 13, Provision 8, Denial, Deferral, or Modification of Prior Authorization Requests, Exhibit A, Attachment 14,

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Member Grievance and Appeal System, and APL 21-011; and

3) Contractor must follow its standard Grievances and Appeals process outlined in Exhibit A, Attachment 14, Member Grievance and Appeal System and APL 21-011.

D. Contractor must follow requirements for transitioning Members previously served by WPC pilots or HHP contained in Provision 7, Member Identification for ECM of this Attachment.

E. Contractor may collaborate with its ECM Providers to develop a process and identify possible circumstances under which presumptive authorization or preauthorization of ECM may occur, where select ECM Providers may directly authorize ECM for a limited period of time until Contractor authorizes or denies ECM.

F. To inform Members that ECM has been authorized, Contractor must follow its standard notice process outlined in Exhibit A, Attachment 13, Provision 8, Denial, Deferral, or Modification of Prior Authorization Requests and APL 21-011.

9. Assignment to an ECM Provider

A. Contractor must assign every Member authorized for ECM to an ECM Provider. Contractor may assign Members to Contractor itself only with a DHCS-approved exception to the ECM Provider contracting requirement as described in Provision 5, ECM Provider Capacity, of this Attachment.

B. Contractor must develop a process to disseminate information of assigned Members to ECM Providers on a regular basis.

C. Contractor must ensure communication of Member assignment to the designated ECM Provider occurs within ten (10) Working Days of authorization or on an agreed upon schedule.

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D. If a Member prefers a specific ECM Provider, Contractor must assign the Member to that ECM Provider, to the extent practicable.

E. If a Member's assigned PCP is a Network Provider and an ECM Provider, Contractor must assign the Member to the PCP as the ECM Provider, unless the Member indicates otherwise or Contractor identifies a more appropriate ECM Provider given the Member's individual needs and health conditions.

F. If a Member receives services from a behavioral health Provider for SED, SUD, or SMI and the Member's behavioral health Provider is a Network Provider and an ECM Provider, Contractor must assign that Member to that behavioral health Provider as the ECM Provider, unless the Member indicates otherwise or Contractor identifies a more appropriate ECM Provider given the Member's individual needs and health conditions.

G. If a Member is enrolled in CCS and the Member's CCS Case Manager is affiliated with a Network Provider or Subcontractor that is also an ECM Provider, Contractor must assign that Member to the CCS Case Manager as the ECM Provider, unless the Member or parent, legal guardian, or authorized representative has indicated otherwise or Contractor identifies a more appropriate ECM Provider given the Member's individual needs and health conditions.

H. Contractor must notify the Member's PCP, if different from the ECM Provider, of the assignment to the ECM Provider, within ten (10) Working Days of the date of assignment.

I. Contractor must document the Member's ECM Lead Care Manager in its system of record.

J. Contractor must permit Members to change ECM Providers at any time. Contractor must implement any Member's request to change their ECM Provider within 30 calendar days, to the extent practicable.

10. Initiating Delivery of ECM

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A. Contractor must not require Member authorization for ECM-related data sharing (whether in writing or otherwise) as a condition of initiating delivery of ECM, unless such authorization is required by federal law.

B. Contractor must develop policies and procedures for its network of ECM Providers that meet the following requirements, including but not limited to:

1) Where required by law, ECM Providers must obtain Member's authorization to share information with Contractor and all others involved in the Member's care to maximize the benefits of ECM; and

2) ECM Providers must provide Contractor with Member-level records of any obtained authorizations for ECM-related data sharing as required by federal law and to facilitate ongoing data sharing with Contractor.

C. Contractor must ensure that upon the initiation of ECM, each Member receiving ECM has a Lead Care Manager with responsibility for interacting directly with the Member and the Member's family, legal guardians, authorized representatives, caregivers, and other authorized support persons, as appropriate.

The assigned ECM Lead Care Manager is responsible for engaging with a multi-disciplinary care team to identify gaps in Member's care and, at a minimum, ensure effective coordination of all 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.

11. Discontinuation of ECM

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A. Contractor must ensure Members are able to decline or end ECM upon initial outreach and engagement, or at any other time.

B. Contractor must require the ECM Provider to notify Contractor to discontinue ECM for Members when any of the following circumstances are met:

1) The Member has met all care plan goals;

2) The Member is ready to transition to a lower level of care;

3) The Member no longer wishes to receive ECM or is unresponsive or unwilling to engage; or

4) The ECM Provider has not been able to connect with the Member after multiple attempts.

C. Contractor must develop processes to determine if the Member is no longer authorized to receive ECM and, if so, to notify ECM Provider to initiate discontinuation of services in accordance with the NOA process as described in Exhibit A, Attachment 13, Provision 8, Denial, Deferral, or Modification of Prior Authorization Requests; Exhibit A, Attachment 14, Member Grievance and Appeal System; and APL 21-011.

D. Contractor must develop processes for transitioning Members from ECM to lower levels of care management to provide coordination of ongoing needs.

E. Contractor must notify the ECM Provider when ECM has been discontinued by Contractor.

F. Contractor must notify the Member of the discontinuation of the ECM benefit and ensure the Member is informed of their right to an Appeal and the Appeals process by way of a NOA process as described in Exhibit A, Attachment 13, Provision 8, Denial, Deferral, or Modification of Prior Authorization Requests, Exhibit A, Attachment 14, Member Grievance and Appeal System, and APL 21-011.

12. Core Service Components of ECM

Contractor must ensure all Members receiving ECM benefits receive all of the following seven (7) ECM core service components, as further defined in applicable APLs:

A. Outreach and engagement

B. Comprehensive assessment and care management plan;

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.

13. Data System Requirements and Data Sharing to Support ECM

A. Contractor must have an IT infrastructure and data analytic capabilities to support ECM, including the capabilities to:

1) Consume and use claims and Encounter Data, as well as other data types listed in Provision 7, Member Identification for ECM, of this Attachment;

2) Assign Members to ECM Providers;

3) Keep records of Members receiving ECM and authorizations necessary for sharing Protected Health Information and Personal Identifying Information between Contractor and ECM Providers and other Providers, and among ECM Providers and family member(s) or support person(s), whether obtained by ECM Provider or by Contractor;

4) Securely share data with ECM Providers and other Providers in support of ECM;

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5) Receive, process, and send Encounter Data from ECM Providers to DHCS;

6) Receive and process supplemental reports from ECM Providers;

7) Send ECM supplemental reports to DHCS; and

8) Open, track, and manage referrals to Community Supports Providers.

B. In order to support ECM, Contractor must follow DHCS guidance on data sharing and provide the following information to all ECM Providers:

1) Member assignment files, defined as a list of Medi-Cal Members authorized for ECM and assigned to the ECM Provider;

2) Encounter Data and claims data;

3) Physical, behavioral, administrative, and Social Drivers of Health data, such as HMIS data, for all Members assigned to the ECM Provider; and

4) Reports of performance on quality measures and metrics, as requested.

C. Contractor must use defined federal and State standards, specifications, code sets, and terminologies when sharing physical, behavioral, social, and administrative data with ECM Providers and with DHCS.

14. Oversight of ECM Providers

A. Contractor must perform oversight of ECM Providers, holding them accountable to all ECM requirements contained in this Contract, DHCS policies and guidance, including all applicable APLs, and Contractor's ECM MOC.

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1) Contractor must evaluate the prospective Subcontractor's or Network Provider's ability to perform services;

2) Contractor must ensure the Subcontractor's or Network Provider's ECM Provider capacity is sufficient to serve all Populations of Focus;

3) Contractor must report to DHCS the names of all Subcontractors or Network Providers, as appropriate, by type and service(s) provided, and identify the county or counties in which Members are served; 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 6, Provision 14, Network Provider Agreements and Subcontractor Agreements.

B. Contractor must hold ECM Providers responsible for the same reporting requirements as those Contractor has with DHCS.

1) Contractor must not impose mandatory reporting requirements that differ from or are additional to those required for Encounter and supplemental reporting; and

2) Contractor may collaborate with other Medi-Cal Managed Care Health Plans within the same county on oversight of ECM Providers.

Commented [A59]: This language does not apply to COHS and San Benito.

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

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Exhibit A, Attachment 7, Provision 5, Network Provider Training.

E. Contractor must ensure Subcontractor Agreements and Network Provider Agreements, as appropriate, mirror the requirements set forth in this Contract and in accordance with all applicable APLs, as applicable to the Subcontractor or Network Provider.

Contractor may collaborate with its Subcontractors or Network Providers, as appropriate, on the approach to administration of ECM to minimize divergence in how ECM will be implemented between Contractor and its Subcontractors or Network Providers, and to ensure a streamlined, seamless experience for ECM Providers and Members.

15. Payment of ECM 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 defined in Provision 10, Initiating Delivery of ECM, of this Attachment.

C. Contractor may tie ECM Provider payments to value, including payment strategies and arrangements that focus on achieving outcomes related to high-quality care and improved health status.

D. Contractor must utilize the claims timeframes as described in Exhibit A, Attachment 8, Provision 5, Claims Processing.

16. DHCS Oversight of ECM

A. Contractor must submit the following data and reports to DHCS to support DHCS oversight of ECM:

1) Encounter Data

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a) Contractor must submit all ECM Encounter Data to DHCS using national standard specifications and code sets to be defined by DHCS.

b) Contractor shall be responsible for submitting to DHCS all Encounter Data for ECM services to its Members, regardless of the number of levels of delegation or sub-delegation between Contractor and the ECM Provider.

c) In the event the ECM Provider is unable to submit ECM Encounter Data to Contractor using the national standard specifications and code sets to be defined by DHCS, Contractor is responsible for converting the ECM Provider's Encounter Data information into the national standard specifications and code sets, for submission to DHCS.

2) ECM supplemental reports, on a schedule and in a format to be defined by DHCS.

B. Contractor must track and report to DHCS, on a schedule and in a format specified by DHCS, information about outreach efforts related to Members who could potentially be enrolled in ECM.

C. In the event of underperformance by Contractor in relation to its administration of ECM, DHCS may impose sanctions as described in Exhibit E, Attachment 2, Provision 17, Sanctions.

17. ECM Quality and Performance Incentive Program

A. Contractor must meet all quality management and quality improvement requirements in Exhibit A, Attachment 4, Quality Improvement System, and any additional quality requirements set forth in associated guidance from DHCS for ECM.

B. Contractor may participate in a performance incentive program related to building provider capacity for ECM, related health care quality and outcomes, and other performance

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milestones and measures, to be defined in forthcoming DHCS guidance.

18. Contractor's Responsibility for Administration of Community Supports

A. Contractor may provide DHCS pre-approved Community Supports as described in Provision 19, DHCS Pre-Approved Community Supports, of this Attachment.

The remainder of Exhibit A, Attachment 22 refers only to Community Supports that Contractor may choose to offer, unless otherwise specified.

B. In accordance with 42 CFR section 438.3(e)(2), all applicable APLs, and the Community Supports Policy Guide, Contractor may select and offer Community Supports from the list of Community Supports pre-approved by DHCS as medically appropriate and cost-effective substitutes for Covered Services or settings under the State Plan. See Provision 19, DHCS Pre-Approved Community Supports below for list.

1) Contractor must ensure medically appropriate State Plan services are available to the Member regardless of whether the Member has been offered Community Supports, is currently receiving Community Supports, or has received Community Supports in the past.

2) Contractor may not require a Member to utilize Community Supports. Members always retain their right to receive the California Medicaid State Plan Covered 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 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, referenced in APL 21-017 and the Community Supports Policy Guide, that Contractor chooses to provide. Upon approval from DHCS, Contractor may adopt a more narrowly defined eligible population than outlined in the Community Supports Policy Guide.

1) Contractor is not permitted to extend Community Supports to Members beyond those for whom DHCS has determined the Community Supports will be cost-effective and medically appropriate, as indicated in the DHCS guidance on eligible populations.

2) Contractor must provide public notice of any limitations on Community Supports when Contractor requests an alternate approach involving narrowing eligible populations, including specifying such limitations in the Member Services Guide/EOC and on Contractor's website, in addition to receiving DHCS' written approval.

D. If Contractor elects to offer one (1) or more pre-approved Community Supports, it need not offer the Community Supports in each county it serves. Contractor must report to DHCS the counties in which it intends to offer the Community Supports. Contractor must provide Community Supports in a county selected by Contractor in accordance with the requirements set forth below in Provision 21, Community Supports Provider Capacity.

E. Contractor must identify Members who may benefit from Community Supports and for whom Community Supports will be a medically appropriate and cost-effective substitute for Covered Services, and accept requests for Community Supports from Members and Members' Providers and organizations that serve them, including community-based organizations as described below in Provision 23, Identifying Members for Community Supports.

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F. Contractor must authorize Community Supports for Members deemed eligible in accordance below with Provision 24, Authorizing Members for Community Supports and Communication of Authorization Status.

G. Contractor may elect to offer value-added services in addition to offering one (1) or more Community Supports. Offering Community Supports does not preclude Contractor from offering value-added services.

H. In the event of any discontinuation of Community Supports resulting in a change in the availability of services, Contractor must adhere to the requirements set forth in Exhibit A, Attachment 9, Provision 10, Changes in Availability or Location of Covered Services, and Exhibit A, Attachment 13, Provision 4, Notification of Changes in Access to Covered Services.

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

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

19. DHCS Pre-Approved Community Supports

A. Contractor may choose to offer Members one (1) or more of the following pre-approved Community Supports, and any subsequent Community Supports additions pre-approved by DHCS, in each county:

1) Housing Transition Navigation Services;

2) Housing Deposits;

3) Housing Tenancy and Sustaining Services;

4) Short-Term Post-Hospitalization Housing;

5) Recuperative Care (Medical Respite);

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6) Respite Services;

7) Day Habilitation Programs;

8) Nursing Facility Transition/Diversion to Assisted Living Facilities;

9) Community Transition Services/Nursing Facility Transition to a Home;

10) Personal Care and Homemaker Services;

11) Environmental Accessibility Adaptations;

12) Medically Tailored Meals/Medically Supportive Food;

13) Sobering Centers; and

14) Asthma Remediation.

B. Contractor must list all Community Supports it offers in its Contractor's Community Supports MOC template and Community Supports MOC amendments.

C. Contractor must ensure Community Supports are provided in accordance with all applicable APLs, unless DHCS has provided written approval of an alternate approach requested by Contractor.

D. Contractor must ensure Community Supports are provided to Members in a timely manner, and must develop policies and procedures outlining its approach to managing Community Supports Provider shortages or other barriers to ensure timely provision of Community Supports.

E. Contractor may discontinue offering Community Supports annually with notice to DHCS at least 90 calendar days prior to the discontinuation date.

Contractor must ensure Community Supports that were authorized for a Member prior to the discontinuation of those

specific Community Supports are not disrupted by a change in Community Supports offerings, either by completing the authorized service or by seamlessly transitioning the Member into other Medically Necessary services or programs that meet the Member's needs.

F. At least 30 calendar days before discontinuing Community Supports, Contractor must notify Members affected by the discontinuation of the Community Supports of the following:

1) The change and timing of discontinuation, and

2) The procedures that will be used to ensure completion of the authorized Community Supports or a transition into other comparable Medically Necessary services.

G. Contractor may provide voluntary services that are neither State-approved Community Supports nor Covered Services when medically appropriate for the Member, in accordance with 42 CFR section 438.3(e)(1). Such voluntary services are not subject to the terms of Provision 18, Contractor's Responsibility for Administration of Community Supports, through Provision 31, Community Supports Quality and Performance Incentive Program, and are subject to the limitations of 42 CFR section 438.3(e)(1).

20. Community Supports Providers

A. Community Supports Providers are entities that Contractor has determined can provide the Community Supports to eligible Members in an effective manner consistent with culturally and linguistically appropriate care, as outlined in Exhibit A, Attachment 9, Provision 13, Cultural and Linguistic Program.

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

C. Contractor must ensure all Community Supports Providers for whom a State-level enrollment pathway exists enroll in Medi-

Cal, pursuant to relevant APLs, including APL 19-004. If APL 19-004 does not apply to a Community Supports Provider, Contractor must have a process for verifying qualifications and experience of Community Supports Providers, which must extend to individuals employed by or delivering services on behalf of the Community Supports Provider. Contractor must ensure that all Community Supports Providers meet the capabilities and standards required to be a Community Supports Provider.

D. In accordance with Provision 26 below, Data System Requirements and Data Sharing to Support Community Supports, Contractor must support Community Supports Provider access to systems and processes allowing them to do the following, at a minimum:

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

2) Contractor must also support Community Supports Provider notification to Contractor and ECM Providers and Member's PCP, as applicable, when a referral has been fulfilled, as described below in Provision 26, Data System Requirements and Data Sharing to Support Community Supports.

D. To the extent Contractor elects to offer Community Supports, Contractor may coordinate its approach with other Medi-Cal Managed Care Health Plans offering Community Supports in the same county.

Commented [A60]: This language does not apply to COHS and San Benito.

21. Community Supports Provider Capacity

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

B. If Contractor is unable to offer its elected Community Supports to all eligible Members for whom it is medically appropriate and cost-effective within a particular county, Contractor must

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submit ongoing progress reports to DHCS in a format and manner specified by DHCS.

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

22. Community Supports MOC

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

B. In developing and executing Subcontractor Agreements or Network Provider 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 all applicable APLs.

C. Contractor may collaborate with other Medi-Cal Managed Care Health Plans within the same county, on the development of its Community Supports MOC.

Commented [A61]: This language does not apply to COHS and San Benito.

D. Contractor must submit its Community Supports MOC for DHCS review and approval. Contractor must submit to DHCS any significant changes to its Community Supports MOC for DHCS review and approval at least 60 calendar days in advance of any occurrence of changes or updates, in accordance with DHCS policies and guidance, including all applicable APLs. Significant changes may include, but are not limited to, changes to Contractor's approach to administer or deliver Community Supports services, approved policies and procedures, and Subcontractor Agreement or Network Provider Agreement boilerplates, as appropriate.

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23. Identifying Members for Community Supports

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

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

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

2) How Contractor will notify Members; and

3) How Contractor will accept requests for Community Supports from Providers, other community-based entities, and Member or Member's family, legal guardians, authorized representatives, caregivers, and other authorized support persons.

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

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

E. Transition of WPC and HHP to Community Supports

1) In HHP and WPC pilot counties, Contractor may offer Community Supports to HHP and WPC Members who receive similar services through WPC or HHP for continuity of the services being delivered as part of those programs.

2) In HHP and WPC pilot counties, Contractor must enter into Subcontractor Agreements or Network Provider Agreements, as appropriate, with all WPC Lead Entities and HHP CB-CMEs as Community Supports Providers,

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regardless of whether Contractor offers Community Supports on a county-wide basis, unless Contractor receives prior written approval from DHCS, through the Community Supports MOC review process, based on one (1) or more of the following exceptions:

a) The Community Supports Provider does not provide the Community Supports that Contractor elected to offer;

b) There is a justified quality of care concern with the Community Supports Provider;

c) Contractor and the Community Supports Provider are unable to agree on contracted rates;

d) The Community Supports Provider is unwilling to enter into a Subcontractor Agreement or Network Provider Agreement, as appropriate;

e) The Community Supports Provider is unresponsive to multiple attempts to enter into a Subcontractor Agreement or Network Provider Agreement, as appropriate;

f) The Community Supports Provider is unable to comply with the Medi-Cal enrollment process or vetting by Contractor; or

g) The Community Supports Provider without a State-level pathway to Medi-Cal enrollment is unable to comply with Contractor's processes for vetting qualifications and experience.

24. Authorizing Members for Community Supports and Communication of Authorization Status

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

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

C. For Members with an assessed risk of incurring other California Medicaid State Plan services, such as inpatient hospitalizations, skilled nursing facility stays, or emergency department visits, Contractor must develop policies and procedures to ensure appropriate clinical support authorization of Community Supports for Members. Contractor's policies and procedures must include detailed documentation that a Network Provider using their professional judgement has determined it to be medically appropriate for the Member to receive Community Supports as it is likely to reduce or prevent the need for acute care or other California Medicaid State Plan services in accordance with all applicable APLs and to be defined in forthcoming guidance.

D. Contractor must not restrict the authorization of Community Supports only to Members transitioning from WPC or HHP.

E. Contractor must develop and maintain policies and procedures to ensure Members do not experience undue delays pending the authorization process for Community Supports.

1) If Medically Necessary, Contractor must make available the California Medicaid State Plan services that the Community Supports replaces, pending authorization of the requested Community Supports.

2) Contractor must evaluate and document whether a service is medically appropriate and cost-effective when determining whether to provide Community Supports to a Member. Providing particular Community Supports to a Member in one (1) instance does not automatically mean that providing other Community Supports to the same Member, the same Community Supports to

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another Member, or the same Community Supports to the same Member in a different instance would be medically appropriate and cost-effective.

F. Contractor must have policies and procedures for expediting the authorization of certain Community Supports for urgent needs, as appropriate, and that identify the circumstances in which any expedited authorization processes apply, in accordance with all applicable APLs.

G. When a Member has requested Community Supports, directly or through a Provider, community-based organization, or other entity, Contractor must notify the requesting entity and Member of Contractor's decision regarding Community Supports authorization, in accordance with all applicable APLs. If the Member is enrolled in ECM, Contractor must ensure the ECM Provider is informed of the Community Supports authorization decision.

H. Member always retains the right to file Appeals and/or Grievances if they request one (1) or more Community Supports offered by Contractor, but were not authorized to receive the requested Community Supports because of a determination that it was not medically appropriate or cost effective.

I. For Members who sought Community Supports offered by Contractor, but were not authorized to receive the Community Supports, Contractor must submit necessary data to monitor Appeals and Grievances as well as follow its standard Grievances and Appeals process outlined in Exhibit A, Attachment 14, Member Grievance and Appeal System and APL 21-011.

25. Referring Members to Community Supports Providers for Community Supports

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

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1) For Members enrolled in ECM, policies and procedures must address how Contractor will work with the ECM Provider to coordinate the Community Supports referral and communicate the outcome of the referral back to the ECM Provider, such as using closed loop referrals.

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

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

D. Contractor must not require Member authorization for Community Supports-related data sharing as a condition of initiating delivery of Community Supports, unless such authorization is required by 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 law, ensure that Members authorize information sharing with Contractor and all others involved in the Member's care as needed, to support the Member and maximize the benefits of Community Supports, in accordance with all applicable APLs;

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

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

26. Data System Requirements and Data Sharing to Support Community Supports

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

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

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

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

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

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

C. Contractor must use defined federal and State standards,

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specifications, code sets, and terminologies when sharing physical, behavioral, social, and administrative data with Community Supports Providers and with DHCS.

27. Contractor's Oversight of Community Supports Providers

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

B. Contractor must perform oversight of Community Support Providers, holding them accountable to all Community Supports requirements contained in this Contract, and all applicable APLs.

C. Contractor must use all applicable APLs to develop its Subcontractor Agreements and Network Provider Agreements, as appropriate, with Community Support Providers and must incorporate all of its Community Supports Provider requirements. Contractor must submit its Subcontractor Agreements and Network Provider Agreements, as appropriate, with Community Supports Providers to DHCS for review and approval in a form and manner specified by DHCS.

D. To streamline Community Supports implementation, Contractor must ensure the following:

1) Contractor must hold Community Supports Providers responsible for the same reporting requirements as are required of Contractor by DHCS.

2) Contractor must not impose mandatory reporting requirements that are alternative or additional to those required for Encounter and supplemental reporting.

3) Contractor may collaborate with other Medi-Cal Managed Care Health Plans within the same county on reporting requirements and oversight.

Commented [A62]: This language does not apply to COHS and San Benito.

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 7, Provision 5, Network Provider Training.

28. Delegation of Community Supports Administration to Subcontractors or Network Providers

A. Contractor may enter into Subcontractor Agreements or Network Provider 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 6, Provision 14, Network Provider Agreements and Subcontractor Agreements;

2) Contractor is responsible for developing and maintaining DHCS-approved policies and procedures to ensure Subcontractors and Network Providers meet required responsibilities and functions as described in Exhibit A, Attachment 6, Provision 14, Network Provider Agreements and Subcontractor Agreements;

3) Contractor must evaluate the prospective Subcontractor's or Network Provider's ability to perform services as described in Exhibit A, Attachment 6, Provision 14, Network Provider Agreements and Subcontractor Agreements;

4) Contractor must ensure the Subcontractor's or Network Provider'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 by type and service(s) provided, and identify the county or counties in which

Members are served; and

6) Contractor must make all Subcontractor Agreements and Network Provider Agreements available to DHCS upon request. Such agreements must contain minimum required information specified by DHCS, including method and amount of compensation as described in Exhibit A, Attachment 6, Provision 14, Network Provider Agreements and Subcontractor Agreements.

B. Contractor must ensure that Subcontractor Agreements and Network Provider Agreements, as appropriate, mirror the requirements set forth in this Contract and all applicable APLs, as applicable to the Subcontractor or Network Provider.

C. Contractor may collaborate with its Subcontractors and Network Providers on its approach to Community Supports to minimize divergence in how the Community Supports will be implemented between Contractor and its Subcontractor(s) and Network Providers and ensure a streamlined, seamless experience for Community Supports Providers and Members.

29. Payment of Community Support Providers

A. Contractor must pay contracted Community Supports Providers for the provision of authorized Community Supports to Members in accordance with established Subcontractor Agreements or Network Provider Agreements, as appropriate, between Contractor and each Community Supports Provider.

B. Contractor must utilize the claims timeline and process as described in Exhibit A, Attachment 8, Provision 5, Claims Processing.

C. Contractor must identify any circumstances under which payment for Community Supports must be expedited to facilitate timely delivery of the Community Supports to the Member, such as recuperative care for an individual who is homeless and being discharged from the hospital.

For such circumstances, Contractor must develop and maintain policies and procedures to ensure payment to the

Community Supports Provider is expedited. Contractor must submit these policies and procedures to DHCS for review and approval prior to implementation.

D. Contractor shall ensure Community Supports Providers submit a claim for rendered Community Supports, to the greatest extent possible.

1) If a Community Supports Provider is unable to submit a claim for Community Supports rendered, Contractor must ensure the Community Supports Provider documents services rendered using an invoice approved by DHCS.

2) Upon receipt of such invoice, Contractor must document the Encounter for the Community Supports rendered.

30. DHCS Oversight of Community Supports

A. In the Community Supports MOC, Contractor must include details on the Community Supports Contractor plans to offer, including which counties Community Supports will be offered and its network of Community Supports Providers, in accordance with all applicable APLs.

B. After implementation of Community Supports, Contractor must submit the following data and reports to DHCS to support DHCS oversight of Community Supports:

1) Encounter Data

a) Contractor must submit all Community Supports Encounter Data to DHCS using national standard specifications and code sets to be defined by DHCS. Contractor must be compliant with DHCS guidance on invoicing standards for Contractor to use with Community Supports Providers.

b) Contractor must submit to DHCS all Community Supports Encounter Data, including Encounter Data for Community Supports generated under

Subcontractor Agreements or Network Provider Agreements.

c) In the event the Community Supports Provider is unable to submit Community Supports Encounter Data to Contractor using the national standard specifications and code sets to be defined by DHCS, Contractor must convert Community Supports Providers' invoice data into the national standard specifications and code sets, for submission to DHCS.

d) Encounter Data, when possible, must include data necessary for DHCS to stratify services by age, sex, race, ethnicity, and language spoken to inform health equity initiatives and efforts to mitigate health disparities undertaken by the DHCS.

2) Supplemental reporting on a schedule and in a form to be defined by DHCS.

C. Contractor must timely submit any related data requested by DHCS, CMS, or an independent entity conducting an evaluation of Community Supports including, but not limited to:

1) Data to evaluate the utilization and effectiveness of a Community Supports.

2) Data necessary to monitor health outcomes and quality metrics at the local and aggregate levels through timely and accurate Encounter Data and supplemental reporting on health outcomes and equity of care. When possible, metrics must be stratified by age, sex, race, ethnicity, and language spoken.

3) Data necessary to monitor Member Appeals and Grievances associated with Community Supports.

D. In the event of underperformance by Contractor in relation to its administration of Community Supports, DHCS may impose

sanctions in accordance with Exhibit E, Attachment 2, Provision 17, Sanctions.

31. Community Supports Quality and Performance Incentive Program

A. Contractor must meet all quality management and Quality Improvement requirements described in Exhibit A, Attachment 4, Quality Improvement System and any additional quality requirements for Community Supports set forth in associated guidance from DHCS.

B. Contractor may participate in a performance incentive program related to adoption of Community Supports, building infrastructure and Provider capacity for Community Supports, related health care quality and outcomes, and other performance milestones and measures, in accordance with DHCS policies and guidance.

32. Person-Centered Planning for Seniors and Persons with Disabilities (SPD) Beneficiaries

A. Upon the Enrollment of a SPD beneficiary, Contractor shall provide, or ensure the provision of, Person-Centered Planning and treatment approaches that are collaborative and responsive to the SPD beneficiary's continuing health care needs.

B. Person-Centered Planning shall include identifying each SPD beneficiary's preferences and choices regarding treatments and services, and abilities.

C. Contractor shall allow or ensure the participation of the SPD beneficiary, and any family, friends, and professionals of their choosing, to participate fully in any discussion or decisions regarding treatments and services.

D. Contractor shall ensure that SPD beneficiaries receive all necessary information regarding treatment and services so that they may make an informed choice.

E. Complex Case Management services for SPD beneficiaries must include the concepts of Person-Centered Planning.

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33. Discharge Planning and Care Coordination for SPD Beneficiaries

Contractor shall ensure the provision of discharge planning when a SPD beneficiary is admitted to a hospital or institution and continuation into the post discharge period. Discharge planning shall include ensuring that necessary care, services, and supports are in place in the community for the SPD beneficiary once they are discharged from a hospital or institution, including scheduling an outpatient appointment and/or conducting follow-up with the patient and/or caregiver. Minimum criteria for a discharge planning checklist must include:

A. Documentation of pre-admission status, including living arrangements, physical and mental function, social support, Durable Medical Equipment (DME), and other services received.

B. Documentation of pre-discharge factors, including an understanding of the medical condition by the SPD beneficiary or a representative of the SPD beneficiary as applicable, physical and mental function, financial resources, and social supports.

C. Services needed after discharge, the type of placement preferred by the SPD beneficiary or the representative of the SPD beneficiary and hospital/institution, type of placement agreed to by the SPD beneficiary or the representative of the SPD beneficiary, the specific agency or home recommended by the hospital, the specific agency or home agreed to by the SPD beneficiary or the representative of the SPD beneficiary, and the pre-discharge counseling that is recommended.

D. Summary of the nature and outcome of the SPD beneficiary's, or the SPD beneficiary's representative's, involvement in the discharge planning process, anticipated problems in implementing post-discharge plans, and further action contemplated by the hospital or institution.

XXIII. Exhibit B, BUDGET DETAIL AND PAYMENT PROVISIONS, is amended to read:

Budget Detail and Payment Provisions

1. Budget Contingency Clause
2. Amounts Payable
3. Contractor Risk in Providing Services
4. Capitation Rates
5. Capitation Payment Rates Constitute Payment in Full
6. Determination of Capitation Payment Rates
7. Redetermination of Capitation Payment Rates - Obligation Changes
8. Reinsurance
9. Catastrophic Coverage Limitation
10. Financial Performance Guarantee
11. Recovery of Amounts Paid to Contractor
12. Medical Loss Ratio (MLR)
13. Adult Expansion Risk Corridor
14. Supplemental Payments
15. Additional Payments
16. Special Contract Provisions Related to Payment
17. Medicare Coordination
18. Covid-19 Risk Corridor
19. State Programs Receiving Federal Financial Participation
20. Enhanced Care Management (ECM) Risk Corridor

Commented [A63]: Renumbering only, technical edit

4. Capitation Rates

A. DHCS shall remit to Contractor a Capitation Payment each month for each Member that appears on the approved list of Members supplied to Contractor by DHCS. The payment period for health care services shall commence on the first day of operations, as determined by DHCS.

Capitation Payments shall be made in accordance with the following schedule of capitation rates. For aid codes, see DEFINITIONS, Eligible Beneficiary:

For the period ~~01/01/2021 – 12/31/2021~~ 01/01/2022 – 12/31/2022	**County**
Groups	**Rates**
Adult & Family/Optional Targeted Low-Income Child (Under 19)	

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Adult & Family/Optional Targeted Low-Income Child (19 & Older)	
Adult & Family/Optional Targeted Low-Income Child (Dual)	
SPD	
SPD/Dual	
SPD/Dual (Non-CCI)	
Long Term Care/Full Dual	
Long Term Care/Non-Full Dual	
Long Term Care/Full Dual (Non-CCI)	
Breast and Cervical Cancer Treatment Program (BCCTP)	
Maternity	
Adult Expansion	
Maternity Expansion	
~~Hepatitis C/340B~~	
~~Hepatitis C/Non-340B~~	
~~HCBS High~~	
BHT/Ages 0-6	
BHT/Ages 7-20	
~~Health Homes Program/Non-Dual Eligible~~	
~~Health Homes Program/Dual Eligible~~	

Commented [A64]: Rx only

Commented [A65R64]: Plans have already reviewed RX language as of 2/4/2021.

Commented [A66]: Only applies to those plans who have HHP in their contracts.

Commented [A67]: Only applies to those plans who have HHP in their contracts.

11. Recovery Of Capitation Payments

DHCS shall have the right to recover from Contractor amounts paid to Contractor in the following circumstances as specified:

A. If DHCS determines that a Member has either been improperly enrolled due to ineligibility of the Member to enroll in Contractor's plan, residence outside of Contractor's Service Area, or pursuant to ~~Title~~ 22~~,~~ ~~S~~**s**ection 53891(a)(2), or should have been disenrolled with an effective date in a prior month, DHCS may recover the Capitation Payments made to Contractor for the Member for the months 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 shall inform Providers that claims for services provided to Members during the month(s) in question may be paid by the DHCS fiscal intermediary, if the Member is determined eligible for the Medi-Cal program.

Upon request by Contractor, DHCS may allow Contractor to retain the Capitation Payments made for Members that are eligible to enroll in Contractor's plan, but should have been retroactively disenrolled pursuant to Exhibit A, Attachment 11, Provision ~~18~~**16**~~.~~ Excluded Services Requiring Member Disenrollment, or under other circumstances as approved by DHCS. If Contractor retains the Capitation Payments, Contractor shall provide or arrange and pay for all Medically Necessary Covered Services for the Member, until the Member is disenrolled on a nonretroactive basis pursuant to Exhibit A, Attachment 16, Provision 3, Disenrollment.

14. Supplemental Payments

~~C. Supplemental Payments for Hepatitis C Prescriptions~~

~~Contractor shall be paid a monthly Supplemental Payments based on a weekly rate for each Member who receives prescriptions for specific Hepatitis C drugs identified by DHCS. Payments are based on the Member's utilization as reported by Contractor.~~

~~D~~**C**. Supplemental Payments for Partial Dual Eligible and Medi-Cal Only Members

Commented [A68]: Rx only

Commented [A69R68]: Plans have already reviewed RX language as of 2/4/2021.

2) Contractor shall receive a Supplemental Payment for each Partial Dual Eligible Member and Medi-Cal Only Member who meets the following criteria~~:~~ **for**

~~a)~~ Institutional: Members who reside in a nursing facility for 90 days or more and are identified by Contractor in a file per Section C of this Provision. Exceptions will include Members with a LTC aid code as identified in Exhibit E, DEFINITIONS, Eligible Beneficiary.

~~b) HCBS High: Members who are at a high risk for institutionalization based on an IHSS classification of "Severely Impaired", or are in the MSSP 1915(c) Waiver, or are receiving CBAS as defined by Contractor.~~

3) Supplemental Payments for Partial Dual Eligible and Medi-Cal Only Members shall be made in accordance with the existing schedule of Capitation Payment rates at the end of the month. Payments for Members identified as Institutional cannot exceed the rate as stated

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in this Provision and will be adjusted if DHCS has sent a separate rate payment for the Member for the same month of service. ~~Payments for Members identified as HCBS High will be made in addition to any other monthly rate payments sent for the Member for the same month of service.~~

~~E~~**D**. Supplemental Payment for BHT Services

~~F. Supplemental Health Homes Program Payment~~

~~1) Contractor shall be entitled to receive a monthly supplemental HHP payment when the following criteria are met:~~

~~a) The Member is eligible and enrolled in HHP, in accordance with Exhibit A, Attachment 23, Provision 4,~~

~~b) The Member received a HHP Service, in accordance with Exhibit A, Attachment 23, Provision 6, or has received a HHP Service within the prior two (2) service months.~~

~~2) Contractor shall receive a maximum of one (1) supplemental HHP payment per enrolled HHP Enrolled Member per service month.~~

~~3) The payment period for health care services described in this Provision shall commence on July 1, 2018.~~

Commented [A70]: Rx only

Commented [A71R70]: Plans have already reviewed RX language as of 2/4/2021.

Commented [A72]: Only applies to those plans who have HHP in their contracts.

~~21~~20. Enhanced Care Management (ECM) Risk Corridor

Commented [A73]: Renumbering only.

XXIV. Exhibit E, ADDITIONAL PROVISIONS, is amended to read:

1. Additional Incorporated Provisions

The following Attachments 1 through ~~24~~ **22** are incorporated herein and made a part hereof by this referenced:

Attachment 11 – Case Management and **External** Coordination of Care

Attachment 20 – ~~Mental Health and Substance Use Disorder Benefits~~ **Behavioral Health Services**

~~Attachment 22 – Health Homes Program~~

Commented [A74]: Applies to contracts with HHP only

Attachment 22 – Case Management and Internal Coordination of Care

XXV. Exhibit E, Attachment 1, DEFINITIONS, is amended to read:

Care Coordination means services which are included in Basic Case Management, Complex Case Management, ~~Comprehensive Medical Case Management Services,~~ **Enhanced Care Management,** Person Centered Planning**,** and-Discharge Planning, are included as part of a functioning Medical Home.

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.

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

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 when the substitute service or setting is and are medically appropriate and more cost-effective that the service or setting listed in the California Medicaid State Plan.

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 9, Provision 13, Cultural and Linguistic Program.

Covered Services means Medical Case Management and those services set forth in ~~Title~~ 22 CCR, Division 3, Subdivision 1, Chapter 3, beginning with ~~S~~**s**ection 51301, and ~~Title~~ 17 CCR, Chapter 4, Subchapter 13, Article 4, beginning with ~~S~~**s**ection 6840. Covered Services do not include:

~~A. Services for major organ transplants as specified in Exhibit A, Attachment 11, Provision 18~~.

~~B~~**A**. Home and Community Based Services (HCBS) Waiver Program Services as specified in Exhibit A, Attachment 11, ~~p~~**P**rovisions ~~14~~ **12** and ~~21~~**19** regarding Waiver Programs, and Department of Developmental Services (DDS) Administered Medicaid Home and Community Based Services Waiver. *HCBS do not include any service that is available as an* ***Early and Periodic Screening, Diagnostic 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 10 regarding ~~Early and Periodic Screening, Diagnostic and Treatment (EPSDT)~~ Services.*

~~C~~**B**. California Children's Services (CCS) as specified in Exhibit A, Attachment 11, Provision ~~9~~**7**.

~~D~~**C**. Specialty Mental Health Services as specified in Exhibit A, Attachment 11, Provision ~~6~~**4**.

~~E~~**D**. Specialty Mental Health Services provided by psychiatrists; psychologists; licensed clinical social workers; or marriage, family, and child counselors.

~~F~~**E**. Alcohol and substance use disorder treatment services and outpatient heroin detoxification as specified in Exhibit A, Attachment 11, Provision ~~7~~**5**.

~~G~~**F**. Fabrication of optical lenses as specified in Exhibit A, Attachment 10, Provision 8.

~~H~~**G**. Directly observed therapy for treatment of tuberculosis as specified in Exhibit A, Attachment 11, Provision ~~16~~**14**.

~~I~~**H**. Dental services as specified in ~~W & I~~ **W&I** Code ~~Sections~~ **sections** 14132(h), 14131.10, 14132.22, 14132.23, and 14132.88, and EPSDT dental services as described in ~~Title~~ 22 CCR ~~S~~**s**ection 51340.1(b). *~~H~~However, Contractor is responsible for all Covered Services as specified in Exhibit A, Attachment 11, Provision ~~15~~**13** regarding dental services.*

~~J~~**I**. Chiropractic services as specified in Title 22 CCR Section 51308.

~~K~~**J**. Prayer or spiritual healing as specified in ~~Title~~ 22 CCR ~~S~~**s**ection 51312.

~~L~~**K**. Local Education Agency (LEA) assessment services as specified in ~~Title~~ 22 CCR Section 51360(b) provided to a Member who qualifies for LEA services based on ~~Title~~ 22 CCR ~~S~~**s**ection 51190.1.

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~~M~~**L**. Any LEA services as specified in ~~Title~~ 22 CCR ~~S~~**s**ection 51360 provided pursuant to an Individualized Education Plan (IEP) as set forth in Education Code, ~~S~~**s**ection 56340 et seq. or an Individualized Family Service Plan (IFSP) as set forth in Government Code ~~S~~**s**ection 95020, or LEA services provided under an Individualized Health and Support Plan (IHSP), as described in ~~Title~~ 22 CCR ~~S~~**s**ection 51360.

~~N~~**M**. Laboratory services provided under the State serum alpha-fetoprotein-testing program administered by the Genetic Disease Branch of California Department of Public Health.

~~O~~**N**. Pediatric Day Health Care.

~~P~~**O**. Personal Care Services.

~~Q~~**P**. State Supported Services.

~~Q. Except as set forth in Attachment 3.1.B.1 (effective 1/1/2006) of the California Medicaid State Plan or as otherwise authorized by Welfare & Institutions Code Section 14133.23, effective January 1, 2006, drug benefits for full benefit dual eligible beneficiaries who are eligible for drug benefits under Part D of Title XVIII of the Social Security Act (42 USC Section 1395w-101 et seq) are not a Covered Service under this Contract.~~

~~R~~**Q**. Targeted case management services as specified in ~~Title~~ 22 CCR ~~S~~**s**ections 51185 and 51351, and as described in Exhibit A, Attachment 11, Provision ~~3~~**1**. However, if Members under the age of 21 are not eligible for or accepted by a Regional Center or a local government health program for TCM services, Contractor shall ensure access to comparable services under the EPSDT benefit in accordance with APL 19-010.

~~S~~**R**. Childhood lead poisoning case management provided by county health departments.

~~T. Psychotherapeutic drugs that are listed in the Medi-Cal Provider Manual, MCP: Two-Plan Model, Capitated/Noncapitated Drugs section, which lists excluded psychiatric drugs.~~

~~U. Human Immunodeficiency Virus (HIV) and AIDS drugs that are listed in the Medi-Cal Provider Manual, MCP: Two-Plan Model, Capitated/Noncapitated Drugs section, which lists excluded HIV/AIDS drugs.~~

Commented [A75]: This Q. applies to COHS only

Commented [A76R75]: Language is duplicative here, and already lives in Ex. A Attachment 10.

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~~V~~**S**. Optional benefits as set forth in Welfare and Institutions Code ~~S~~**s**ection 14131.10, as implemented by the Medi-Cal Fee-For-Service program.

T. Prescribed covered outpatient drugs dispensed by pharmacies, in accordance with APL 21-018.

~~U. Except as set forth in Attachment 3.1.B.1 (effective 01/01/2006) of the California Medicaid State Plan or as otherwise authorized by Welfare and Institutions Code section 14133.23, effective January 1, 2006, drug benefits for full benefit dual eligible beneficiaries who are eligible for drug benefits under Part D of Title XVIII of the Social Security Act (42 USC 1395w-101 et seq.) are not a Covered Service under this Contract.~~

~~W~~**U**. Non-medical services provided by Regional Centers to individuals with developmental disabilities, including but not limited to, respite, out-of-home placement, and supportive living.

~~X~~**V**. End of life services as stated in Health and Safety Code ~~S~~**s**ection 443 et seq., and APL 16-006.

~~**Chronically Homeless** means a Member with a condition limiting the activities of daily living and who has been continually Homeless for one (1) year or more, or at least four (4) times in the past three (3) years. In addition, and for the purposes of this Contract, a Member who is currently residing in transitional housing, as defined in Health and Safety Code, Section 50675.2, or who has been residing in permanent supportive housing, as defined in Health and Safety Code, Section 50675.14, for less than two (2) years shall also be considered Chronically Homeless if the Member was Chronically Homeless prior to residence.~~

~~**Community-Based Care Management Entity (CB-CME)** means Providers within the community that have a contractual relationship with Contractor, or Contractor acting directly, to provide HHP Services to HHP Enrolled Members.~~

Eligible Beneficiary means any Medi-Cal beneficiary who is residing in Contractor's Service Area with one **(1)** 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, 2C, **2V,** 30, 32, 33, 34, 35, ~~37,~~ 38, 39, 3A, 3C, 3E, 3F, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 3W,	03, 04, 06, 07,**2P, 2R, 2S, 2T, 2U,** 40, 42, 43, 45, 46, 49, ~~86,~~ 4A, 4F, 4G, 4H, 4K, 4L, 4M, 4N, 4S, 4T, 4W, 5K, 5L, **76 *(Effective***

Commented [A77]: Rx only

Commented [A78R77]: Plans have already reviewed RX language as of 2/4/2021.

Commented [A79]: This U. applies to GMC only.

Commented [A80R79]: Language is duplicative here, and already lives in Ex. A Attachment 10.

Commented [A81]: Only applies to those plans who have HHP in their contracts.

	47, 54, 59, 5C, 5D, **5V,** 72, 7A, 7J, 7S, 7W, 7X, **81,** 82, ~~83,~~ **85, 86,** ~~87,~~ **8E,** 8P, 8R, 8U, ~~E2, E5,~~ E6, E7, H1, H2, H3, H4, H5, K1, M3, M5, M7, **M9,** P5, P7, P9, **R1,** T1, T2, T3, T4, T5	***4/1/2022)***
Family/Dual Eligible	0E, **2V,** 30, 32, 33, 34, 35, ~~37,~~ 38, 39, 3E, 3F, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 3W, 47, 54, 59, **5V,** 72, 7A, 7J, 7W, 7X, 82, **8E,** 8P, 8R, 8U, ~~E2, E5,~~ K1, M3, M7, P5, P7, P9, R1	03, 04, 06, 07, 40, 42, 43, 45, 46, 49, 4A, 4F, 4G, 4H, 4K, 4L, 4M, 4N, 4S, 4T, 4W, 5K, 5L
SPD Dual	10, 14, 16, ~~17,~~ 1E, 1H, 1X, ~~1Y,~~ 20, 24, 26, ~~27,~~ 2E, 2H, 36, 60, 64, 66, ~~67,~~ 6A, 6C, 6E, 6G, 6H, 6J, 6N, 6P, 6V, ~~6W~~, 6X, ~~6Y,~~ L6	
SPD	10, 14, 16, 1E, 1H, 20, 24, 26, 2E, 2H, 36, 60, 64, 66, 6A, 6C, 6E, 6G, 6H, 6J, 6N, 6P, ~~6R,~~ 6V, L6	
Adult Expansion	L1, M1, 7U	
Breast and Cervical Cancer Treatment Program (BCCTP)	**0M, 0N, 0P, 0R, 0T, 0U, 0W**	~~0N, 0P, 0W~~
Long Term Care	13, 23, 53, 63	
Long Term Care Dual	13, 23, 53, 63	
~~OBRA~~	~~55, 58, 5F, 5G, 5N, C1, C2, C3, C4, C5, C6, C7, C8, C9, D1, D2, D3, D4, D5, D6, D7, D8, D9~~	

An Eligible Beneficiary may continue to be a Member following any redetermination of Medi-Cal eligibility that determines that the individual is eligible for, and the individual thereafter enrolls in, the BCCTP.

The following exclusion~~s~~ apply**ies** to all the above:

B. ~~Individuals who have commercial HMO coverage.~~ Individuals with Medicare FFS coverage are not excluded from enrolling under this Contract.

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

ECM Provider means community-based entities with experience and expertise providing intensive, in-person care management services to Members in one (1) or more of the Populations of Focus for ECM.

~~**Health Action Plan (HAP)** means a comprehensive individualized care plan with the inclusion of any elements specific to HHP.~~

~~**Health Homes Program (HHP)** means all of the California Medicaid State Plan amendments and relevant waivers that DHCS seeks and CMS approves for the provision of HHP Services that provide supplemental services to eligible Members coordinating the full range of physical health, behavioral health, and community-based long-term services and supports needed for chronic conditions.~~

~~**Health Homes Program Member** means a Member who is enrolled and continuously participating in the Health Homes Program, and qualifies for a supplemental HHP payment.~~

~~**Health Homes Program Multi-Disciplinary Care Team** means a team of staff employed by Contractor and/or the CB-CME to provide HHP Services.~~

~~**Health Homes Program Provider** means a Physician, clinical practice or clinical group practice, rural clinic, community health center, community mental health center, home health agency, or any other entity or Provider (including pediatricians, gynecologists, and obstetricians) that is determined by the State to be qualified to be a health home for eligible Members with chronic conditions on the basis of documentation evidencing that the Physician, practice, or clinic:~~

~~A. Has the systems and infrastructure in place to provide HHP Services; and~~

~~B. Satisfies the qualification standards established by DHCS and Contractor~~

~~**Health Homes Program Services means** services described in Exhibit A, Attachment 23, Health Homes Program, Provision 6, that are provided by Contractor, a HHP Provider, a team of health care professionals operating with such a Provider, a HHP~~

~~Multi-Disciplinary Care Team, or a health team. The HHP Services described in this Provision include:~~

~~A. Comprehensive Care Management~~

~~B. Care Coordination~~

~~C. Health promotion~~

~~D. Comprehensive transitional care~~

~~E. Individual and family support services~~

~~F. Referral to community and social supports~~

~~**Homeless** means a Member who, as defined in 24 CFR 91.5, lacks a fixed, regular, and adequate nighttime residence, or who will imminently lose their primary nighttime residence; or are an unaccompanied Member under 25 years of age; or a Member who is fleeing dangerous or life-threatening conditions, has no other residence, and lacks the resources to obtain permanent housing.~~

~~**Individual Housing Transition Services** means services that support a Member's ability to prepare for and transition to housing, and are further described in the Center for Medicaid & CHIP Services (CMCS) informational bulletin titled, "Coverage of Housing-Related Activities and Services for Individuals with Disabilities", dated June 26, 2015.~~

~~**Individual Housing & Tenancy Sustaining Services** means services that support Members in being successful tenants in their housing arrangement, thus able to sustain tenancy, and are further described in the Center for Medicaid & CHIP Services (CMCS) informational bulletin titled "Coverage of Housing-Related Activities and Services for Individuals with Disabilities", dated June 26, 2015.~~

Commented [A82]: Only applies to those plans who have HHP in their contracts.

Managed Long Term Services and Support (MLTSS) means services and supports provided by Contractor to Members who have functional limitations and/or chronic illnesses and which have the primary purpose of supporting the ability of the Member to live or work in the setting of their choice, which may include the Member's home, a worksite, a Provider-owned or controlled residential setting, a nursing facility, or other institutional setting. In this Contract, MLTSS includes CBAS, LTC, ~~MSSP,~~ and SNFs, to the extent Contractor is at-risk for covering SNF services.

Medi-Cal Only Member means a Member who is eligible for only Medi-Cal and receives CBAS, ~~MSSP,~~ or LTC services from Contractor.

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

Multipurpose Senior Service Program (MSSP) means the Waiver program that provides social and health care management to a Member who is 65 years or older and meets a nursing facility level of care as an alternative to nursing facility placement in order to allow the Member to remain in their home, pursuant to the Medi-Cal 2020 Waiver. **Effective January 1, 2022, MSSP will no longer be part of the MLTSS benefit provided by Contractor and will no longer be covered in the Contract.**

Network means PCPs, Specialists, hospitals, ~~pharmacy,~~ ancillary Providers, facilities, and any other Providers that Subcontract with Contractor for the delivery of Medi-Cal Covered Services.

Commented [A83]: Applies to Rx only

Commented [A84R83]: Plans have already reviewed RX language as of 2/4/2021.

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

Population of Focus means a subset of Medi-Cal Managed Care Health Plan Members that meet eligibility criteria, as defined by DHCS, by which they are eligible to receive the ECM benefit.

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 PCP assignment data received or determined by Contractor for each Member as of the last calendar day of the reporting month.

Social Drivers of Health 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.

~~**Targeted Engagement List** means the lists developed by DHCS of Contractor's Medi-Cal Members who 1) appear to meet the HHP eligibility criteria based on Member characteristics identified in DHCS administrative data; and 2) may be targeted for engagement.~~

Commented [A85]: Only applies to those plans who have HHP in their contracts.

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 health care Provider. ~~Telehealth facilitates the Member's self-management and caregiver support for the Member.~~

XXVI. Exhibit E, Attachment 2, PROGRAM TERMS AND CONDITIONS, is amended to read:

16. 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, suppliers, laborers, and any other person, firm, or corporation furnishing or supplying work services, materials, or supplies in connection with the performance of this Contract, and from any and all claims and losses accruing or resulting to any person, firm or corporation who may be injured or damaged by Contractor in the performance of this Contract.

B. Contractor further agrees to indemnify, defend, and hold harmless the State, DHCS and its officers, agents, and employees from any and all claims and losses, any and all attorneys' fees and costs, judgments, damages, and any administrative costs incurred by DHCS or a Member from any and all litigation, arbitration or mediation resulting directly, indirectly, or arising out of Contractor's denial, delay, or modification of requested covered health care 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.

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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 Enrollees, and any other costs associated with any actual or alleged breach 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, California Civil Code section 1798 *et seq.* by Contractor and any vendor, plan-to-plan contractors, Subcontractors and Network Providers that Contractor contracts with in the performance of this Contract.

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.

~~16~~ 17. Sanctions

~~17~~ 18. Liquidated Damages

~~18~~ 19. Contractor's Dispute Resolution Requirements

~~19~~ 20. Audit

~~20~~ 21. Inspection Rights

~~21~~ 22. Confidentiality of Information

~~22~~ 23. Pilot Projects

~~23~~ 24. Cost Avoidance and Post-Payment Recovery (PPR) of Other Health Coverage (OHC)

F. ~~If~~ Contractor ~~does not perform PPR for a Member with OHC, Contractor shall demonstrate to DHCS, upon request, that the cost of PPR exceeds the total revenues Contractor projects it would receive from such activity~~ **shall conduct Post-Payment Recovery using the threshold guidelines as described in State Plan Amendment 4.22-B**.

I. Post-Payment Recovery

4) Monies recovered by DHCS or a 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 **unless Contractor has an active repayment agreement as described in Paragraph D above.**

~~24~~ 25. Third-Party Tort and Worker's Compensation Liability

Contractor shall 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 shall ~~meet the following requirements~~:

A. Within 30 days of ~~a~~ 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, and Subcontractors. Service and utilization information and copies of paid invoices/claims shall set out any services provided by Contractor, including, but not limited to, physical, mental, and dental health services. Records shall include services provided on a FFS, capitated basis, and any other payment arrangements, regardless of whether a payment was made or denied. The reasonable value of the services shall be calculated as the usual, customary and reasonable charge made to the general public for similar services or the amount paid to

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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~~/and~~ claims via a designated secure file transfer protocol, in compliance with the electronic format and process as set forth in applicable APL(s) and as provided in a form supplied by DHCS. Contractor shall include the DHCS attestation form signed by the custodian of records or a designee with knowledge of the Member information provided to DHCS, as specified in applicable APL(s).

D. Use the TPLManagedCare@dhcs.ca.gov inbox for all communications regarding Contractor's service and utilization information~~,~~ and paid invoices ~~and/~~ claims submissions, to submit questions or comments related to the preparation and submission of these reports, and for issues related to accessing the secure file transfer protocol folders.

~~25~~ 26. Records Related To Recovery for Litigation

~~26~~ 27. Fraud and Abuse Reporting

B. Contractor shall meet the requirements set forth in 42 CFR **section** 438.608 by establishing administrative and management arrangements or procedures, as well as a mandatory compliance plan, which are designed to guard against fraud and abuse. These requirements shall be met through the following:

2) Prompt reporting**, within three (3) Working Days** to DHCS of all Overpayments identified or recovered, specifying which Overpayments are due to potential fraud.

3) Prompt notification**, within three (3) Working Days** to DHCS when Contractor receives information about changes in a Member's circumstances that may affect the Member's eligibility including the following:

4) Prompt notification**, within three (3) Working Days** to DHCS when Contractor receives information about a change in a Network Provider's circumstances that may affect the Network Provider's eligibility to participate in the Medi-Cal managed care program,

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including the termination of their Provider agreement with Contractor.

~~27~~ 28. Equal Opportunity Employer

~~28~~ 29. Discrimination Prohibitions

~~29~~ 30. Federal and State Nondiscrimination Requirements

~~30~~ 31. Disabled Veteran Business Enterprises (DVBE)

~~31~~ 32. Word Usage

~~32~~ 33. Federal False Claims Act Compliance

~~33~~ 34. Disclosures

~~34~~ 35. Treatment of Recoveries

XXVII. Exhibit G, HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA), is being amended to remove:

~~**Exhibit G**~~
~~**HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)**~~

~~**I. Recitals**~~

~~A. This Contract (Agreement) has been determined to constitute a business associate relationship under 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 U.S.C. section 17921 et seq., and their implementing privacy and security regulations at 45 CFR Parts 160 and 164 ("the HIPAA regulations").~~

~~B. The Department of Health Care Services ("DHCS") wishes to disclose to Business Associate certain information pursuant to the terms of this Agreement, some of which may constitute Protected Health Information ("PHI"), including protected health information in electronic media ("ePHI"), under federal law, and personal~~

~~information ("PI") under state law.~~

~~C. As set forth in this Agreement, Contractor, here and after, is the Business Associate of DHCS acting on DHCS' behalf and provides services, arranges, performs or assists in the performance of functions or activities on behalf of DHCS and creates, receives, maintains, transmits, uses or discloses PHI and PI. DHCS and Business Associate are each a party to this Agreement and are collectively referred to as the "parties."~~

~~D. The purpose of this Addendum is to protect the privacy and security of the PHI and PI that may be created, received, maintained, transmitted, used or disclosed pursuant to this Agreement, and to comply with certain standards and requirements of HIPAA, the HITECH Act and the HIPAA regulations, including, but not limited to, the requirement that DHCS must enter into a contract containing specific requirements with Contractor prior to the disclosure of PHI to Contractor, as set forth in 45 CFR Parts 160 and 164 and the HITECH Act.~~

~~E. The terms used in this Addendum, but not otherwise defined, shall have the same meanings as those terms have in the HIPAA regulations. Any reference to statutory or regulatory language shall be to such language as in effect or as amended.~~

~~**II. Definitions**~~

~~A. Breach shall have the meaning given to such term under HIPAA, the HITECH Act, and the HIPAA regulations.~~

~~B. Business Associate shall have the meaning given to such term under HIPAA, the HITECH Act, and the HIPAA regulations.~~

~~C. Covered Entity shall have the meaning given to such term under HIPAA, the HITECH Act, and the HIPAA regulations.~~

~~D. Electronic Health Record shall have the meaning given to such term in the HITECH Act, including, but not limited to, 42 U.S.C Section 17921 and implementing regulations.~~

~~E. Electronic Protected Health Information (ePHI) means individually identifiable health information transmitted by electronic media or~~

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~~maintained in electronic media, including but not limited to electronic media as set forth under 45 CFR section 160.103.~~

~~F. Individually Identifiable Health Information means health information, including demographic information collected from an individual, that is created or received by a health care provider, health plan, employer or health care clearinghouse, and relates to the past, present or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual, that identifies the individual or where there is a reasonable basis to believe the information can be used to identify the individual, as set forth under 45 CFR section 160.103.~~

~~G. Privacy Rule shall mean the HIPAA Regulation that is found at 45 CRF Parts 160 and 164.~~

~~H. Personal Information shall have the meaning given to such term in California Civil Code section 1798.29.~~

~~I. Protected Health Information means individually identifiable health information that is transmitted by electronic media, maintained in electronic media, or is transmitted or maintained in any other form or medium, as set forth under 45 CFR section 160.103.~~

~~J. Required by law, as set forth under 45 CFR section 164.103, means a mandate contained in law that compels an entity to make a use or disclosure of PHI that is enforceable in a court of law. This includes, but is not limited to, court orders and court ordered warrants, subpoenas or summons issued by a court, grand jury, a governmental or tribal inspector general, or an administrative body authorized to require the production of information, and a civil or an authorized investigative demand. It also includes Medicare conditions of participation with respect to health care providers participating in the program, and statutes or regulations that require the production of information, including statutes or regulations that require such information if payment is sought under a government program providing public benefits.~~

~~K. Secretary means the Secretary of the U.S. Department of Health and Human Services ("HHS") or the Secretary's designee.~~

~~L. Security Incident means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of PHI or PI, or confidential data that is essential to the ongoing operation of the Business Associate's organization and intended for internal use; or interference with system operations in an information system.~~

~~M. Security Rule shall mean the HIPAA regulation that is found at 45 CFR Parts 160 and 164.~~

~~N. Unsecured PHI shall have the meaning given to such term under the HITECH Act, 42 U.S.C. section 17932(h), any guidance issued pursuant to such Act and the HIPAA regulations.~~

~~III. Terms of Agreement~~

~~A. Permitted Uses and Disclosures of PHI by Business Associate~~

~~***Permitted Uses and Disclosures***. Except as otherwise indicated in this Addendum, Business Associate may use or disclose PHI only to perform functions, activities or services specified in this Agreement, for, or on behalf of DHCS, provided that such use or disclosure would not violate the HIPAA regulations, if done by DHCS. Any such use or disclosure must, to the extent practicable, be limited to the limited data set, as defined in 45 CFR section 164.514(e)(2), or, if needed, to the minimum necessary to accomplish the intended purpose of such use or disclosure, in compliance with the HITECH Act and any guidance issued pursuant to such Act, and the HIPAA regulations.~~

~~1. ***Specific Use and Disclosure Provisions***. Except as otherwise indicated in this Addendum, Business Associate may:~~

~~a. ***Use and disclose for management and administration***. Use and disclose PHI for the proper management and administration of the Business Associate provided that such disclosures are required by law, or the Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and will be used or further disclosed only as required by law or~~

~~for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware that the confidentiality of the information has been breached.~~

~~b. ***Provision of Data Aggregation Services***. Use PHI to provide data aggregation services to DHCS. Data aggregation means the combining of PHI created or received by the Business Associate on behalf of DHCS with PHI received by the Business Associate in its capacity as the Business Associate of another covered entity, to permit data analyses that relate to the health care operations of DHCS.~~

~~**B. Prohibited Uses and Disclosures**~~

~~1. Business Associate shall not disclose PHI about an individual to a health plan for payment or health care operations purposes if the PHI pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full and the individual requests such restriction, in accordance with 42 U.S.C. section 17935(a) and 45 CFR section 164.522(a).~~

~~2. Business Associate shall not directly or indirectly receive remuneration in exchange for PHI, except with the prior written consent of DHCS and as permitted by 42 U.S.C. section 17935(d)(2).~~

~~***C*. Responsibilities of Business Associate**~~

~~Business Associate agrees:~~

~~1. ***Nondisclosure***. Not to use or disclose Protected Health Information (PHI) other than as permitted or required by this Agreement or as required by law.~~

~~2. ***Safeguards***. To implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the~~

~~PHI, including electronic PHI, that it creates, receives, maintains, uses or transmits on behalf of DHCS, in compliance with 45 CFR sections 164.308, 164.310 and 164.312, and to prevent use or disclosure of PHI other than as provided for by this Agreement. Business Associate shall implement reasonable and appropriate policies and procedures to comply with the standards, implementation specifications and other requirements of 45 CFR section 164, subpart C, in compliance with 45 CFR section 164.316. Business Associate shall develop and maintain a written information privacy and security program that includes administrative, technical and physical safeguards appropriate to the size and complexity of the Business Associate's operations and the nature and scope of its activities, and which incorporates the requirements of section 3, Security, below. Business Associate will provide DHCS with its current and updated policies.~~

~~3. ***Security***. To take any and all steps necessary to ensure the continuous security of all computerized data systems containing PHI and/or PI, and to protect paper documents containing PHI and/or PI. These steps shall include, at a minimum:~~

~~a. Complying with all of the data system security precautions listed in Attachment A, the Business Associate Data Security Requirements;~~

~~b. Achieving and maintaining compliance with the HIPAA Security Rule (45 CFR Parts 160 and 164), as necessary in conducting operations on behalf of DHCS under this Agreement;~~

~~c. Providing a level and scope of security that is at least comparable to the level and scope of security established by the Office of Management and Budget in OMB Circular No. A-130, Appendix III - Security of Federal Automated Information Systems, which sets forth guidelines for automated information systems in Federal agencies; and~~

~~d. In case of a conflict between any of the security~~

~~standards contained in any of these enumerated sources of security standards, the most stringent shall apply. The most stringent means that safeguard which provides the highest level of protection to PHI from unauthorized disclosure. Further, Business Associate must comply with changes to these standards that occur after the effective date of this Agreement.~~

~~Business Associate shall designate a Security Officer to oversee its data security program who shall be responsible for carrying out the requirements of this section and for communicating on security matters with DHCS.~~

~~**D. *Mitigation of Harmful Effects***. To mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate or its subcontractors in violation of the requirements of this Addendum.~~

~~**E. *Business Associate's Agents and Subcontractors***.~~

~~1. To enter into written agreements with any agents, including subcontractors and vendors, to whom Business Associate provides PHI or PI received from or created or received by Business Associate on behalf of DHCS, that impose the same restrictions and conditions on such agents, subcontractors and vendors that apply to Business Associate with respect to such PHI and PI under this Addendum, and that comply with all applicable provisions of HIPAA, the HITECH Act and the HIPAA regulations, including the requirement that any agents, subcontractors or vendors implement reasonable and appropriate administrative, physical, and technical safeguards to protect such PHI and PI. Business Associate shall incorporate, when applicable, the relevant provisions of this Addendum into each subcontract or subaward to such agents, subcontractors and vendors, including the requirement that any security incidents or breaches of unsecured PHI or PI be reported to Business Associate.~~

~~2. In accordance with 45 CFR section 164.504(e)(1)(ii), upon~~

~~Business Associate's knowledge of a material breach or violation by its subcontractor of the agreement between Business Associate and the subcontractor, Business Associate shall:~~

~~a. Provide an opportunity for the subcontractor to cure the breach or end the violation and terminate the agreement if the subcontractor does not cure the breach or end the violation within the time specified by DHCS; or~~
~~b. Immediately terminate the agreement if the subcontractor has breached a material term of the agreement and cure is not possible.~~

~~**F. *Availability of Information to DHCS and Individuals***. To provide access and information:~~

~~1. To provide access as DHCS may require, and in the time and manner designated by DHCS (upon reasonable notice and during Business Associate's normal business hours) to PHI in a Designated Record Set, to DHCS (or, as directed by DHCS), to an Individual, in accordance with 45 CFR section 164.524. Designated Record Set means the group of records maintained for DHCS that includes medical, dental and billing records about individuals; enrollment, payment, claims adjudication, and case or medical management systems maintained for DHCS health plans; or those records used to make decisions about individuals on behalf of DHCS. Business Associate shall use the forms and processes developed by DHCS for this purpose and shall respond to requests for access to records transmitted by DHCS within fifteen (15) calendar days of receipt of the request by producing the records or verifying that there are none.~~

~~2. If Business Associate maintains an Electronic Health Record with PHI, and an individual requests a copy of such information in an electronic format, Business Associate shall provide such information in an electronic format to enable DHCS to fulfill its obligations under the HITECH Act, including but not limited to, 42 U.S.C. section 17935(e).~~

3. If Business Associate receives data from DHCS that was provided to DHCS by the Social Security Administration, upon request by DHCS, Business Associate shall provide DHCS with a list of all employees, contractors and agents who have access to the Social Security data, including employees, contractors and agents of its subcontractors and agents.

G. ***Amendment of PHI.*** To make any amendment(s) to PHI that DHCS directs or agrees to pursuant to 45 CFR section 164.526, in the time and manner designated by DHCS.

H. ***Internal Practices***. To make Business Associate's internal practices, books and records relating to the use and disclosure of PHI received from DHCS, or created or received by Business Associate on behalf of DHCS, available to DHCS or to the Secretary of the U.S. Department of Health and Human Services in a time and manner designated by DHCS or by the Secretary, for purposes of determining DHCS' compliance with the HIPAA regulations. If any information needed for this purpose is in the exclusive possession of any other entity or person and the other entity or person fails or refuses to furnish the information to Business Associate, Business Associate shall so certify to DHCS and shall set forth the efforts it made to obtain the information.

I. ***Documentation of Disclosures***. To document and make available to DHCS or (at the direction of DHCS) to an Individual such disclosures of PHI, and information related to such disclosures, necessary to respond to a proper request by the subject Individual for an accounting of disclosures of PHI, in accordance with the HITECH Act and its implementing regulations, including but not limited to 45 CFR section 164.528 and 42 U.S.C. section 17935(c). If Business Associate maintains electronic health records for DHCS as of January 1, 2009.

Business Associate must provide an accounting of disclosures, including those disclosures for treatment, payment or health care operations, effective with disclosures on or after January 1, 2014. If Business Associate acquires electronic health records for DHCS after January 1, 2009, Business Associate must provide an accounting of disclosures, including those disclosures for treatment, payment or health care operations, effective with disclosures on or

~~after the date the electronic health record is acquired, or on or after January 1, 2011, whichever date is later. The electronic accounting of disclosures shall be for disclosures during the three years prior to the request for an accounting.~~

~~**J.** ***Breaches and Security Incidents.*** During the term of this Agreement, Business Associate agrees to implement reasonable systems for the discovery and prompt reporting of any breach or security incident, and to take the following steps:~~

~~1. ***Notice to DHCS.*** (1) To notify DHCS **immediately by telephone call plus email or fax** upon the discovery of a breach of unsecured PHI or PI in electronic media or in any other media if the PHI or PI was, or is reasonably believed to have been, accessed or acquired by an unauthorized person, or upon the discovery of a suspected security incident that involves data provided to DHCS by the Social Security Administration. (2) To notify DHCS **within 24 hours by email or fax** of the discovery of any suspected security incident, intrusion or unauthorized access, use or disclosure of PHI or PI in violation of this Agreement and this Addendum, or potential loss of confidential data affecting this Agreement. A breach shall be treated as discovered by Business Associate as of the first day on which the breach is known, or by exercising reasonable diligence would have been known, to any person (other than the person committing the breach) who is an employee, officer or other agent of Business Associate.~~

~~Notice shall be provided to the DHCS Program Contract Manager, the DHCS Privacy Officer and the DHCS Information Security Officer. If the incident occurs after business hours or on a weekend or holiday and involves electronic PHI, notice shall be provided by calling the DHCS ITSD Service Desk. Notice shall be made using the "DHCS Privacy Incident Report" form, including all information known at the time. Business Associate shall use the most current version of this form, which is posted on the DHCS Privacy Office website (www.dhcs.ca.gov, then select "Privacy" in the left column and then "Business Use" near the middle of the page) or use this link: http://www.dhcs.ca.gov/formsandpubs/laws/priv/Pages/DHC~~

~~SBusinessAssociatesOnly.aspx~~

~~Upon discovery of a breach or suspected security incident, intrusion or unauthorized access, use or disclosure of PHI or PI, Business Associate shall take:~~

~~a. Prompt corrective action to mitigate any risks or damages involved with the breach and to protect the operating environment; and~~
~~b. Any action pertaining to such unauthorized disclosure required by applicable Federal and State laws and regulations.~~

~~2. ***Investigation and Investigation Report***. To immediately investigate such security incident, breach, or unauthorized access, use or disclosure of PHI or PI. Within 72 hours of the discovery, Business Associate shall submit an updated "DHCS Privacy Incident Report" containing the information marked with an asterisk and all other applicable information listed on the form, to the extent known at that time, to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer.~~

~~3. ***Complete Report***. To provide a complete report of the investigation to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer within ten (10) working days of the discovery of the breach or unauthorized use or disclosure. The report shall be submitted on the "DHCS Privacy Incident Report" form and shall include an assessment of all known factors relevant to a determination of whether a breach occurred under applicable provisions of HIPAA, the HITECH Act, the HIPAA regulations and/or state law. The report shall also include a full, detailed corrective action plan, including information on measures that were taken to halt and/or contain the improper use or disclosure. If DHCS requests information in addition to that listed on the "DHCS Privacy Incident Report" form, Business Associate shall make reasonable efforts to provide DHCS with such information. If necessary, a Supplemental Report may be used to submit revised or additional information after the completed report is submitted, by submitting the revised or additional information~~

~~on an updated "DHCS Privacy Incident Report" form. DHCS will review and approve the determination of whether a breach occurred and individual notifications are required, and the corrective action plan.~~

~~4. ***Notification of Individuals***. If the cause of a breach of PHI or PI is attributable to Business Associate or its subcontractors, agents or vendors, Business Associate shall notify individuals of the breach or unauthorized use or disclosure when notification is required under state or federal law and shall pay any costs of such notifications, as well as any costs associated with the breach. The notifications shall comply with the requirements set forth in 42 U.S.C. section 17932 and its implementing regulations, including, but not limited to, the requirement that the notifications be made without unreasonable delay and in no event later than 60 calendar days. The DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer shall approve the time, manner and content of any such notifications and their review and approval must be obtained before the notifications are made.~~

~~5. ***Responsibility for Reporting of Breaches.*** If the cause of a breach of PHI or PI is attributable to Business Associate or its agents, subcontractors or vendors, Business Associate is responsible for all required reporting of the breach as specified in 42 U.S.C. section 17932 and its implementing regulations, including notification to media outlets and to the Secretary. If a breach of unsecured PHI involves more than 500 residents of the State of California or its jurisdiction, Business Associate shall notify the Secretary of the breach immediately upon discovery of the breach. If Business Associate has reason to believe that duplicate reporting of the same breach or incident may occur because its subcontractors, agents or vendors may report the breach or incident to DHCS in addition to Business Associate, Business Associate shall notify DHCS, and DHCS and Business Associate may take appropriate action to prevent duplicate reporting. The breach reporting requirements of this paragraph are in addition to the reporting requirements set forth in subsection 1, above.~~

6. ***DHCS Contact Information***. To direct communications to the above referenced DHCS staff, the Contractor shall initiate contact as indicated herein. DHCS reserves the right to make changes to the contact information below by giving written notice to the Contractor. Said changes shall not require an amendment to this Addendum or the Agreement to which it is incorporated.

DHCS Program Contract Manager
DHCS Privacy Officer
DHCS Information Security Officer

See the Scope of Work exhibit for Program Contract Manager information Privacy Officer
c/o: Office of HIPAA Compliance
Department of Health Care Services
P.O. Box 997413, MS 4722
Sacramento, CA 95899-7413

Toll Free: (866) 866-0602
Telephone: (916) 445-4646
Email: privacyofficer@dhcs.ca.gov
Fax: (916) 440-7680

Information Security Officer
DHCS Information Security Office
P.O. Box 997413, MS 6400
Sacramento, CA 95899-7413

Email: iso@dhcs.ca.gov
Fax: (916) 440-5537

Telephone: ITSD Service Desk
(916) 440-7000 or
(800) 579-0874

K. ***Termination of Agreement.*** In accordance with Section 13404(b) of the HITECH Act and to the extent required by the HIPAA regulations, if Business Associate knows of a material breach or violation by DHCS of this Addendum, it shall take the following steps:

1. Provide an opportunity for DHCS to cure the breach or end the violation and terminate the Agreement if DHCS does not cure the breach or end the violation within the time specified by Business Associate; or
2. Immediately terminate the Agreement if DHCS has breached a material term of the Addendum and cure is not possible.

L. ***Due Diligence.*** Business Associate shall exercise due diligence and shall take reasonable steps to ensure that it remains in compliance with this Addendum and is in compliance with applicable provisions of HIPAA, the HITECH Act and the HIPAA regulations, and that its agents, subcontractors and vendors are in compliance with their obligations as required by this Addendum.

M. ***Sanctions and/or Penalties.*** Business Associate understands that a failure to comply with the provisions of HIPAA, the HITECH Act and the HIPAA regulations that are applicable to Business Associate may result in the imposition of sanctions and/or penalties on Business Associate under HIPAA, the HITECH Act and the HIPAA regulations.

IV. Obligations of DHCS

DHCS agrees to:

A. ***Notice of Privacy Practices.*** Provide Business Associate with the Notice of Privacy Practices that DHCS produces in accordance with 45 CFR section 164.520, as well as any changes to such notice. Visit the DHCS Privacy Office to view the most current Notice of Privacy Practices at: http://www.dhcs.ca.gov/formsandpubs/laws/priv/Pages/default.aspx or the DHCS website at www.dhcs.ca.gov (select "Privacy in the left column and "Notice of Privacy Practices" on the right side of the page).

B. ***Permission by Individuals for Use and Disclosure of PHI.*** Provide the Business Associate with any changes in, or revocation of, permission by an Individual to use or disclose PHI, if such changes affect the Business Associate's permitted or required uses and disclosures.

~~**C.** ***Notification of Restrictions***. Notify the Business Associate of any restriction to the use or disclosure of PHI that DHCS has agreed to in accordance with 45 CFR section 164.522, to the extent that such restriction may affect the Business Associate's use or disclosure of PHI.~~

~~**D.** ***Requests Conflicting with HIPAA Rules***. Not request the Business Associate to use or disclose PHI in any manner that would not be permissible under the HIPAA regulations if done by DHCS.~~

~~**V. Audits, Inspection and Enforcement**~~

~~**A.** From time to time, DHCS may inspect the facilities, systems, books and records of Business Associate to monitor compliance with this Agreement and this Addendum. Business Associate shall promptly remedy any violation of any provision of this Addendum and shall certify the same to the DHCS Privacy Officer in writing. The fact that DHCS inspects, or fails to inspect, or has the right to inspect, Business Associate's facilities, systems and procedures does not relieve Business Associate of its responsibility to comply with this Addendum, nor does DHCS':~~

~~1. Failure to detect or~~

~~2. Detection, but failure to notify Business Associate or require Business Associate's remediation of any unsatisfactory practices constitute acceptance of such practice or a waiver of DHCS' enforcement rights under this Agreement and this Addendum.~~

~~**B.** If Business Associate is the subject of an audit, compliance review, or complaint investigation by the Secretary or the Office of Civil Rights, U.S. Department of Health and Human Services, that is related to the performance of its obligations pursuant to this HIPAA Business Associate Addendum, Business Associate shall notify DHCS and provide DHCS with a copy of any PHI or PI that Business Associate provides to the Secretary or the Office of Civil Rights concurrently with providing such PHI or PI to the Secretary. Business Associate is responsible for any civil penalties assessed due to an audit or investigation of Business Associate, in accordance with 42 U.S.C. section 17934(c).~~

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~~**VI. Termination**~~

~~**A.** ***Term.*** The Term of this Addendum shall commence as of the effective date of this Addendum and shall extend beyond the termination of the contract and shall terminate when all the PHI provided by DHCS to Business Associate, or created or received by Business Associate on behalf of DHCS, is destroyed or returned to DHCS, in accordance with 45 CFR 164.504(e)(2)(ii)(I).~~

~~**B.** ***Termination for Cause***. In accordance with 45 CFR section 164.504(e)(1)(ii), upon DHCS' knowledge of a material breach or violation of this Addendum by Business Associate, DHCS shall:~~

~~1. Provide an opportunity for Business Associate to cure the breach or end the violation and terminate this Agreement if Business Associate does not cure the breach or end the violation within the time specified by DHCS; or~~

~~2. Immediately terminate this Agreement if Business Associate has breached a material term of this Addendum and cure is not possible~~

~~**C.** ***Judicial or Administrative Proceedings***. Business Associate will notify DHCS if it is named as a defendant in a criminal proceeding for a violation of HIPAA. DHCS may terminate this Agreement if Business Associate is found guilty of a criminal violation of HIPAA. DHCS may terminate this Agreement if a finding or stipulation that the Business Associate has violated any standard or requirement of HIPAA, or other security or privacy laws is made in any administrative or civil proceeding in which the Business Associate is a party or has been joined.~~

~~**D.** ***Effect of Termination***. Upon termination or expiration of this Agreement for any reason, Business Associate shall return or destroy all PHI received from DHCS (or created or received by Business Associate on behalf of DHCS) that Business Associate still maintains in any form, and shall retain no copies of such PHI. If return or destruction is not feasible, Business Associate shall notify DHCS of the conditions that make the return or destruction infeasible, and DHCS and Business Associate shall determine the terms and conditions under which Business Associate may retain~~

~~the PHI. Business Associate shall continue to extend the protections of this Addendum to such PHI, and shall limit further use of such PHI to those purposes that make the return or destruction of such PHI infeasible. This provision shall apply to PHI that is in the possession of subcontractors or agents of Business Associate.~~

~~**VII. Miscellaneous Provisions**~~

~~**A.** ***Disclaimer***. DHCS makes no warranty or representation that compliance by Business Associate with this Addendum, HIPAA or the HIPAA regulations will be adequate or satisfactory for Business Associate's own purposes or that any information in Business Associate's possession or control, or transmitted or received by Business Associate, is or will be secure from unauthorized use or disclosure. Business Associate is solely responsible for all decisions made by Business Associate regarding the safeguarding of PHI.~~

~~**B.** ***Amendment***. The parties acknowledge that federal and state laws relating to electronic data security and privacy are rapidly evolving and that amendment of this Addendum may be required to provide for procedures to ensure compliance with such developments. The parties specifically agree to take such action as is necessary to implement the standards and requirements of HIPAA, the HITECH Act, the HIPAA regulations and other applicable laws relating to the security or privacy of PHI. Upon DHCS' request, Business Associate agrees to promptly enter into negotiations with DHCS concerning an amendment to this Addendum embodying written assurances consistent with the standards and requirements of HIPAA, the HITECH Act, the HIPAA regulations or other applicable laws. DHCS may terminate this Agreement upon thirty (30) days written notice in the event:~~

~~1. Business Associate does not promptly enter into negotiations to amend this Addendum when requested by DHCS pursuant to this Section; or~~

~~2. Business Associate does not enter into an amendment providing assurances regarding the safeguarding of PHI that DHCS in its sole discretion, deems sufficient to satisfy the standards and requirements of HIPAA and the HIPAA~~

~~regulations.~~

~~**C.** ***Assistance in Litigation or Administrative Proceedings***~~. ~~Business Associate shall make itself and any subcontractors, employees or agents assisting Business Associate in the performance of its obligations under this Agreement, 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 or employees based upon claimed violation of HIPAA, the HIPAA regulations or other laws relating to security and privacy, which involves inactions or actions by the Business Associate, except where Business Associate or its subcontractor, employee or agent is a named adverse party.~~

~~**D.** ***No Third-Party Beneficiaries***~~. ~~Nothing express or implied in the terms and conditions of this Addendum is intended to confer, nor shall anything herein confer, upon any person other than DHCS or Business Associate and their respective successors or assignees, any rights, remedies, obligations or liabilities whatsoever.~~

~~**E.** ***Interpretation***~~. ~~The terms and conditions in this Addendum shall be interpreted as broadly as necessary to implement and comply with HIPAA, the HITECH Act, the HIPAA regulations and applicable state laws. The parties agree that any ambiguity in the terms and conditions of this Addendum shall be resolved in favor of a meaning that complies and is consistent with HIPAA, the HITECH Act and the HIPAA regulations.~~

~~**F.** ***Regulatory References***~~. ~~A reference in the terms and conditions of this Addendum to a section in the HIPAA regulations means the section as in effect or as amended.~~

~~**G.** ***Survival.***~~ ~~The respective rights and obligations of Business Associate under Section VI.D of this Addendum shall survive the termination or expiration of this Agreement~~

~~**H.** ***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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XXIII. Exhibit G, Attachment A, HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA), is being amended to read:

~~**Exhibit G, Attachment A**~~
~~**HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)**~~

~~**II. Personnel Controls**~~

~~**A.** ***Employee Training.*** All workforce members who assist in the performance of functions or activities on behalf of DHCS, or access or disclose DHCS PHI or PI must complete information privacy and security training, at least annually, at Business Associate's expense. Each workforce member who receives information privacy and security training must sign a certification, indicating the member's name and the date on which the training was completed. These certifications must be retained for a period of six (6) years following contract termination.~~

~~**B.** ***Employee Discipline.*** Appropriate sanctions must be applied against workforce members who fail to comply with privacy policies and procedures or any provisions of these requirements, including termination of employment where appropriate.~~

~~**C.** ***Confidentiality Statement.*** All persons that will be working with DHCS PHI or PI must sign a confidentiality statement that includes, at a minimum, General Use, Security and Privacy Safeguards, Unacceptable Use, and Enforcement Policies. The statement must be signed by the workforce member prior to access to DHCS PHI or PI. The statement must be renewed annually. The Contractor shall retain each person's written confidentiality statement for DHCS inspection for a period of six (6) years following contract termination.~~

~~**D.** ***Background Check.*** Before a member of the workforce may access DHCS PHI or PI, a thorough background check of that worker must be conducted, with evaluation of the results to assure that there is no indication that the worker may present a risk to the security or integrity of confidential data or a risk for theft or misuse of confidential data. The Contractor shall retain each workforce member's background check documentation for a period of three~~

~~(3) years following contract termination.~~

~~**III. Technical Security Controls**~~

~~**A.** ***Workstation/Laptop encryption.*** All workstations and laptops that process and/or store DHCS PHI or PI must be encrypted using a FIPS 140-2 certified algorithm which is 128bit or higher, such as Advanced Encryption Standard (AES). The encryption solution must be full disk unless approved by the DHCS Information Security Office~~

~~**B.** ***Server Security.*** Servers containing unencrypted DHCS PHI or PI must have sufficient administrative, physical, and technical controls in place to protect that data, based upon a risk assessment/system security review.~~

~~**C.** ***Minimum Necessary.*** Only the minimum necessary amount of DHCS PHI or PI required to perform necessary business functions may be copied, downloaded, or exported.~~

~~**D.** ***Removable media devices.*** All electronic files that contain DHCS PHI or PI data must be encrypted when stored on any removable media or portable device (i.e. USB thumb drives, floppies, CD/DVD, Blackberry, backup tapes etc.). Encryption must be a FIPS 140-2 certified algorithm which is 128bit or higher, such as AES.~~

~~**E.** ***Antivirus software.*** All workstations, laptops and other systems that process and/or store DHCS PHI or PI must install and actively use comprehensive anti-virus software solution with automatic updates scheduled at least daily.~~

~~**F.** ***Patch Management.*** All workstations, laptops and other systems that process and/or store DHCS PHI or PI must have critical security patches applied, with system reboot if necessary. There must be a documented patch management process which determines installation timeframe based on risk assessment and vendor recommendations. At a maximum, all applicable patches must be installed within 30 days of vendor release.~~

~~**G.** ***User IDs and Password Controls.*** All users must be issued a unique user name for accessing DHCS PHI or PI. Username must be promptly disabled, deleted, or the password changed upon the~~

~~transfer or termination of an employee with knowledge of the password, at maximum within 24 hours. Passwords are not to be shared. Passwords must be at least eight characters and must be a non-dictionary word. Passwords must not be stored in readable format on the computer. Passwords must be changed every 90 days, preferably every 60 days. Passwords must be changed if revealed or compromised. Passwords must be composed of characters from at least three of the following four groups from the standard keyboard:~~

- ~~Upper case letters (A-Z)~~
- ~~Lower case letters (a-z)~~
- ~~Arabic numerals (0-9)~~
- ~~Non-alphanumeric characters (punctuation symbols)~~

~~**H. *Data Destruction.*** When no longer needed, all DHCS PHI or PI must be wiped using the Gutmann or US Department of Defense (DOD) 5220.22-M (7 Pass) standard, or by degaussing. Media may also be physically destroyed in accordance with NIST Special Publication 800-88. Other methods require prior written permission of the DHCS Information Security Office.~~

~~**I. *System Timeout.*** The system providing access to DHCS PHI or PI must provide an automatic timeout, requiring re-authentication of the user session after no more than 20 minutes of inactivity.~~

~~**J. *Warning Banners.*** All systems providing access to DHCS PHI or PI must display a warning banner stating that data is confidential, systems are logged, and system use is for business purposes only by authorized users. User must be directed to log off the system if they do not agree with these requirements.~~

~~**K. *System Logging.*** The system must maintain an automated audit trail which can identify the user or system process which initiates a request for DHCS PHI or PI, or which alters DHCS PHI or PI. The audit trail must be date and time stamped, must log both successful and failed accesses, must be read only, and must be restricted to authorized users. If DHCS PHI or PI is stored in a database, database logging functionality must be enabled. Audit trail data must be archived for at least 3 years after occurrence.~~

~~**L. *Access Controls.*** The system providing access to DHCS PHI or~~

PI must use role based access controls for all user authentications, enforcing the principle of least privilege.

M. ***Transmission encryption.*** All data transmissions of DHCS PHI or PI outside the secure internal network must be encrypted using a FIPS 140-2 certified algorithm which is 128bit or higher, such as AES. Encryption can be end to end at the network level, or the data files containing PHI can be encrypted. This requirement pertains to any type of PHI or PI in motion such as website access, file transfer, and E-Mail.

N. ***Intrusion Detection***. All systems involved in accessing, holding, transporting, and protecting DHCS PHI or PI that are accessible via the Internet must be protected by a comprehensive intrusion detection and prevention solution.

IIIIII. Audit Controls

A. ***System Security Review.*** All systems processing and/or storing DHCS PHI or PI must have at least an annual system risk assessment/security review which provides assurance that administrative, physical, and technical controls are functioning effectively and providing adequate levels of protection. Reviews should include vulnerability scanning tools.

B. ***Log Reviews.*** All systems processing and/or storing DHCS PHI or PI must have a routine procedure in place to review system logs for unauthorized access.

C. ***Change Control.*** All systems processing and/or storing DHCS PHI or PI must have a documented change control procedure that ensures separation of duties and protects the confidentiality, integrity and availability of data.

IVIV. Business Continuity / Disaster Recovery Controls

A. ***Emergency Mode Operation Plan.*** Contractor must establish a documented plan to enable continuation of critical business processes and protection of the security of electronic DHCS PHI or PI in the event of an emergency. Emergency means any circumstance or situation that causes normal computer operations to become unavailable for use in performing the work

~~required under this Agreement for more than 24 hours.~~

~~***B. Data Backup Plan.*** Contractor must have established documented procedures to backup DHCS PHI to maintain retrievable exact copies of DHCS PHI or PI. The plan must include a regular schedule for making backups, storing backups offsite, an inventory of backup media, and an estimate of the amount of time needed to restore DHCS PHI or PI should it be lost. At a minimum, the schedule must be a weekly full backup and monthly offsite storage of DHCS data.~~

~~**V. Paper Document Controls**~~

~~***A. Supervision of Data.*** DHCS PHI or PI in paper form shall not be left unattended at any time, unless it is locked in a file cabinet, file room, desk or office. Unattended means that information is not being observed by an employee authorized to access the information. DHCS PHI or PI in paper form shall not be left unattended at any time in vehicles or planes and shall not be checked in baggage on commercial airplanes.~~

~~***B. Escorting Visitors.*** Visitors to areas where DHCS PHI or PI is contained shall be escorted and DHCS PHI or PI shall be kept out of sight while visitors are in the area.~~

~~***C. Confidential Destruction.*** DHCS PHI or PI must be disposed of through confidential means, such as cross cut shredding and pulverizing.~~

~~***D. Removal of Data.*** DHCS PHI or PI must not be removed from the premises of the Contractor except with express written permission of DHCS.~~

~~***E. Faxing.*** Faxes containing DHCS PHI or PI shall not be left unattended and fax machines shall be in secure areas. Faxes shall contain a confidentiality statement notifying persons receiving faxes in error to destroy them. Fax numbers shall be verified with the intended recipient before sending the fax.~~

~~***F. Mailing.*** Mailings of DHCS PHI or PI shall be sealed and secured from damage or inappropriate viewing of PHI or PI to the extent possible. Mailings which include 500 or more individually~~

~~identifiable records of DHCS PHI or PI in a single package shall be sent using a tracked mailing method which includes verification of delivery and receipt, unless the prior written permission of DHCS to use another method is obtained.~~

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 at California Civil Code section 1798.3(a). PHI includes information in any form, including paper, oral, and electronic.

   4.2 As used in this Agreement, the term "confidential information" refers to information not otherwise defined as PHI in Section 4.1 of this Agreement, but to which state and/or federal privacy and/or security protections apply.

5. **Contractor (however named elsewhere in this Agreement) is the Business Associate of DHCS acting on DHCS's behalf and provides services or arranges, performs or assists in the performance of functions or activities on behalf of DHCS, and may create, receive, maintain, transmit, aggregate, use or disclose PHI (collectively, "use or disclose PHI") in order to fulfill Business Associate's obligations under this Agreement. DHCS and Business Associate**

are each a party to this Agreement and are collectively referred to as the "parties."

6. The terms used in this Agreement, but not otherwise defined, shall have the same meanings as those terms in HIPAA. Any reference to statutory or regulatory language shall be to such language as in effect or as amended.

7. Permitted Uses and Disclosures of PHI by Business Associate. Except as otherwise indicated in this Agreement, Business Associate may use or disclose PHI, inclusive of de-identified data derived from such PHI, only to perform functions, activities or services specified in this Agreement on behalf of DHCS, provided that such use or disclosure would not violate HIPAA or other applicable laws if done by DHCS.

7.1 Specific Use and Disclosure Provisions. Except as otherwise indicated in this Agreement, Business Associate may use and disclose PHI if necessary for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate. Business Associate may disclose PHI for this purpose if the disclosure is required by law, or the Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will be held confidentially and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware that the confidentiality of the information has been breached.

8. Compliance with Other Applicable Law

8.1 To the extent that other state and/or federal laws provide additional, stricter and/or more protective (collectively, more protective) privacy and/or security protections to PHI or other confidential information covered under this Agreement beyond those provided through HIPAA, Business Associate agrees:

8.1.1 To comply with the more protective of the privacy and security standards set forth in applicable state or federal laws to the extent such standards provide a greater degree of protection and security than HIPAA or are otherwise more favorable to the individuals whose information is concerned; and

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8.1.2 To treat any violation of such additional and/or more protective standards as a breach or security incident, as appropriate, pursuant to Section 18. of this Agreement.

8.2 Examples of laws that provide additional and/or stricter privacy protections to certain types of PHI and/or confidential information, as defined in Section 4. of this Agreement, include, but are not limited to the Information Practices Act, California Civil Code sections 1798-1798.78, Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, Welfare and Institutions Code section 5328, and California Health and Safety Code section 11845.5.

8.3 If Business Associate is a Qualified Service Organization (QSO) as defined in 42 CFR section 2.11, Business Associate agrees to be bound by and comply with subdivisions (2)(i) and (2)(ii) under the definition of QSO in 42 CFR section 2.11.

9. Additional Responsibilities of Business Associate

9.1 Nondisclosure. Business Associate shall not use or disclose PHI or other confidential information other than as permitted or required by this Agreement or as required by law.

9.2 Safeguards and Security.

9.2.1 Business Associate shall use safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of PHI and other confidential data and comply, where applicable, with subpart C of 45 CFR Part 164 with respect to electronic protected health information, to prevent use or disclosure of the information other than as provided for by this Agreement. Such safeguards shall be based on applicable Federal Information Processing Standards (FIPS) Publication 199 protection levels.

9.2.2 Business Associate shall, at a minimum, utilize an industry-recognized security framework when selecting and implementing its security controls, and shall maintain continuous compliance with its selected framework as it may be updated from time to time. Examples of industry-recognized security frameworks include but are not limited to

9.2.2.1 NIST SP 800-53 – National Institute of Standards and Technology Special Publication 800-53

9.2.2.2 FedRAMP – Federal Risk and Authorization Management Program

9.2.2.3 PCI – PCI Security Standards Council

9.2.2.4 ISO/ESC 27002 – International Organization for Standardization / International Electrotechnical Commission standard 27002

9.2.2.5 IRS PUB 1075 – Internal Revenue Service Publication 1075

9.2.2.6 HITRUST CSF – HITRUST Common Security Framework

9.2.3 Business Associate shall employ FIPS 140-2 compliant encryption of PHI at rest and in motion unless Business Associate determines it is not reasonable and appropriate to do so based upon a risk assessment, and equivalent alternative measures are in place and documented as such. In addition, Business Associate shall maintain, at a minimum, the most current industry standards for transmission and storage of PHI and other confidential information.

9.2.4 Business Associate shall apply security patches and upgrades, and keep virus software up-to-date, on all systems on which PHI and other confidential information may be used.

9.2.5 Business Associate shall ensure that all members of its workforce with access to PHI and/or other confidential information sign a confidentiality statement prior to access to such data. The statement must be renewed annually.

9.2.6 Business Associate shall identify the security official who is responsible for the development and implementation of the policies and procedures required by 45 CFR Part 164, Subpart C.

9.3 Business Associate's Agent. Business Associate shall ensure that any agents, subcontractors, subawardees, vendors or others (collectively, "agents") that use or disclose PHI and/or confidential information on behalf of Business Associate agree to the same restrictions and

conditions that apply to Business Associate with respect to such PHI and/or confidential information.

10. **Mitigation of Harmful Effects. Business Associate shall mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI and other confidential information in violation of the requirements of this Agreement.**

11. **Access to PHI. Business Associate shall make PHI available in accordance with 45 CFR section 164.524.**

12. **Amendment of PHI. Business Associate shall make PHI available for amendment and incorporate any amendments to protected health information in accordance with 45 CFR section 164.526.**

13. **Accounting for Disclosures. Business Associate shall make available the information required to provide an accounting of disclosures in accordance with 45 CFR section 164.528.**

14. **Compliance with DHCS Obligations. To the extent Business Associate is to carry out an obligation of DHCS under 45 CFR Part 164, Subpart E, comply with the requirements of the subpart that apply to DHCS in the performance of such obligation.**

15. **Access to Practices, Books and Records. Business Associate shall make its internal practices, books, and records relating to the use and disclosure of PHI on behalf of DHCS available to DHCS upon reasonable request, and to the federal Secretary of Health and Human Services for purposes of determining DHCS' compliance with 45 CFR Part 164, Subpart E.**

16. **Return or Destroy PHI on Termination; Survival. At termination of this Agreement, if feasible, Business Associate shall return or destroy all PHI and other confidential information received from, or created or received by Business Associate on behalf of, DHCS that Business Associate still maintains in any form and retain no copies of such information. If return or destruction is not feasible, Business Associate shall notify DHCS of the conditions that make the return or destruction infeasible, and DHCS and Business Associate shall determine the terms and conditions under which Business Associate may retain the PHI. If such return or destruction is not feasible, Business Associate shall extend the protections of this Agreement to the information and limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.**

17. Special Provision for SSA Data. If Business Associate receives data from or on behalf of DHCS that was verified by or provided by the Social Security Administration (SSA data) and is subject to an agreement between DHCS and SSA, Business Associate shall provide, upon request by DHCS, a list of all employees and agents and employees who have access to such data, including employees and agents of its agents, to DHCS.

18. Breaches and Security Incidents. Business Associate shall implement reasonable systems for the discovery and prompt reporting of any breach or security incident, and take the following steps:

18.1 Notice to DHCS.

18.1.1 Business Associate shall notify DHCS immediately upon the discovery of a suspected breach or security incident that involves SSA data. This notification will be provided by email upon discovery of the breach. If Business Associate is unable to provide notification by email, then Business Associate shall provide notice by telephone to DHCS.

18.1.2 Business Associate shall notify DHCS within 24 hours by email (or by telephone if Business Associate is unable to email DHCS) of the discovery of:

18.1.2.1 Unsecured PHI if the PHI is reasonably believed to have been accessed or acquired by an unauthorized person;

18.1.2.2 Any suspected security incident which risks unauthorized access to PHI and/or other confidential information;

18.1.2.3 Any intrusion or unauthorized access, use or disclosure of PHI in violation of this Agreement; or

18.1.2.4 Potential loss of confidential data affecting this Agreement.

18.1.3 Notice shall be provided to the DHCS Program Contract Manager (as applicable), the DHCS Privacy Office, and the DHCS Information Security Office (collectively, "DHCS Contacts") using the DHCS Contact Information at Section 18.6. below.

Notice shall be made using the current DHCS "Privacy Incident Reporting Form" ("PIR Form"; the initial notice of a security

incident or breach that is submitted is referred to as an "Initial PIR Form") and shall include all information known at the time the incident is reported. The form is available online at http://www.dhcs.ca.gov/formsandpubs/laws/priv/Pages/DHCSBusinessAssociatesOnly.aspx.

Upon discovery of a breach or suspected security incident, intrusion or unauthorized access, use or disclosure of PHI, Business Associate shall take:

18.1.3.1 Prompt action to mitigate any risks or damages involved with the security incident or breach; and

18.1.3.2 Any action pertaining to such unauthorized disclosure required by applicable Federal and State law.

18.2 Investigation. Business Associate shall immediately investigate such security incident or confidential breach.

18.3 Complete Report. To provide a complete report of the investigation to the DHCS contacts within ten (10) working days of the discovery of the security incident or breach. This "Final PIR" must include any applicable additional information not included in the Initial Form. The Final PIR Form shall include an assessment of all known factors relevant to a determination of whether a breach occurred under HIPAA and other applicable federal and state laws. The report shall also include a full, detailed corrective action plan, including its implementation date and information on mitigation measures taken to halt and/or contain the improper use or disclosure. If DHCS requests information in addition to that requested through the PIR form, Business Associate shall make reasonable efforts to provide DHCS with such information. A "Supplemental PIR" may be used to submit revised or additional information after the Final PIR is submitted. DHCS will review and approve or disapprove Business Associate's determination of whether a breach occurred, whether the security incident or breach is reportable to the appropriate entities, if individual notifications are required, and Business Associate's corrective action plan.

18.3.1 If Business Associate does not complete a Final PIR within the ten (10) working day timeframe, Business Associate shall request approval from DHCS within the ten (10) working day timeframe of a new submission timeframe for the Final PIR.

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18.4 Notification of Individuals. If the cause of a breach is attributable to Business Associate or its agents, Business Associate shall notify individuals accordingly and shall pay all costs of such notifications, as well as all costs associated with the breach. The notifications shall comply with applicable federal and state law. DHCS shall approve the time, manner and content of any such notifications and their review and approval must be obtained before the notifications are made.

18.5 Responsibility for Reporting of Breaches to Entities Other than DHCS. If the cause of a breach of PHI is attributable to Business Associate or its subcontractors, Business Associate is responsible for all required reporting of the breach as required by applicable federal and state law.

18.6 DHCS Contact Information. To direct communications to the above referenced DHCS staff, the Contractor shall initiate contact as indicated here. DHCS reserves the right to make changes to the contact information below by giving written notice to Business Associate. These changes shall not require an amendment to this Agreement.

DHCS Program Contract Manager	DHCS Privacy Office	DHCS Information Security Office
See the Scope of Work exhibit for Program Contract Manager information. If this Business Associate Agreement is not attached as an exhibit to a contract, contact the DHCS signatory to this Agreement.	Privacy Office c/o: Office of HIPAA Compliance Department of Health Care Services P.O. Box 997413, MS 4722 Sacramento, CA 95899-7413 Email: incidents@dhcs.ca.gov Telephone: (916) 445-4646	Information Security Office DHCS Information Security Office P.O. Box 997413, MS 6400 Sacramento, CA 95899-7413 Email: incidents@dhcs.ca.gov

19. Responsibility of DHCS. DHCS agrees to not request the Business Associate to use or disclose PHI in any manner that would not be permissible under HIPAA and/or other applicable federal and/or state law.

20. Audits, Inspection and Enforcement

20.1 From time to time, DHCS may inspect the facilities, systems, books and records of Business Associate to monitor compliance with this Agreement. Business Associate shall promptly remedy any violation of this Agreement and shall certify the same to the DHCS Privacy Officer in writing. Whether or how DHCS exercises this provision shall not in any respect relieve Business Associate of its responsibility to comply with this Agreement.

20.2 If Business Associate is the subject of an audit, compliance review, investigation or any proceeding that is related to the performance of its obligations pursuant to this Agreement, or is the subject of any judicial or administrative proceeding alleging a violation of HIPAA, Business Associate shall promptly notify DHCS unless it is legally prohibited from doing so.

21. Termination

21.1 Termination for Cause. Upon DHCS' knowledge of a violation of this Agreement by Business Associate, DHCS may in its discretion:

21.1.1 Provide an opportunity for Business Associate to cure the violation and terminate this Agreement if Business Associate does not do so within the time specified by DHCS; or

21.1.2 Terminate this Agreement if Business Associate has violated a material term of this Agreement.

21.2 Judicial or Administrative Proceedings. DHCS may terminate this Agreement if Business Associate is found to have violated HIPAA, or stipulates or consents to any such conclusion, in any judicial or administrative proceeding.

22. Miscellaneous Provisions

22.1 Disclaimer. DHCS makes no warranty or representation that compliance by Business Associate with this Agreement will satisfy Business Associate's business needs or compliance obligations. Business Associate is solely responsible for all decisions made by Business Associate regarding the safeguarding of PHI and other confidential information.

22.2. Amendment.

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22.2.1 Any provision of this Agreement which is in conflict with current or future applicable Federal or State laws is hereby amended to conform to the provisions of those laws. Such amendment of this Agreement shall be effective on the effective date of the laws necessitating it, and shall be binding on the parties even though such amendment may not have been reduced to writing and formally agreed upon and executed by the parties.

22.2.2 Failure by Business Associate to take necessary actions required by amendments to this Agreement under Section 22.2.1 shall constitute a material violation of this Agreement.

22.3 Assistance in Litigation or Administrative Proceedings. Business Associate shall make itself and its employees and agents available to DHCS at no cost to DHCS to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against DHCS, its directors, officers and/or employees based upon claimed violation of HIPAA, which involve inactions or actions by the Business Associate.

22.4 No Third-Party Beneficiaries. Nothing in this Agreement is intended to or shall confer, upon any third person any rights or remedies whatsoever.

22.5 Interpretation. The terms and conditions in this Agreement shall be interpreted as broadly as necessary to implement and comply with HIPAA and other applicable laws.

22.6 No Waiver of Obligations. No change, waiver or discharge of any liability or obligation hereunder on any one or more occasions shall be deemed a waiver of performance of any continuing or other obligation, or shall prohibit enforcement of any obligation, on any other occasion.

XXIX. All rights, duties, obligations and liabilities of the parties hereto otherwise remain unchanged.

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Category	Requirement	Sub-Regulatory Guidance
Management Information System (MIS)	-MIS shall be fully compliant with federal requirements and maintain a MIS that collects and reports data to DHCS, including allowed amounts and paid amounts as required. -Maintain a MIS that consumes and transmits Program Data to DHCS in accordance with all applicable DHCS All – Plan Letters (APLs). -Implement policies and procedures for ensuring complete, accurate, and timely submission of Program Data to DHCS. -Require Network Providers, Subcontractors, and Out-of-Network Providers to submit Program Data to meet administrative functions and contract requirements. -Submit complete accurate, and timely Program Data within ten (10) calendar days following the end of each month.	All – Plan Letter (APL) 20 – 017: Requirements for Reporting Managed Care Program Data
Utilization Management	-Review prior authorizations billed on a medical claim for Physician Administered Drugs (PADs), medical supplies, enteral nutritional products, and covered outpatient drugs. -Report internal reporting mechanisms used to detect member utilization patterns to DHCS no later than 30 calendar days after the beginning of each calendar year and upon request.	APL 20 – 020: Governor's Executive Order N – 01 – 19, Regarding Transitioning Medi-Cal Pharmacy Benefits from Managed Care to Medi-Cal Rx
Provider Compensation	-Reimburse providers furnishing organ or bone marrow transplant surgeries to a member at the amount the provider could collect for those same services in the Medi-Cal Fee-For-Service (FFS) delivery system.	APL 21 – 015: Benefit Standardization and Mandatory Managed Care Enrollment Provisions of the California Advancing and Innovating Medi-Cal Initiative

Covered Services	-Adds rapid whole genome sequencing as a covered service for any Medi-Cal member who is one (1) year of age or younger and receiving inpatient hospital services in an intensive care unit (ICU). -Ensure pregnant members are referred to medically appropriate specialists and ensure postpartum members have access to genetic screening. -Arrange for fabrication of optical lenses for members through the Prison Industry Authority (PIA) and cover cost of lens material, fabrication, and dispensing of lens not available through PIA. -Refer members needing specialty mental health services (SMHS) to county mental health plan (MHP). -Updated Drug Utilization Review (DUR) requirements. -Cover Non – Emergency Medical Transportation (NEMT) for Medi-Cal covered services and pharmacy services. -Cover all medically necessary organ and bone marrow transplant surgeries as set forth in the DHCS contract and Medi-Cal Provider Manual.	APL 21 – 015: Benefit Standardization and Mandatory Managed Care Enrollment Provisions of the California Advancing and Innovating Medi-Cal Initiative CalAIM APL 21 – 015 Attachment 2: Major Organ Transplants (MOT) Requirements
Memorandum of Understanding (MOU)	-MOUs with Multipurpose Senior Services Program (MSSP) providers shall be submitted to DHCS for prior approval at least 60 calendar days prior to the effective date of the MOU.	
Member Services	-Provider directories shall include Enhanced Care Management (ECM) and Community Supports providers and a link to the Medi-Cal Rx pharmacy locator. -Added clarification regarding comprehensive Other Health Coverage (OHC) requirements including scenarios for members who transition out of comprehensive OHC.	
Terminology Changes	- Update terms and definitions used in the agreement.	

Aid Code Categories	-Addition of aid codes 81, 85, 86, R1 to the Adult & Family / Optional Targeted Low – Income Child Aid Group. - All other new aid codes identified in the contract amendment have been previously authorized for inclusion into CalOptima's contract with DHCS.	
Indemnification	-MCPs must comply with indemnification requirements as a condition of entering into the contract with DHCS.	
Fraud and Abuse Reporting	-Updates to the following fraud and abuse reporting requirements: 1. Prompt reporting, within three (3) working days to DHCS of all overpayments identified or recovered, specifying which overpayments are due to potential fraud. 2. Prompt notification, within three (3) working days to DHCS when the MCP receives information about changes in a member's circumstances that may affect their eligibility. 3. Prompt notification, within three (3) working days to DHCS when the MCP receives information about a change in the Network Provider's circumstances that may affect the Network Provider's eligibility to participate in the Medi-Cal managed care plan, including termination of their provider agreement with the MCP.	

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Consent Calendar

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

Contacts

Carmen Dobry, Executive Director, Compliance, (657) 235-6997
Mike Herman, Interim Executive Director, Program Implementation, (714) 246-8820

Recommended Action

Authorize and direct the Chairman of the Board of Directors to execute an Amendment(s) to CalOptima's Primary Medi-Cal Agreement with the Department of Health Care Services (DHCS) related to Enhanced Care Management (ECM), In Lieu of Services (ILOS), and additional covered aid codes.

Background

As a County Organized Health System (COHS), CalOptima contracts with DHCS to provide health care services to Medi-Cal beneficiaries in Orange County. In January 2009, CalOptima entered into a new five (5) year agreement with the California Department of Health Care Services (DHCS). Amendments to this agreement are summarized in the attached appendix, including Amendment 49, which extends the agreement through December 31, 2021. The agreement contains, among other terms and conditions, the payment rates CalOptima receives from DHCS to provide health care services.

Discussion

In June 2021, DHCS provided managed care plans (MCPs) with finalized DHCS – MCP Enhanced Care Management (ECM) and In Lieu of Services (ILOS) contract amendment provisions, but did not indicate a date when this contract amendment would be submitted to the Centers for Medicare and Medicaid Services (CMS).

The contract amendment provisions include standardized statewide requirements regarding the administration and delivery of ECM and ILOS that will be incorporated into MCP contracts, including CalOptima's, effective January 1, 2022 as part of DHCS's California Advancing and Innovating Medi-Cal (CalAIM) proposal.

The new ECM benefit transitions successful elements from the current Health Homes Program (HHP) and Whole Person Care (WPC) pilot to provide a whole-person approach to care that addresses the clinical and non-clinical needs of high-need/high-cost Medi-Cal members. The ECM benefit will be available for Medi-Cal managed care members, including CalOptima members, who are at the highest risk level and need long-term and intensive coordination for multiple chronic conditions and who access various system types and delivery systems. The goals of the benefit are to improve care coordination, integrate services, facilitate access to and utilization of community resources, improve health outcomes, address social determinants of health, and decrease inappropriate utilization.

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ILOS are voluntary non-traditional services that are deemed medically appropriate and cost-effective alternatives to existing State Plan benefits. ILOS provides for flexible wrap-around services that Medi-Cal MCPs, including CalOptima, will be able to offer as part of the overall population health management strategy as viable substitutes to more costly services such as hospital inpatient and long-term institutional care.

The amendment does not contain any rate changes or otherwise set any rates Staff anticipates receiving final Calendar Year (CY) 2022 rates from the DHCS in September 2021 and will subsequently request authority from the Board of Directors to authorize and direct the Chairman to execute such an amendment. To date, DHCS has only shared draft boilerplate contract amendments with MCPs at this time. If the final CalOptima-specific contract amendment is not consistent with staff's understanding as presented in this document, or if it includes substantive and unexpected language changes, staff will return to the Board of Directors for further consideration.

Following is a description of the ECM contract amendment requirements sorted by category:

ECM Category	Requirement
Administration of Enhanced Care Management (ECM)	- Take a whole-person approach to offering ECM ensuring that ECM addresses the clinical and non-clinical needs of high-cost and/or high-need members in distinct populations of focus. - Ensure ECM is available throughout CalOptima's service area. - Ensure ECM is offered primarily through in-person interaction where members/family members seek or prefer to access services in their local community. - In-person visits may be supplemented with secure teleconferencing and telehealth, when appropriate and with the member's consent. - Ensure members who may benefit from ECM receive ECM. - Ensure ECM provided to each member encompasses the ECM Core Services Components. - Oversee the delivery of ECM to authorized members through its contracted ECM providers. - Pay contracted ECM providers for the provision of ECM, including outreach to assigned members. - Develop member-facing written material about ECM for use across the ECM provider network.
Populations of Focus for ECM	- Provide ECM to highest risk members who are part of the populations of focus. - Follow all DHCS guidance that further defines the approach to ECM for each population of focus.
ECM Providers	- Ensure ECM is provided primarily through in-person interaction in settings most appropriate for the members. - Contract with ECM providers to provide ECM services.

	- Contract with each Whole Person Care (WPC) entity or Health Homes Program (HHP) Community-Based Care Management Entities (CB-CMEs) as an ECM provider unless there is an applicable exception. - Ensure ECM providers have processes in place to serve ECM populations of focus. - Ensure ECM providers are Medicaid-enrolled where a State-level pathway exists.
ECM Provider Capacity	- Develop and manage a network of ECM providers. - Ensure sufficient ECM capacity to meet the needs of all ECM populations of focus. - Report ECM provider capacity to DHCS initially with the Model of Care template and on an ongoing basis pursuant to DHCS reporting requirements.
Model of Care (MOC)	- Develop and submit a MOC to DHCS outlining the MCP's framework for providing ECM. - Incorporate MOC requirements into ECM provider contracts.
Transition of Whole Person Care and Health Homes Program to ECM	- Promote continuity from the WPC Pilot and HHP to ECM. - Authorize ECM for members in HHP and WPC Pilot counties, following DHCS's implementation schedule.
Identifying Members for ECM	- Identify members who can benefit from ECM and meet the criteria for ECM populations of focus. - Engage with Network Providers and County agencies to inform these entities of ECM, the ECM populations of focus, and how to request ECM for members. - Encourage ECM providers to identify members who meet the criteria for the ECM populations of focus. - Implement a process for allowing members and/or family members, and authorized representative (AR) to request ECM on the member's behalf and provide information to members regarding the ECM request and approval process.
Authorizing Members for ECM	- Authorize ECM for each member identified as eligible for ECM. - Develop policies and procedures that explain how ECM will be authorized in an equitable and nondiscriminatory manner. - Ensure members are informed of ECM authorization decisions within medical authorization timeframe requirements. - For ECM services not authorized, ensure members are informed of their appeal rights through the Notice of Action (NOA). - Encourage plans to work with ECM providers to define a process and appropriate circumstances for presumptive authorization or preauthorization of ECM.

Assignment to ECM Provider	- Members authorized for ECM shall be assigned to an ECM provider. - Ensure communication of assignment to the designated ECM provider occurs within ten business days of authorization. - MCPs shall permit members to change ECM providers at any time and must implement any requested ECM provider change within thirty days.
Initiating Delivery of ECM	- MCPs shall not require member authorization for ECM-related data sharing as a condition of initiating delivery of ECM, unless such authorization is required by federal law. - Upon initiation of ECM, ensure each member receiving ECM has a Lead Care Manager, with responsibility for interacting directly with the member and/or family, AR, caretakers, and/or other authorized support person(s) as appropriate. - Ensure accurate and up-to-date Member-level records related to the provision of ECM services are maintained for members authorized for ECM.
Discontinuation of ECM	- Ensure that members are able to decline or end ECM upon initial outreach and engagement, or at any time thereafter. - Providers must notify the MCP when ECM services are being discontinued. - Develop processes to determine if members are no longer authorized to receive ECM and notify ECM providers to initiate discontinuation of services. - Notify members of the discontinuation of ECM and their appeals rights through the NOA process.
Core Service Components of ECM	- Ensure all members receiving ECM receive all core service components including (1) outreach and engagement (2) comprehensive assessment and care management plan, (3) enhanced coordination of care, (4) health promotion, (5) comprehensive transitional care, (6) member and family supports and (7) coordination of and referral to community and social support services.
Data Systems Requirements and Data Sharing to Support ECM	- Have IT infrastructure capabilities to support ECM. - Use defined Federal and State standards, specifications, code sets and terminologies when sharing data with ECM providers and DHCS, to the extent practicable.
Oversight of ECM Providers	- MCPs shall perform oversight of ECM providers, holding them accountable to all ECM requirements contained in these contract provisions. - MCPs shall use ECM Provider Standard Terms and Conditions to develop its ECM contracts with ECM providers and shall incorporate all ECM provider requirements, reviewed and

	approved by DHCS, as part of the MOC, including all monitoring and reporting expectations and criteria. - Provide ECM training and technical assistance to ECM providers.
Delegation of ECM to Subcontractors	- MCPs may subcontract with other entities to administer ECM in accordance with the contract provisions.
Payment	- MCPs shall pay contracted ECM providers for the provision of ECM in accordance with contracts established between the MCP and each ECM provider.
DHCS Oversight of ECM	- Submission of encounter data and supplemental reporting to DHCS to support DHCS's oversight of ECM. - Track and report to DHCS, in a format defined by DHCS, information about outreach efforts related to potential members to be enrolled in ECM. - DHCS may impose sanctions in the event of underperformance by the MCP in relation to the administration of ECM.
ECM Quality and Performance Incentive Program	- Meet all quality management and quality improvement requirements and any additional quality requirements for ECM as set forth by DHCS.

Following is a description of the ILOS contract amendment requirements sorted by category:

ILOS Category	Requirement
Contractor's Responsibility for Administration of In Lieu of Services (ILOS)	- MCPs are authorized and encouraged to provide DHCS pre-approved ILOS. - Adhere to DHCS guidance on eligible populations, code sets, potential ILOS providers, and parameters for each ILOS that the MCP chooses to provide. - Identify members who may benefit from ILOS and for whom ILOS will be a medically appropriate and cost-effective substitute for State Plan covered services and accept requests for ILOS from members and on behalf of members from providers and organizations that serve them.
DHCS Pre-Approved ILOS	- MCPs can choose to offer members one or more of the pre-approved ILOS included in the CalAIM Proposal and any subsequent DHCS – approved ILOS additions. - MCPs must indicate which ILOS it will offer in the MOC template and through MOC amendments. - Ensure ILOS are provided to members in as timely a manner as possible, and develop policies and procedures outlining the approach to managing provider shortages or other barriers to timely provision of ILOS.

	- MCPs are permitted to begin offering new pre-approved ILOS every six (6) months upon notice and submission of an updated MOC to DHCS. - MCPs may discontinue offering ILOS annually with a notice to DHCS. - Notify members affected by decision to discontinue an ILOS of the change and timing of discontinuation and procedures that will be used to ensure completion of authorized ILOS or transition into other medically necessary services.
ILOS Providers	- Contract with ILOS providers for the delivery of elected ILOS. - Ensure all ILOS providers contracted with the MCP have sufficient experience/training in the provision of ILOS being offered. - Ensure ILOS providers are enrolled in Medi-Cal where a State-level pathway exists pursuant to relevant DHCS All-Plan Letters (APLs).
ILOS Provider Capacity	- Make best efforts to develop a robust network of ILOS providers to deliver all elected ILOS. - MCPs shall take appropriate steps outlined in the contract provision when unable to offer its elected ILOS to all eligible members for whom it is medically appropriate and cost-effective. - Ensure contracted ILOS providers have sufficient capacity to receive referrals for ILOS and provide the ILOS to members authorized for the services on an ongoing basis.
Model of Care	- Develop and submit a MOC to DHCS outlining the MCP's framework for providing ILOS. - Submit any significant MOC changes to DHCS for review and approval 60 days in advance of any changes or updates, consistent with DHCS guidance.
Transition of Whole Person Care (WPC) and Health Homes Program (HHP) to ILOS	- Encourage MCPs to offer ILOS to HHP and WPC participants who are being provided similar services through WPC or HHP to provide continuity of services. - Contract with all WPC Lead Entities and HHP CB-CMEs ILOS providers with various exceptions as specified by DHCS.
Identifying Members for ILOS	- Utilize a variety of methods to identify members who may benefit from ILOS. - Develop policies and procedures defining how MCPs will identify members, accept ILOS requests from providers, other community-based entities, and member and/or their family and inform members of ILOS for which they may be eligible.

Authorizing Members for ILOS and Communication of Authorization Status	- Develop policies and procedures explaining how the MCP will authorize ILOS for eligible members in an equitable and non-discriminatory manner. - Monitor and evaluate ILOS authorizations to ensure they are equitable and non-discriminatory. - Validate member eligibility for ILOS using a consistent methodology and authorize ILOS for members for whom ILOS is determined to be a medically appropriate and cost-effective alternative to services and settings covered under the State Plan. - Encourage MCPs to work with ILOS providers to define a process and appropriate circumstances for presumptive authorization of ILOS. - Follow standard grievance and appeals processes for ILOS services not authorized. - Notify requesting provider, entity, or member of ILOS authorization decisions.
Referring Members to ILOS Providers for ILOS	- Develop policies and procedures defining the ILOS provider referral process. - If member's preferences for an ILOS provider are known, MCPs shall follow those preferences, to the extent practicable. - MCPs shall not require member authorization for ILOS-related data sharing as a condition of initiating delivery of ILOS unless such authorization is required by federal law. - Track referrals to ILOS providers to verify delivery of authorized service.
Data System Requirements and Data Sharing to Support ILOS	- MCPs shall use systems and processes capable of tracking ILOS referrals, access to ILOS, and grievances and appeals to the MCP. - As part of the referral process to ILOS providers, ensure ILOS providers have access to demographic, administrative, clinical, social service, and billing information. - Use defined Federal and State standards, specifications, code sets and terminologies when sharing data with ILOS providers and DHCS, to the extent practicable.
Oversight of ILOS Providers	- MCPs shall perform oversight of ILOS providers, holding them accountable to all ILOS requirements contained in these contract provisions and associated guidance and the MCP's MOC. - MCPs shall use ILOS Provider Standard Terms and Conditions to develop its ILOS contracts with ILOS providers. - Provide ILOS training and technical assistance to ILOS providers.

Delegation of ILOS to Subcontractors	- MCPs may contract with other entities to administer ILOS.
Payment of ILOS Providers	- MCPs shall pay contracted ILOS providers for the provision of authorized ILOS to members in accordance with established contracts between the MCP and each ILOS provider. - Utilize claims timeline and process as outlined in the MCP contract with DHCS. - Ensure ILOS providers submit a claim for ILOS rendered, to the greatest extent possible.
DHCS Oversight of ILOS	- The MOC must include details on the ILOS to be provided by the MCP. - Submission of encounter data and supplemental reporting to DHCS to support DHCS's oversight of ILOS. - DHCS may administer sanctions in the event of underperformance by the MCP in relation to the administration of ILOS.
ILOS Quality and Performance Incentive Program	- Meet all quality management and quality improvement requirements and any additional quality requirements for ECM as set forth by DHCS. - MCPs may participate in a performance incentive program related to the adoption of ILOS, building infrastructure and provider capacity for ILOS, related health care quality and outcomes, and/or other performance milestones and measures, to be defined in DHCS guidance.

Aid Code Additions

Additionally, as outlined in DHCS's CalAIM proposal, DHCS is proposing to standardize which aid code groups will require mandatory managed care enrollment versus mandatory Fee-for-Service (FFS) enrollment, across all models of care and aid code groups, statewide. Under the proposal, members in a voluntary aid code or aid code that is excluded from managed care enrollment and are currently accessing the Medi-Cal FFS delivery system, would be required to participate in the Medi-Cal managed care plan delivery system and will not be permitted to remain in FFS. The aid codes outlined below incorporate the populations that currently receive benefits through the FFS delivery system that will transition to Medi-Cal managed care upon implementation of the CalAIM proposal effective January 1, 2022.

New Aid Code – 2V

Effective January 1, 2022, DHCS will begin to enroll newly eligible members into MCPs, including CalOptima, using aid code 2V. Aid code 2V covers non-citizen victims of human trafficking, domestic violence, and other serious crimes. Aid code 2V is considered an "Adult & Family/Optional Targeted Low–Income Child" aid code for payment purposes.

New Aid Code – 5V
Effective January 1, 2022, DHCS will begin to enroll newly eligible members into MCPs, including CalOptima, using aid code 5V. Aid code 5V covers non-citizen victims of human trafficking, domestic violence, and other serious crimes. Aid code 5V is considered an "Adult & Family/Optional Targeted Low–Income Child" aid code for payment purposes.

New Aid Code 8E
Effective January 1, 2022, DHCS will begin to enroll newly eligible members into MCPs, including CalOptima, using aid code 8E. Aid code 8E provides immediate, temporary, Fee-for-Service (FFS), full-scope Medi-Cal benefits for children age 19 or younger. Aid code 8E is considered an "Adult & Family/Optional Targeted Low–Income Child" aid code for payment purposes.

New Aid Code – 44
Effective January 1, 2022, DHCS will begin to enroll newly eligible members into MCPs, including CalOptima, using aid code 44. Aid code 44 provides eligible pregnant women of any age with family planning, pregnancy-related services, including services for conditions that may complicate the pregnancy, and postpartum services if family income is at or below 213 percent of the federal poverty level (FPL). Aid code 44 is considered an "Adult & Family/Optional Targeted Low–Income Child" aid code for payment purposes.

New Aid Code – M9
Effective January 1, 2022, DHCS will begin to enroll newly eligible members into MCPs, including CalOptima, using aid code M9. Aid code M9 provides family planning, pregnancy-related services, including services for conditions that may complicate the pregnancy, postpartum services, and emergency services to citizens/lawfully present pregnant women with income at 139 up to and including 213 percent of the FPL. Aid code M9 is considered an "Adult & Family/Optional Targeted Low–Income Child" aid code for payment purposes.

DHCS has informed CalOptima that it intends to include language authorizing these aid codes into a forthcoming contract amendment for CalOptima but has not specified the timing or additional content of that contract amendment. If the updated contract amendment is not consistent with staff's understanding as presented in this document, or if it includes substantive and unexpected language changes, staff will return to the Board of Directors for further consideration.

Fiscal Impact
The Fiscal Year (FY) 2021-22 Operating Budget approved by the Board on June 3, 2021, assumes that CalOptima will take on financial risk for the mandatory ECM benefit and optional ILOS effective January 1, 2022. Payments related to these new benefits and services were treated as budget neutral. However, given the limited available information, projected costs for these changes are difficult to predict. DHCS intends to release final ECM rates in late September 2021. CalOptima will continue to advocate for adequate funding with DHCS and will monitor utilization and expenses related to the new benefit and services.

The net fiscal impact of the additional covered aid codes is not anticipated to have a significant impact and is expected to increase enrollment by approximately 2,500 members. Staff assumes DHCS will provide sufficient Medi-Cal revenue to cover anticipated expenses.

Rationale for Recommendation

CalOptima's execution of the ECM and ILOS contract amendment to its Primary Agreement with the DHCS is necessary to ensure compliance with the ECM and ILOS components of DHCS's CalAIM proposal. The added aid codes will ensure that CalOptima is authorized to provide services for and receive capitation payments for populations deemed eligible by the State of California.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Appendix summary of amendments to Primary Agreements with DHCS
2. DHCS's California Advancing and Innovating Medi-Cal (CalAIM) Proposal
3. DHCS-MCP ECM and ILOS Contract Template Provisions

/s/ Richard Sanchez — *09/29/2021*

Authorized Signature — **Date**

APPENDIX TO AGENDA ITEM 9

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

Amendments to Primary Agreement	Board Approval
A-01 provided language changes related to Indian Health Services, home and community-based services, and addition of aid codes effective January 1, 2009.	October 26, 2009
A-02 provided rate changes that reflected implementation of the gross premiums tax authorized by AB 1422 (2009) for the period January 1, 2009, through June 30, 2009.	October 26, 2009
A-03 provided revised capitation rates for the period July 1, 2009, through June 30, 2010; and rate increases to reflect the gross premiums tax authorized by AB 1422 (2009) for the period July 1, 2009, through June 30, 2010.	January 7, 2010
A-04 included the necessary contract language to conform to AB X3 (2009), to eliminate nine (9) Medi-Cal optional benefits.	July 8, 2010
A-05 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, including rate increases to reflect the gross premium tax authorized by AB 1422 (2009), the hospital quality assurance fee (QAF) authorized by AB 1653 (2010), and adjustments for maximum allowable cost pharmacy pricing.	November 4, 2010
A-06 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, for funding for legislatively mandated rate adjustments to Long Term Care facilities effective August 1, 2010; and rate increases to reflect the gross premiums tax on the adjusted revenues for the period July 1, 2010, through June 30, 2011.	September 1, 2011
A-07 included a rate adjustment that reflected the extension of the supplemental funding to hospitals authorized in AB 1653 (2010), as well as an Intergovernmental Transfer (IGT) program for Non-Designated Public Hospitals (NDPHs) and Designated Public Hospitals (DPHs).	November 3, 2011
A-08 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, for funding related to the Intergovernmental Transfer (IGT) Agreement between CalOptima and the University of California, Irvine.	March 3, 2011
A-09 included contract language and supplemental capitation rates related to the addition of the Community Based Adult Services (CBAS) benefit in managed care plans.	June 7, 2012

A-10 included contract language and capitation rates related to the transition of Healthy Families Program (HFP) subscribers into CalOptima's Medi-Cal program	December 6, 2012
A-11 provided capitation rates related to the transition of HFP subscribers into CalOptima's Medi-Cal program.	April 4, 2013
A-12 provided capitation rates for the period July 1, 2011 to June 30, 2012.	April 4, 2013
A-13 provided capitation rates for the period July 1, 2012 to June 30, 2013	June 6, 2013
A-14 extended the Primary Agreement until December 31, 2014	June 6, 2013
A-15 included contract language related to the mandatory enrollment of seniors and persons with disabilities, requirements related to the Balanced Budget Amendment of 1997 (BBA) and Health Insurance Portability and Accountability Act (HIPAA) Omnibus Rule	October 3, 2013
A-16 provided revised capitation rates for the period July 1, 2012, through June 30, 2013 and revised capitation rates for the period January 1, 2013, through June 30, 2014 for Phases 1, 2 and 3 transition of Healthy Families Program (HFP) children to the Medi-Cal program	November 7, 2013
A-17 included contract language related to implementation of the Affordable Care Act, expansion of Medi-Cal, the integration of the managed care mental health and substance use benefits and revised capitation rates for the period July 1, 2013 through June 30, 2014.	December 5, 2013
A-18 provided revised capitation rates for the period July 1, 2013, through June 30, 2014.	June 5, 2014
A-19 extended the Primary Agreement until December 31, 2015 and included language that incorporates provisions related to **Medicare Improvements for Patients and Providers Act** (MIPPA)-compliant contracts and eligibility criteria for Dual Eligible Special Needs Plans (D-SNPs)	August 7, 2014
A-20 provided revised capitation rates for the period July 1, 2012, through June 30, 2013, for funding related to the Intergovernmental Transfer (IGT) Agreement between CalOptima and the University of California, Irvine and Optional Targeted Low-Income Child Members	September 4, 2014
A-21 provided revised 2013-2014 capitation rates.	November 7, 2013
A-22 revised capitation rates for Fiscal Year (FY) 2013-14 and added an aid code to implement Express Lane/CalFresh Eligibility	November 6, 2014
A-23 revised ACA 1202 rates for January – June 2014, established base capitation rates for FY 2014-2015, added an aid code related to the OTLIC and AIM programs, and contained language revisions related to supplemental payments for coverage of Hepatitis C medications.	December 4, 2014
A-24 revises capitation rates to include SB 239 Hospital Quality Assurance Fees for the period January 1, 2014 to June 30, 2014.	May 7, 2015
A-25 extends the contract term to December 31, 2016. DHCS is obtaining a continuation of the services identified in the original agreement.	May 7, 2015

A-26 adjusts the 2013-2014 Intergovernmental Transfer (IGT) rates.	May 7, 2015
A-27 adjusts 2013-2014 capitation rates for Optional Expansion and SB 239.	May 7, 2015
A-28 incorporates language requirements and supplemental payments for BHT into primary agreement.	October 2, 2014
A-29 added optional expansion rates for January- June 2015; also added updates to MLR language.	April 2, 2015
A-30 incorporates language regarding Provider Preventable Conditions (PPC), determination of rates, and adjustments to 2014-2015 capitation rates with respect to Intergovernmental Transfer (IGT) Rate Range and Hospital Quality Assurance Fee (QAF).	December 1, 2016
A-31 extends the Primary Agreement with DHCS to December 31, 2020.	December 1, 2016
A-32 incorporates base rates for July 2015 to June 2016 with Behavioral Health Treatment (BHT) and Hepatitis–C supplemental payments, and Partial Dual/Medi-Cal only rates, and added aid codes 4U, and 2P–2U as covered aid codes.	February 2, 2017
A-33 incorporates base rates for July 2016 to June 2017.	February 2, 2017
A-34 incorporates revised Adult Optional Expansion rates for January 2015 to June 2015. These rates were revised to include the impact of the Hospital Quality Assurance Fee (HQAF) required by Senate Bill (SB) 239.	June 1, 2017
A–35 incorporates Managed Long–Term Services and Supports (MLTSS) into CalOptima's Primary Agreement with the DHCS.	March 6, 2014 February 2, 2017
A–36 incorporates revised base rates for July 2015 to June 2016.	December 7, 2017
A–37 incorporates revised base rates for July 2016 to June 2017.	February 7, 2019
A–38 incorporates full dual rates for Calendar Year (CY) 2015	August 1, 2019
A–39 incorporates full dual rates for Calendar Year (CY) 2016	August 1, 2019
A-40 incorporates Final Rule contract language.	June 1, 2017 February 6, 2020
A-41 incorporates base rates for July 2017 to June 2018, Transportation, American Indian Health Program, Mental Health Parity, CCI updates and Adult Expansion Risk Corridor language for SFY 2017-18.	December 7, 2017 June 7, 2018 February 6, 2020
A-42 incorporated revised base rates for July 2017 to June 2018, directed payments language and mental health parity documentation requirements.	August 1, 2019
A–43 incorporates revises Hospital Quality Assurance Fee (HQAF) rates for January 1, 2017 to June 30, 2017.	August 1, 2019
A-44 incorporates full dual rates for Calendar Year (CY) 2017.	August 1, 2019
A–45 incorporates the new requirements of the 2018 Final Rule Amendment, Behavioral Health Treatment (BHT) and State Fiscal Year (SFY) 2018 – 19 capitation rates	June 7, 2018 August 1, 2019 August 6, 2020
A-46 incorporates full dual rates for Calendar Year (CY) 2018.	August 1, 2019
A-47 incorporates full dual rates for Calendar Year (CY) 2019.	October 1, 2020

A-48 incorporates new Bridge Period, Health Homes Program (HHP) and Whole Child Model (WCM) language and adds 2019 – 2020 capitation rates	June 7, 2018 October 1, 2020 February 4, 2021
A-49 extends the Primary Agreement with DHCS to December 31, 2021	November 5, 2020
A-50 incorporates full dual rates for Calendar Year (CY) 2020.	February 4, 2021
A-51 incorporates full dual rates for Calendar Year (CY) 2021.	February 4, 2021

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

Amendments to Secondary Agreement	Board Approval
A-01 implemented rate amendments to conform to rate amendments contained in the Primary Agreement with DHCS (08-85214).	July 8, 2010
A-02 implemented rate adjustments to reflect a decrease in the statewide average cost for Sensitive Services for the rate period July 1, 2010 through June 30, 2011.	August 4, 2011
A-03 extended the term of the Secondary Agreement to December 31, 2014.	June 6, 2013
A-04 incorporates rates for the periods July 1, 2011 through June 30, 2012, and July 1, 2012 through June 30, 2013 as well as extends the current term of the Secondary Agreement to December 31, 2015	January 5, 2012 (FY 11-12 and FY 12-13 rates) May 1, 2014 (term extension)
A-05 incorporates rates for the periods July 1, 2013 through June 30, 2014, and July 1, 2014 through June 30, 2015. For the period July 1, 2014 through June 30, 2015, Amendment A-05 also adds funding for the Medi-Cal expansion population for services provided through the Secondary Agreement.	December 4, 2014
A-06 incorporates rates for the period July 1, 2015 onward. A-06 also extends the term of the Secondary Agreement to December 31, 2016.	May 7, 2015 (term extension) Ratification of rates requested April 7, 2016
A-07 extends the Secondary Agreement with the DHCS to December 31, 2020.	December 1, 2016
A–08 incorporates Adult & Family/Optional Targeted Low–Income Child and Adult Expansion rates for July 2016 to June 2017 and July 2017 to June 2018.	December 6, 2018
A-10 extends the Secondary Agreement with DHCS to December 31, 2021	November 5, 2020

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

Amendments to Agreement 16-93274	Board Approval

A-01 extends the Agreement 16-93274 with DHCS to December 31, 2018.	August 3, 2017
A–02 extends the Agreement 16–93274 with DHCS to December 31, 2019	June 7, 2018
A–03 extends the Agreement 16–93274 with DHCS to December 31, 2020	May 2, 2019
A–04 extends the Agreement 16–93274 with DHCS to December 31, 2021	June 4, 2020
A–05 extends the Agreement 16–93274 with DHCS to December 31, 2023.	June 3, 2021

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

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

State of California—Health and Human Services Agency
Department of Health Care Services

California Advancing & Innovating Medi-Cal (CalAIM) Proposal

January 2021

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1. Executive Summary

The Department of Health Care Services (DHCS) has developed a framework that encompasses broad-based delivery system, program and payment reform across the Medi-Cal program, called CalAIM: California Advancing and Innovating Medi-Cal. CalAIM advances several key priorities of the Administration by leveraging Medicaid as a tool to help address many of the complex challenges facing California's most vulnerable residents, such as homelessness, behavioral health care access, children with complex medical conditions, the growing number of justice-involved populations who have significant clinical needs, and the growing aging population.

This proposal recognizes the opportunity to provide for non-clinical interventions focused on a whole-person care approach via Medi-Cal that targets social determinants of health and reduces health disparities and inequities. Furthermore, the broader system, program, and payment reforms included in CalAIM allow the state to take a population health, person-centered approach to providing services with the goal of improving outcomes for all Californians. Attaining such goals will have significant impact on an individuals' health and quality of life and, through iterative system transformation, will ultimately reduce the per-capita costs over time. DHCS intends to work with the Administration, Legislature and our other partners on these proposals and recognizes the important need to discuss these issues and their prioritization within the state budget process. These are updated proposals based on extensive stakeholder feedback. Implementation will ultimately depend on the availability of funding and the requisite federal approvals.

CalAIM implementation was originally scheduled to begin in January 2021, but was delayed due the impact of the COVID-19 public health emergency. As a result, DHCS is proposing a new CalAIM start date of January 1, 2022.

1.1 Background and Overview

Medi-Cal has significantly expanded and changed over the last ten years, most predominantly because of changes brought by the Affordable Care Act and various federal regulations, as well as state-level statutory and policy changes. During this time, DHCS has also undertaken many initiatives and embarked on innovative demonstration projects to improve the beneficiary experience. In particular, DHCS has increased the number of beneficiaries receiving the majority of their physical health care through Medi-Cal managed care plans. These plans are able to offer more complete care coordination and care management than is possible through a fee-for-service system. They can also provide a broader array of services aimed at stabilizing and supporting the lives of Medi-Cal beneficiaries.

Depending on their needs, some beneficiaries may access six or more separate delivery systems (managed care, fee-for-service, mental health, substance use disorder, dental,

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developmental, In Home Supportive Services, etc.) in order to get their needs addressed. As one would expect, the need for care coordination increases with greater system fragmentation, greater clinical complexity, and/or decreased patient capacity for coordinating their own care. Therefore, in order to meet the behavioral, developmental, physical, and oral health needs of all members in an integrated, patient centered, whole person fashion, DHCS is seeking to integrate our delivery systems and align funding, data reporting, quality and infrastructure to mobilize and incentivize towards common goals.

Together, these CalAIM proposals offer solutions designed to ensure the stability of the Medi-Cal program and allow the critical successes of waiver demonstrations such as Whole Person Care Pilots, the Health Homes Program, the Coordinated Care Initiative, and the public hospital system delivery transformation, that advance the coordination and delivery of quality care to continue and be expanded to all Medi-Cal enrollees.

Our vision is that people served by our programs should have longer, healthier and happier lives. There will be a whole system, person centered approach to health and social care, in which services are only one element of supporting people to have better health and wellbeing throughout their whole lives. It will be an integrated “wellness” system, which aims to support and anticipate health needs, to prevent illness, and to reduce the impact of poor health.

The whole system, person centered approach will be equitable. Services and supports will deliver the same high quality of care, and achieve more equal health outcomes across the entire continuum of care, for all. It will improve the physical, behavioral, developmental, oral and long term services and supports, throughout their lives, from birth to a dignified end of life.

When people need support, care or treatment they will be able to access a range of services which are made seamless, and delivered as close to home as possible. Services will be designed around the individual and around groups of people, based on their unique need and what matters to them, as well as quality and safety outcomes.

To do this, we must change the expectations for our managed care and behavioral health systems. Holding our delivery system partners accountable for a set of programmatic and administrative expectations is no longer enough. We must provide a wider array of services and supports for complex, high need patients whose health outcomes are in part driven by unmet social needs and systemic racism. We must make the system changes necessary to close the gap in transitions between delivery systems, create opportunities for appropriate step-down care and mitigate social determinants of health, all hindering the ability to improve health outcomes and morbidity.

1.2 Guiding Principles

In 2018, the Care Coordination Advisory Committee developed a core set of guiding principles that were refined and established as the principles for the CalAIM initiative:

- Improve the member experience.
- Deliver person-centered care that meets the behavioral, developmental, physical, long term services and supports, and oral health needs of all members.
- Work to align funding, data reporting, quality, and infrastructure to mobilize and incentivize toward common goals.
- Build a data-driven population health management strategy to achieve full system alignment.
- Identify and mitigate social determinants of health and reduce disparities and inequities.
- Drive system transformation that focuses on value and outcomes.
- Eliminate or reduce variation across counties and plans, while recognizing the importance of local innovation.
- Support community activation and engagement.
- Improve the plan and provider experience by reducing administrative burden when possible.
- Reduce the per-capita cost over time through iterative system transformation.

1.3 Key Goals

To achieve these principles, CalAIM has three primary goals:

- Identify and manage member risk and need through whole person care approaches and addressing Social Determinants of Health;
- Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility; and
- Improve quality outcomes, reduce health disparities, and drive delivery system transformation and innovation through value-based initiatives, modernization of systems, and payment reform.

Below is an overview of the various proposals and recommendations that make up CalAIM. See **Appendix A: 2021 and Beyond: CalAIM Implementation Timeline** for more information.

1.4 Identify and Manage Member Risk and Need Through Whole Person Care Approaches and Addressing Social Determinants of Health

California continues to strengthen integration within the state's health care delivery system aimed at achieving better care and better health. In line with these objectives, DHCS is proposing reforms that would better identify and manage member risk and need for beneficiaries who may be challenged with medical and behavioral conditions, access to care, chronic illnesses and disabilities, and require multidisciplinary care to regain health and function.

To achieve these goals, DHCS proposes the following whole system, person centered approach that focuses on addressing the needs of beneficiaries across the system with the overarching goal of improving quality of life and health.

- Develop a statewide **population health management** strategy and require plans to submit local population health mangement plans.
- Implement a new statewide **enhanced care management benefit**.
- Implement **in lieu of services** (e.g. housing navigation/supporting services, recuperative care, respite, sobering center, etc.).
- Implement **incentive payments** to drive plans and providers to invest in the necessary infrastructure to build appropriate enhanced care management and in lieu of services capacity statewide.
- Pursue participation in the **Serious Mental Illness/Serious Emotional Disturbance Demonstration Opportunity**.
- Require screening and enrollment for Medi-Cal **prior to release from county jail**.
- **Pilot full integration** of physical health, behavioral health, and oral health under one contracted entity in a county or region.
- Develop a long-term plan for improving health outcomes and delivery of health care for **foster care children and youth**.

Population Health Management

Medi-Cal managed care plans shall develop and maintain a whole system, person-centered population health management strategy, which is a cohesive plan of action for addressing member needs across the continuum of care based on data driven risk stratification, predictive analytics, and standardized assessment processes. Each managed care plan shall provide, at a minimum, a description of how it will:

- Keep all members healthy by focusing on preventive and wellness services;
- Identify and assess member risks and needs on an ongoing basis;
- Manage member safety and outcomes during transitions, across delivery systems or settings, through effective care coordination; and

- Identify and mitigate social determinants of health and reduce health disparities or inequities.

Enhanced Care Management

DHCS proposes to establish a new, statewide enhanced care management benefit. An enhanced care management benefit would provide a whole-person approach to care that addresses the clinical and non-clinical circumstances of high-need Medi-Cal beneficiaries. Enhanced care management is a collaborative and interdisciplinary approach to providing intensive and comprehensive care management services to individuals. The proposed benefit builds on the current Health Homes Program and Whole Person Care Pilots, and transitions those services to this new statewide managed care benefit to provide a broader platform to build on positive outcomes from those programs.

Proposed target populations include:

- Children or youth with complex physical, behavioral, developmental, and oral health needs (e.g. California Children Services, foster care, youth with clinical high-risk syndrome or first episode of psychosis).
- Individuals experiencing homelessness, chronic homelessness or who are at risk of becoming homeless.
- High utilizers with frequent hospital admissions, short-term skilled nursing facility stays, or emergency room visits.
- Individuals at risk for institutionalization who are eligible for long-term care services.
- Nursing facility residents who want to transition to the community.
- Individuals at risk for institutionalization with serious mental illness (SMI), children with serious emotional disturbance (SED) or substance use disorder (SUD) with co-occurring chronic health conditions.
- Individuals transitioning from incarceration who have significant complex physical or behavioral health needs requiring immediate transition of services to the community.

In Lieu of Services & Incentive Payments

In order to build upon and transition the excellent work done under California's Whole Person Care Pilots, DHCS is proposing to implement in lieu of services, which are flexible wrap-around services that a Medi-Cal managed care plan will integrate into its population health strategy. These services are provided as a substitute to, or to avoid, other covered services, such as a hospital or skilled nursing facility admission or a discharge delay. In lieu of services would be integrated with care management for members at high levels of

risk and may fill gaps in state plan benefits to address medical or social determinants of health. The current list of in lieu of services includes:

- Housing Transition Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Short-term Post-Hospitalization Housing
- Recuperative Care (Medical Respite)
- Respite Services
- Day Habilitation Programs
- Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly (RCFE) and Adult Residential Facilities (ARF)
- Community Transition Services/Nursing Facility Transition to a Home
- Personal Care and Homemaker Services
- Environmental Accessibility Adaptations (Home Modifications)
- Meals/Medically Tailored Meals
- Sobering Centers
- Asthma Remediation

The provision of in lieu of services is voluntary for plans and optional for beneficiaries, but the combination of enhanced care management and in lieu of services allows for a number of integration opportunities, including an incentive for building incremental change to achieve integrated managed long-term services and supports (MLTSS) in the managed care program by 2027 and building the necessary clinically-linked housing continuum for our homeless population. In order to be equipped with the required MLTSS and housing infrastructure, the state must use its ability to provide Medi-Cal managed care plans with financial incentive payments to work with their providers to invest in the necessary delivery and systems infrastructure, build appropriate care management and in lieu of services capacity, and achieve improvements in quality performance and measurement reporting that can inform future policy decisions.

SMI/SED Demonstration Opportunity

With some exceptions, federal Medicaid funding cannot be used to pay for services provided to a Medicaid beneficiary while the beneficiary is residing in an Institution for Mental Disease (IMD). This is referred to as the IMD exclusion. Generally, an IMD is a hospital, nursing home or other institution with more than 16 beds that is primarily

engaged in treating persons with mental diseases. However, the federal government has developed an opportunity for states to receive federal funding for institutional services provided to populations with a Serious Mental Illness or Serious Emotional Disturbance (SMI/SED), similar to the flexibility the state has secured for the Drug Medi-Cal Organized Delivery System (DMC-ODS) pilots. DHCS proposes to assess county interest in pursuing the SMI/SED demonstration opportunity, as long as our systems are positioned to achieve the required goals and outcomes, including building out a full continuum of care to offer beneficiaries community-based care in the least restrictive setting. Counties would voluntarily "opt-in" to participate. The main elements of the proposed SMI/SED demonstration opportunity would include:

- Ensuring high quality of care in psychiatric hospitals and residential settings, including required audits;
- Improving care coordination and transitions to community-based care;
- Increasing access to a full continuum of care including crisis stabilization and other clinically enriched forms of housing in the community with robust support services; and
- Earlier identification and engagement in treatment including through increased integration.

In pursuing this demonstration opportunity, counties that "opt-in" should be prepared to build out a robust continuum so individuals who begin at a higher level of institutional care can be stepped down to a less restrictive, community-based, residential setting.

Mandatory Medi-Cal Application Process upon Release from Jail and County Juvenile Facilities

Justice-involved individuals often receive both medical and behavioral health services while incarcerated. Upon release from jail or county juvenile facilities, proper coordination is needed to ensure the medical and behavioral health needs of an individual continue to be met, and additionally ensure critical non-clinical needs, such as housing, transportation, and overall integration back into the community are met. Studies have shown that these types of care coordination activities reduce unnecessary emergency room and inpatient stays, as well as improve treatment and medication adherence upon release from jail. To ensure all county inmates receive timely access to Medi-Cal services upon release from incarceration, DHCS proposes that California mandate a county inmate Medi-Cal application process by January 2023. Additionally, DHCS is proposing to mandate that jails and county juvenile facilities implement a process for facilitated referral and linkage from county institution release to county specialty mental health, Drug Medi-Cal, DMC-ODS, and Medi-Cal managed care plans when the inmate was receiving behavioral health services while incarcerated, to allow for continuation of behavioral health treatment in the community.

Full Integration Plans

DHCS would like to test the effectiveness of an approach to provide full integration of physical health, behavioral health, and oral health under one contracted entity. Due to the complexity of the policy considerations around this concept, DHCS will need to conduct extensive stakeholder engagement around issues such as eligibility criteria for entities, administrative requirements across delivery systems, provider network requirements, quality and reporting requirements, as well as complex financial considerations due to the current realignment and Proposition 30 structure of behavioral health. Given the complexity of this proposal and time needed for consideration and planning, DHCS expects that the first selected full integration plans would go live no sooner than 2027.

Develop a Long-Term Plan for Foster Care

In June 2020, DHCS launched the Foster Care Model of Care Workgroup to provide an opportunity for stakeholders to weigh in on a long-term plan and strategy for improving health outcomes and the delivery of fully-integrated health care services for foster care children and youth. The workgroup will complete its work in June 2021. Based on input from the workgroup, DHCS and the California Department of Social Services (CDSS) will develop a plan of action, which may involve budget recommendations, waiver amendments, state plan changes or other activities.

1.5 Moving Medi-Cal to a More Consistent and Seamless System by Reducing Complexity and Increasing Flexibility

Medi-Cal provides services to some of California's most vulnerable and medically complex beneficiaries, but many of the services vary depending on the county one lives in. DHCS is proposing to standardize and reduce complexity by implementing administrative and financial efficiencies across the state and aligning delivery systems to provide more predictability and reduce county-to-county differences. These reforms stretch across managed care, behavioral health, dental, and other county-based services.

To achieve such goals, DHCS proposes the following recommendations.

Managed Care

- Standardize managed care enrollment statewide
- Standardize managed care benefits statewide
- Transition to statewide managed long-term services and supports
- Require Medi-Cal managed care plans be National Committee for Quality Assurance (NCQA) accredited
- Implement regional rates for Medi-Cal managed care plans

Behavioral Health

- Behavioral health payment reform
- Medical necessity criteria
- Administrative behavioral health integration statewide
- Regional contracting
- Drug Medi-Cal Organized Delivery System (DMC-ODS) program renewal and policy improvements

Dental

- New benefit: Caries Risk Assessment Bundle for young children (0 to 6 years of age) and Silver Diamine Fluoride for young children (0 to 6 years of age) and specified high-risk and institutional populations, as described in detail below.
- Pay for Performance for two adult and 17 children preventive services codes and continuity of care through a Dental Home

County-Based Services

- Enhance oversight and monitoring of Medi-Cal Eligibility
- Enhance oversight and monitoring of California Children's Services and the Child Health and Disability Prevention program
- Improving beneficiary contact and demographic information

Managed Care

Managed Care Enrollment

DHCS proposes requiring all non-dual eligible Medi-Cal beneficiaries by January 2022 and all full- and partial-benefit dual beneficiaries by January 2023, statewide, to be enrolled mandatorily in a managed care plan. The one exception is for those for whom managed care enrollment is not appropriate due to limited scope of benefits or limited time enrolled. The goal is to align managed care enrollment practices that currently vary by aid code, population, and geographic location.

Standardize Managed Care Benefits

DHCS proposes to standardize managed care plan benefits, so that all Medi-Cal managed care plans provide the same benefit package by 2023. Some of the most significant changes are to carve-in institutional long-term care and major organ transplants into managed care statewide.

Transition to Statewide Managed Long-Term Services and Supports

To achieve a more standardized approach to comprehensive care coordination for all populations, DHCS is proposing to discontinue the Cal MediConnect pilot program at the end of calendar year 2022. DHCS proposes to transition from the pilot approach of the Coordinated Care Initiative (CCI) to standardized mandatory enrollment of dual eligibles into managed care. The goal is to achieve Medi-Cal benefits integration of long-term care into managed care for all Medi-Cal populations statewide, and to transition Cal MediConnect plans to Medicare Dual-Eligible Special Needs Plans (D-SNPs). This will be done in phases:

January 2022: The Coordinated Care Initiative (CCI) proceeds as today, except that the Multipurpose Senior Services Programs benefit would be carved out of managed care. DHCS will also implement voluntary in lieu of services at this time.

January 2023: Full transition to mandatory enrollment of dual eligibles into managed care. Further, all dual and non-dual fee-for-service (FFS) Medi-Cal beneficiaries residing in a long-term care facility will be enrolled in a managed care plan effective January 1, 2023. In addition, Medi-Cal managed care plans operating in CCI counties will be required to operate Medicare D-SNPs to transition the Cal MediConnect demonstration to a permanent, ongoing federal authority and to coordinate members' Medi-Cal and Medicare benefits.

January 2025: Medi-Cal managed care plans in non-CCI counties will be required to operate Medicare D-SNPs.

The purpose of these transitions and phases is to achieve a long-term goal of implementing MLTSS statewide in Medi-Cal managed care beginning in 2027, by providing enough time and incentive to develop the needed infrastructure. This will allow many duals to receive needed MLTSS and home and community-based services statewide through their managed care plan, instead of through a variety of 1915(c) HCBS waivers that currently have capped enrollment and are not statewide.

NCQA Accreditation of Medi-Cal Managed Care Plans

In order to streamline Medi-Cal managed care plan oversight and to increase standardization across plans, DHCS recommends requiring all Medi-Cal managed care plans and their health plan subcontractors to achieve National Committee for Quality Assurance (NCQA) accreditation by 2026. DHCS plans to use NCQA findings to certify or deem that Medi-Cal managed care plans meet certain state and federal Medicaid requirements.

Regional Rates

DHCS proposes to shift the development of Medi-Cal managed care plan rates from a county-based model to a regional rate model. The proposal to move to regional rates has two main benefits. The first benefit is a decrease in the number of distinct actuarial rating cells that are required to be submitted to CMS for review and approval. The reduction in rating cells will simplify the presentation of rates to CMS and allow DHCS to pursue/implement financing advancements and innovations utilizing a more flexible rate model. The second benefit of regional rates is cost averaging across all plans. This will continue to incentivize plan cost efficiencies, as plan rates will be inclusive of the costs within the multi-county region. This shift will produce a larger base for the averaging beyond the experience of plans operating within a single county. This change is fundamental to the ability of DHCS to implement and sustain the other changes proposed in CalAIM.

Behavioral Health

Behavioral Health Payment Reform

The state, in partnership with counties, must take serious steps to continue to invest in and improve access to mental health and substance use disorder (SUD) services for Medi-Cal beneficiaries. Behavioral health transformation is a critical priority for the Governor, the California Health and Human Services Agency, and for DHCS. We recognize that we need to improve quality of and access to care for children and other vulnerable populations. In order to achieve true system transformation, DHCS is committed to first achieving behavioral health payment reform, where DHCS will transition counties from a cost-based reimbursement methodology to a structure more consistent

with incentivizing outcomes and quality over volume and cost. This shift is being designed in conjunction with our county partners and will enable counties to participate in broader delivery system transformation efforts and engage in value-based payment arrangements with their health plan partners to support better coordination and integration between physical and behavioral health. This shift will be done thoughtfully with a key focus on ensuring no disruption of services or financial challenges for our county partners.

Behavioral health payment reform is an essential step to other opportunities for the counties around behavioral health integration, regional contracting and delivery system investments needed to advance a high-quality continuum of care for mental health and SUD services in the community.

Revisions to Behavioral Health Medical Necessity

The medical necessity criteria for specialty mental health services is outdated, lacks clarity, and should be re-evaluated. This issue creates confusion, misinterpretation, and could affect beneficiary access to services as well as result in disallowances of claims for specialty mental health and substance use disorder services. DHCS is proposing to update behavioral health medical necessity criteria to more clearly delineate and standardize requirements and to improve access for beneficiaries to appropriate services statewide.

Administrative Behavioral Health Integration

Approximately half of individuals with a serious mental illness (SMI) have co-occurring substance use and those individuals would benefit from integrated treatment. The state covers Medi-Cal SUD and specialty mental health services through separate county contracts, which makes it difficult for counties and contracted providers to offer integrated treatment to individuals with co-occurring disorders. For example, counties are subject to two separate annual quality assessments, two separate post-payment chart audits, and two separate reimbursement and cost reporting methods. In order to comply with these separate processes, providers offering integrated treatment to a Medi-Cal beneficiary must document SUD treatment services separately from specialty mental health services. The purpose of this proposal is to streamline the administrative functions for SUD and specialty mental health services.

Behavioral Health Regional Contracting

Small counties could optimize resources through regional administration and delivery of specialty mental health and SUD services to Medi-Cal beneficiaries. There are a variety of options available to counties, including a Joint Powers Authority to provide services for a multi-county region (e.g., Sutter/Yuba). Counties could also pool resources to contract with an administrative services organization/third-party administrator or other entity, such

as the local Medi-Cal managed care plan or County Medical Services Program, to create administrative efficiencies across multiple counties. Small counties, rural/frontier counties, and counties with shared population centers or complementary resources should consider opportunities for regional partnership. Furthermore, DHCS encourages counties to join the Drug Medi-Cal Organized Delivery System (DMC-ODS) or provide DMC services through a regional approach. DHCS is committed to working with counties to offer technical assistance to help develop regional contracts and establish innovative partnerships.

Drug Medi-Cal Organized Delivery System (DMC-ODS) Program Renewal and Policy Improvements

DHCS proposes to update the DMC-ODS program, based on experience from the first several years of implementation. Accordingly, DHCS proposes clarifying and/or changing policies to support the goal of improved beneficiary access to care, quality of care, and administrative efficiency.

Dental

The Department set an initial goal to achieve at least a 60 percent dental utilization rate for eligible Medi-Cal children. To continue progress toward achieving this goal, and based on lessons learned from the Dental Transformation Initiative (DTI), DHCS proposes the following statewide reforms for Medi-Cal dental coverage:

- Add new dental benefits based on the outcomes and successes from the DTI that will provide better care and align with national oral health standards. The proposed new benefits include a Caries Risk Assessment Bundle for young children and Silver Diamine Fluoride for young children and specified high-risk and institutional populations; and

- Continue and expand Pay for Performance Initiatives initiated under the DTI that reward increasing the use of preventive services and establishing/maintaining continuity of care through a dental home. These expanded initiatives would be available statewide for children and adult Medi-Cal enrollees.

County Partners

Enhancing County Oversight and Monitoring: Eligibility

This proposal will help to improve DHCS' oversight and monitoring of various aspects of Medi-Cal eligibility and enrollment and the activities of its contracted partners. This includes implementing additional county oversight activities to increase the integrity of the administration of the Medi-Cal program, as well as implementing the recommendations of the California State Auditor's Office. This proposal will also ensure that DHCS remains compliant with federal and state eligibility and enrollment requirements. These enhancements will be developed and implemented in direct collaboration with our county partners.

Enhancing County Oversight and Monitoring: CCS and CHDP

There are several programs – including California Children's Services, the Medical Therapy Program, and the Child Health and Disability Prevention program – that provide services to over 750,000 children in Medi-Cal. The state delegates certain responsibilities for these high-risk children to California's 58 counties and three (3) cities (Berkeley, Pasadena, and Long Beach). The state needs to enhance the oversight of counties to ensure they comply with applicable state and federal requirements. Enhancing monitoring and oversight will eliminate disparities in care and reduce vulnerabilities to the state and counties, thereby preserving and improving the overall health and well-being of California's vulnerable populations.

Improving Beneficiary Contact and Demographic Information

DHCS intends to convene a workgroup of interested stakeholders to provide feedback and recommendations on ways in which beneficiary contact and demographic information can be updated by other entities and the means to accomplish this, while maintaining compliance with all applicable state and federal privacy laws. The goal of the workgroup will be to determine the best pathway for ensuring that reported data is accurate and can be used in eligibility and enrollment systems/databases without creating unintended consequences for other social services programs, Medi-Cal beneficiaries, managed care plans, and the provider community.

1.6 Advancing Key Priorities

As DHCS has assessed the changes proposed under CalAIM, it has become apparent that these proposals are critically dependent upon each other -- without one, the others are neither possible nor powerful.

These reforms are fundamental to achieve the overall goals of improving the system and outcomes for Medi-Cal beneficiaries as well as providing long-term fiscal and programmatic sustainability to the Medi-Cal program and delivery system. In developing these recommendations, DHCS has recognized that individual proposals are significantly less likely to be achievable and successful if other key proposals are not pursued. For example, absent the proposed financing changes with respect to both the regional rate setting for Medi-Cal managed care and the structural changes to Medi-Cal behavioral health financing, the ability of our partnered plan and county entities to institute the changes focused on value-based and integrated delivery of care are significantly harder and potentially impossible to achieve.

These fundamental financing changes would not be possible without the elimination of differences across counties with respect to the delivery systems through which Medi-Cal benefits are delivered. Nearly every other proposal contained within CalAIM (such as enhanced care management, in lieu of services, and incentive payments, as well as the possibility of future full integration pilots) is critically dependent on the success of others.

The Medi-Cal program has evolved over the multiple decades since inception with ever-increasing system and fiscal complexities. CalAIM offers DHCS and the entire State of California an opportunity to take a step back to better assess what Medi-Cal beneficiaries need and alter the delivery systems accordingly, while at the same time working to be more effective and efficient with the finite funding available for the program.

CalAIM aligns with and advances several key priorities of the Administration. At its core, CalAIM recognizes the impact of Medi-Cal on the lives of its beneficiaries well beyond just accessing health services in traditional delivery settings. CalAIM establishes a foundation where investments and programs within Medi-Cal can easily integrate, complement and catalyze the Administration's plan to respond to the state's homelessness crisis; support reforms of our justice systems for youth and adults who have significant health issues; build a platform for vastly more integrated systems of care; and move toward a level of standardization and streamlined administration required as we explore single payer principles through the Healthy California for All Commission.

Furthermore, CalAIM will translate a number of existing Medi-Cal efforts such as Whole Person Care and the Health Homes Program, the prescription drug Executive Order, improving screenings for children, proliferating the use of value-based payments across our system, including in behavioral health and long-term care, into the future of the program. CalAIM will also support the ongoing need to increase oversight and monitoring of all county-based services, including specialty mental health and substance use disorder services, Medi-Cal eligibility administration, and other key children's programs currently administered by our county partners.

Below is an overview of the impact CalAIM could have on certain populations, if approved and funded as proposed:

Health for All: In addition to focusing on preventive and wellness services, CalAIM will identify patients with high and emerging risk/need and improve the entire continuum of care across Medi-Cal. This will ensure the system more appropriately manages patients over time, through a comprehensive array of health and social services spanning all levels of intensity of care, from birth and early childhood to end of life.

High Utilizers (top 5%): It is well documented that the highest utilizers represent a majority of the costs in Medi-Cal and in Medicaid nationally. CalAIM proposes enhanced care management and in lieu of services (such as housing-related services, transitions, respite, and sobering centers) that address the clinical and non-clinical needs of these high-cost Medi-Cal beneficiaries. The initiative envisions a collaborative and interdisciplinary whole person care approach to providing intensive and comprehensive care management services to improve health and mitigate social determinants of health.

Behavioral Health: CalAIM's behavioral health proposals would initiate a fundamental shift in how California organizes and administers specialty mental health and substance use disorder services. It aligns the financing of behavioral health with that of physical health, which provides financial flexibility to innovate, and enter into value-based payment arrangements that improve quality and access to care. Similarly, the reforms in CalAIM simplify administration of, and access to, integrated behavioral health care.

Vulnerable Children: CalAIM is designed to improve and streamline care for medically complex children to ensure they get their physical, behavioral, developmental, and oral health needs met. It aims to identify innovative solutions for providing low-barrier, comprehensive care for children and youth in foster care and furthers the efforts already underway to improve preventive services for children, including identifying the complex impacts of trauma, toxic stress, and adverse childhood experiences through, among other things, a reexamination of the existing behavioral health medical necessity definition.

Homelessness and Housing: The addition of in lieu of services would build capacity to the clinically-linked housing continuum for our homeless population, and would include housing transition navigation services, housing deposits, housing tenancy and sustaining services, short-term post hospitalization housing, recuperative care for inpatient transitions, and day habilitation programs.

Justice-Involved: Under the proposed Medi-Cal pre-release application mandate, enhanced care management and in lieu of services would provide the opportunity to better coordinate medical, behavioral health, and non-clinical social services for justice-involved individuals prior to and upon release from county jails and county juvenile

facilities. These efforts will support scaling of diversion and re-entry efforts aimed at keeping some of the most acute and vulnerable individuals with serious medical or behavioral health conditions out of jail/prison and in their communities, further aligning with other state hospital efforts to better support care for those who are incompetent to stand trial and other forensic state-responsible populations.

Aging Population: In lieu of services, carving in long-term care statewide, mandatory Medi-Cal managed care enrollment, and aligned enrollment for dual eligible beneficiaries in Medi-Cal and D-SNP plans would allow the state to build infrastructure over time to provide MLTSS statewide by 2027. MLTSS will provide appropriate services and infrastructure for integrated care and home and community-based services to meet the needs of aging beneficiaries and individuals at risk of institutionalization and is a critical component of the California's Master Plan for Aging.

1.7 From Medi-Cal 2020 to CalAIM

Through CalAIM, DHCS is undertaking a more targeted approach to consolidating its Medi-Cal benefit package to achieve better alignment across the system. While Medicaid Section 1115 authority has historically been the mechanism of choice for states interested in building and expanding managed care delivery systems, the use of the authority has evolved in recent years. The federal government no longer considers the "savings" generated from the shift from fee-for-service to managed care that occurred 15 years ago in Medicaid as relevant in calculating the required budget neutrality for waivers. CMS in recent guidance has also discontinued approval of traditional financing mechanisms in the Section 1115 context, namely the availability of federal funds for Designated State Health Programs and Safety Net Care Pools.

In addition, given that California has significant learnings from our past Section 1115 demonstrations, DHCS believes a primary shift to the use of other authorities is now appropriate to allow us to expand beyond limited pilots to more statewide initiatives. These factors, combined with federal managed care regulations, has encouraged DHCS to shift its focus away from the Section 1115 waiver authority to instead leverage other available pathways for delivery system transformation in the Medi-Cal program.

This proposal outlines all elements of the Medi-Cal 2020 waiver and how they will, or will not, be incorporated in to CalAIM. DHCS does not believe California is losing any critical funding or ability to improve and advance the delivery systems and ultimately improve the beneficiary experience and outcomes. In fact, the proposed shift will allow programs or pilots that have traditionally lived outside the core managed care system, where nearly 85% of all Medi-Cal beneficiaries receive care, to be brought into the main fold of the managed care delivery system.

In March 2020, as COVID-19 community spread accelerated, the State of California moved quickly to stem the spread by enacting one the nation's earliest stay-at-home orders. This stay-at-home order was accompanied by suspension of non-essential medical procedures, transition to telehealth for many services, transition to telework for administrative staff, and reprioritization of health care resources and training, including infection control measures, to address COVID. While the stay-at-home order and related delivery system changes slowed the spread of the virus, these changes caused significant disruption to the overall health care delivery system, and the economy, in California.

As a result, DHCS received multiple requests from organizations representing the state's health care delivery systems (e.g. counties, provider organizations, hospitals, behavioral health directors, and managed care plans). Stakeholders uniformly requested that, since providers and other partners are not able to properly prepare for CalAIM implementation given the focus and attention needed to respond to the COVID-19 emergency, the state request an extension of the Medi-Cal 2020 Section 1115 waiver.

In recognition, the Governor's revision to the state budget released in May 2020 postponed funding for CalAIM. This confluence of events prevented the state from moving ahead with the negotiation and implementation of CalAIM with a January 1, 2021 start. As such, the state prepared a 12-month extension request for the Medi-Cal 2020 Section 1115 demonstration. The request was posted for public comment in June 2020 and submitted to CMS on September 16, 2020. The 12-month extension is meant to serve as a bridge to a 5-year Section 1115 waiver renewal, primarily to continue key programs that require the authority, including the Global Payment Program (GPP) and the Drug Medi-Cal Organized Delivery System (DMC-ODS). In addition, DHCS is designing a comprehensive Section 1915(b) managed care waiver request for CMS that would also be for a 5-year period.

We look forward to working in close partnership with our federal CMS colleagues and local partners to ensure that the Medi-Cal program continues to change in ways that ultimately further the goals of improved health and outcomes, as well as cost-effectiveness, of the Medi-Cal/Medicaid program.

1.8 CalAIM Stakeholder Engagement

DHCS released the original CalAIM proposal in October 2019 ahead of an intensive four-month stakeholder engagement process. Between November 2019 and February 2020, five topic-specific workgroups comprised of stakeholders across the state participated in a series of robust in-person meetings. During these discussions, Workgroup members provided real-time feedback on the proposals as they evolved and offered helpful considerations with respect to implementation and operations. The public also had the opportunity to provide feedback on the proposals, both during the workgroup sessions and in writing. This iteration of the CalAIM proposal incorporates the broad range of

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feedback received during the stakeholder engagement process. It should be noted that this resulting proposal is dependent on the funding availability through the state budget process, and federal approvals.

1.9 Conclusion

CalAIM is an ambitious but necessary proposal to positively affect Medi-Cal beneficiaries' quality of life by improving the entire continuum of care across Medi-Cal, and ensuring the system more appropriately manages patients over time through a comprehensive set of health and social services spanning all levels of intensity of care, from birth to end of life.

CalAIM:

- Keeps all beneficiaries healthy by focusing on preventive and wellness services, while also identifying and assessing member risk and need on an ongoing basis, during transitions in care, and across delivery systems, through effective care coordination.
- Creates a fundamental shift in how California organizes and administers specialty mental health and substance use disorder services, and aligns the financing of behavioral health with physical health, providing financial flexibility to innovate, and enter into value-based payment arrangements that improve quality and access to care.
- Ensures medically complex children and adults get their physical, behavioral, developmental, and oral health needs met.
- Builds capacity in a clinically-linked housing continuum via in lieu of services for California's homeless population, including housing transition navigation services, housing deposits, housing tenancy and sustaining services, short-term post hospitalization housing, recuperative care for inpatient transitions, and day habilitation programs.
- Provides the opportunity to better coordinate clinical and non-clinical services for justice-involved individuals prior to and upon release from jail and county juvenile facilities.
- Allows the state to build infrastructure over time to provide Managed Long-Term Services and Supports (MLTSS) statewide. MLTSS will provide appropriate services and infrastructure for integrated care and home and community-based services to meet the needs of aging beneficiaries and individuals at risk of institutionalization and is a critical component of the State's Master Plan for Aging.

2. Identifying and Managing Member Risk and Need through Whole Person Care Approaches and Addressing Social Determinants of Health

This section will walk through proposals to identify and manage member risk and need:

- Population Health Management Program
- Enhanced Care Management
- In Lieu of Services
- Shared Risk, Shared Savings, and Incentive Payments
- SMI/SED Demonstration Opportunity
- Full Integration Plans
- Long-Term Plan for Foster Care

2.1 Population Health Management Program

2.1.1 Background

DHCS currently does not have a specific requirement for Medi-Cal managed care plans to maintain a population health management (PHM) program, which is a model of care and a plan of action designed to address member health needs at all points along the continuum of care. Many Medi-Cal managed care plans have a population health management program – often in the context of meeting National Committee for Quality Assurance (NCQA) requirements – but some do not. In the absence of a population health management program, beneficiary engagement is often driven by a patchwork of requirements that can lead to gaps in care and a lack of coordination.

The goal of this proposal is to improve health outcomes and efficiency through standardized core population health management requirements for Medi-Cal managed care plans, including NCQA requirements and additional DHCS requirements. The population health management program will be comprehensive and address the full spectrum of care management – including assessing population level and individual member health risks and health-related social needs, creating wellness, prevention, case management, care transitions programs to address identified risks and needs, and using stratification to identify and connect adult and pediatric members to the appropriate programs. Additionally, Medi-Cal managed care plans will develop predictive analytics about which members, communities or populations are emerging as high risk as well as identify and address the needs of outliers with more specific services and supports.

2.1.2 Proposal

All Medi-Cal managed care plans shall develop and maintain a whole system, person-centered population health management program, where the plan will partner with contracted health care providers and community-based partners to identify and address members' health and health-related social needs. Medi-Cal managed care plans shall consult with their local public health department and county behavioral health department during the development of the population health management program.

The population health management program shall meet NCQA standards for population health, regardless of whether the plan is NCQA accredited. In addition to the NCQA accreditation processes, the population health management program description must be filed with the state via the population health management template (forthcoming). After the initial program description submission, the Medi-Cal managed care plan will submit certain portions of the program description, including any changes, to DHCS annually, but significant portions of the program description will only be required to be submitted to DHCS once every three years.

Each Medi-Cal managed care plan shall include, at a minimum, a description of how it will meet the core objectives to:

- Keep all members healthy by focusing on preventive and wellness services;
- Identify and assess member risks and needs on an ongoing basis;
- Manage member safety and outcomes during transitions, across delivery systems or settings, through effective care coordination;
- Identify and mitigate social determinants of health; and
- Reduce health disparities or inequities.

The population health management program shall:

- Include the goal to improve the health outcomes of communities and groups;
- Utilize data to analyze community and population level health and health-related social needs and set measurable goals for improvement;
- Utilize initial and ongoing assessments of data to analyze individual member's needs and identify groups and individuals within groups for targeted interventions;
- Provide assistance for members to navigate health delivery systems, acquire self-care skills to improve functioning and health outcomes, slow the progression of

disease or disability, and support members with serious illness as their disease progresses;

- Coordinate care across the continuum of medical, behavioral health, developmental, oral health, and long-term services and supports, including tracking referrals and outcomes of referrals;
- Deploy strategies to address individual needs and mitigate social determinants of health;
- Deploy strategies to drive improvements in health for specific populations proactively identified as experiencing health disparities;
- Partner with appropriate community-based providers to support individual members, families, and caregivers in managing care.
- Utilize evidence-based practices in screening and intervention;
- Utilize a person-centered and family-centered approach for care planning; and
- Continually evaluate and improve on the population health management program strategy on an ongoing basis through meaningful quality measurement.

Assessment of Risk and Need

1. Initial Data Collection and Population Risk Assessment

As reflected in the NCQA Population Health program requirements and the DHCS Population Needs Assessment All Plan Letter (APL), the Medi-Cal managed care plan shall collect electronically available data sources in order to analyze data that capture the information on member health status and utilization (including physical, behavioral, and oral health), health-related social needs, and linguistic, racial, and cultural characteristics. As part of the population health management requirements, DHCS will continue to apply the existing Population Needs Assessment (PNA) APL requirements to hold the Medi-Cal managed care plans accountable for a PNA, which include requirements for analyzing health disparities and engaging external stakeholders as part of the process. DHCS will consult with NCQA to ensure the PNA APL data requirements meet NCQA data requirements for the population assessment.

The PNA requires that Medi-Cal managed care plans collect and analyze this data across the plan's entire Medi-Cal member population to identify opportunities at a population level to improve health. One example of how this might be done is through a type of analysis commonly known as "hot spotting." As noted in the PNA and NCQA

requirements, key issues Medi-Cal managed care plans must analyze in the assessment include:

- Acute, chronic, and prevention/wellness health needs;
- Areas of clinically inappropriate, over and under-utilization of health care resources;
- Opportunities for better care management and quality improvement;
- Health disparities by race, ethnicity, language, and functional status; and
- Health-related social needs at the community or local level.

The results of the PNA will inform the development of programs and strategies that the Medi-Cal managed care plan will use to address the needs of specific populations. Determining which individuals have access to these specific programs and strategies will be driven by the subsequent member-level risk stratification, population segmentation, and case management activities. Consistent with the PNA APL, Medi-Cal managed care plans must use the assessment to develop and implement an action plan to address community and population needs. DHCS does not currently plan to provide more specific requirements regarding community and population-level program development, but in the population health management template, Medi-Cal managed care plans will be asked indicate what they will be doing in this area, which also may be a focus of future learning collaborative best practice work.

2. Initial Risk Stratification, Segmentation and Tiering

Risk stratification or segmentation will enable Medi-Cal managed care plans to identify specific members who may benefit from wellness, prevention, and disease management activities; members who can benefit from case management; and members who are at risk for developing complex health issues. Consistent with NCQA Population Health program requirements, Medi-Cal managed care plans will be required to risk stratify and segment members into groups that it will use to develop and implement case management, wellness, and health improvement programs and strategies. Medi-Cal managed care plans will also be required to use DHCS-defined criteria to tier its members into four risk tier categories and report that information to DHCS.

Consistent with the NCQA Population Health program requirements, Medi-Cal managed care plans shall conduct the risk stratification and segmentation and DHCS risk tiering using an integrated data and analytics stratification process that considers at least the following sources:

- Previous screening or assessment data;
- Disengaged member reports;
- Claims or encounter data, including all fee-for-service data provided by DHCS;

- And to the extent available:
    - Available social needs data, including housing status ICD-10 data; and
    - Electronic health records.

Risk Stratification or Segmentation: Medi-Cal managed care plans will analyze each individual's data based on the minimum, mandatory list of data sources described above and will then risk stratify and segment members into meaningful sub-populations. The Medi-Cal managed care plan will use risk stratification and segmentation to identify specific members who may benefit from targeted interventions and programs designed to meet identified member needs. Risk stratification and segmentation must occur within 44 days of the effective date of plan enrollment.

The Medi-Cal managed care plan may use its own algorithm to risk stratify or segment its population or it may use the DHCS-defined risk tiers described below as a starting point for further stratification and segmentation. The design of the algorithm, including how the data is stratified and segmented as part of the algorithm, should be informed by the health needs identified through the population assessment and designed so that the Medi-Cal managed care plan can group individual members into meaningful categories and subsequently outreach to individual members within those categories for tailored interventions and programs designed to achieve specific health outcomes. Medi-Cal managed care plans will incorporate enhanced care management into their segmentation in accordance with DHCS enhanced care management target population guidance and Medi-Cal managed care plan flexibility afforded for the enhanced care management benefit. When risk stratifying its member population, Medi-Cal managed care plans must use a validated risk grouper.

Risk stratification or segmentation algorithms shall include past medical and behavioral health service utilization but must also incorporate other data such as health conditions, risk factors, and disease progressions, in order to avoid exacerbating underlying biases in utilization data that may drive health disparities. Medi-Cal managed care plans must analyze the results of its stratification/segmentation algorithm to identify and correct any biases the algorithm may introduce based on race, ethnicity, language, functional status, or other sources of health disparities. In the population health management program description, the Medi-Cal managed care plan will submit to DHCS its list of stratification/segmentation data sources, the risk stratification/segmentation algorithm (or the name of the tool if it is proprietary), and also the method of bias analysis. To promote transparency and best practices, these three pieces of information will be made available for public viewing on DHCS' website and will also be a focus of continuing Medi-Cal managed care plan learning collaborative activities.

Based on the risk stratification/segmentation and the findings from Individual Risk Assessment (IRA) described below, the Medi-Cal managed care plan will link the member with the appropriate services including, but not limited to, wellness and prevention, general case management, complex case management, enhanced care management, in lieu of services (as available) external entity coordination, and transition coordination. Specific minimum requirements for each of these categories are listed in their own sections below.

DHCS Risk Tiering Requirements. This risk tiering process, including the IRA described below, will satisfy federal Medicaid Managed Care Final Rule requirements for initial risk assessment. Medi-Cal managed care plans will use DHCS-defined criteria to assign each member into one of four risk tiers: (1) low risk; (2) medium and rising risk; (3) high risk; and (4) unknown risk. The criteria for these tiers will be developed by DHCS.

The types of criteria used will be similar (but not the same) as the DHCS criteria for risk stratifying seniors and persons with disabilities (SPDs) into low- and high-risk groups. The criteria will align with the questions that DHCS will develop for the IRA survey tool, which is addressed in the next section. “High risk” members are those who are at increased risk of having an adverse health outcome or worsening of their health status. “Medium and rising risk” members are those that are stable at a medium risk level and those whose health status suggest they have the potential to move into the high-risk category.

Members at the medium/rising and high risk levels likely require additional provider-level assessment, care coordination, and/or possibly case management, or other specific services, which will be determined by the Medi-Cal managed care plan’s population segmentation strategy and coordination with providers. “Low risk” members are those who, in general, only require support for wellness and prevention. “Unknown risk” members are those who do not have sufficient data to stratify into a risk tier and for whom the Medi-Cal managed care plan is unable to complete a member-contact screening risk assessment. The IRA survey tool will be designed to have enough information to allow for risk tier assignment on its own if there is insufficient available historical data for the member.

DHCS will develop a process to validate Medi-Cal managed care plans’ implementation of the DHCS risk tier criteria to ensure consistent application and output statewide.

3. Individual Risk Assessment Survey Tool

DHCS will develop a standardized, 10-15 question Individual Risk Assessment (IRA) Survey Tool. There will be two versions, one for children and one for adults. Medi-Cal managed care plans will use the IRA to: (1) confirm or revise the initial DHCS risk tier to which the member was assigned; (2) gather consistent information for members without sufficient data; and (3) add information that will be used as part of its own stratification/segmentation algorithms and population health management strategy.

DHCS' goal in the development of the IRA questions will be to ensure they are validated and can be used with a scoring mechanism so that the IRA information can be integrated into the Medi-Cal managed care plan's risk stratification/segmentation process. DHCS will translate the questions into the threshold languages. Medi-Cal managed care plans will have the flexibility to add questions of their choosing to the IRA and would then also translate those additional questions into all threshold languages. It is expected that Medi-Cal managed care plans will conduct subsequent and separate screenings (or add supplemental questions) to identify specific issues and priorities to address.

The IRA will replace the assessments below:

- Staying Healthy Assessment/Individual Health Education Behavioral Assessment (SHA/IHEBA)
- Health information form/member evaluation tool (HIF/MET)
- Health risk stratification and assessment survey for SPDs
- Whole Child Model Assessment
- The Initial Health Assessment (IHA) provider visit (within 120 days of enrollment) will remain a requirement, but DHCS contracts and policies will not specify provider requirements for that visit.

Medi-Cal managed care plans will continue to be required to ensure the provision of preventive and other services in accordance with contractual requirements and accepted standards of clinical care.

Members assigned to the DHCS medium/rising, high, and unknown risk tiers must be contacted within 90 (medium/rising) and 45 (high and unknown) calendar days respectively to assess their needs. The IRA may be done via multiple modalities, including phone, in-person, electronic, or mail, as long as the screening responses can be transposed into an electronic format that allows for data mining and data exchange of key elements with DHCS. Data exchange of IRA elements with DHCS is not required at this time. Medi-Cal managed care plans should use this modality flexibility to maximize successful contact. Medi-Cal managed care plans shall make at least three (3) attempts to contact a member using available modalities.

If the Medi-Cal managed care plan is unable to obtain a completed IRA from a member, it has the option to create a process for working with the member's assigned primary care provider to: 1) have the member complete the assessment with them; and 2) transfer the resulting information to the Medi-Cal managed care plan.

Medi-Cal managed care plans will use the IRA information to assign or revise the member's DHCS risk tier. Once that process is complete, Medi-Cal managed care plans will be responsible for reporting the member's assigned risk tier to DHCS in an electronic format to enable better tracking and assessment of the impacts of the population health

management program. The Medi-Cal managed care plan will also share information regarding the assigned member's risk tier to the member's assigned PCP in an electronic format. If the member transfers to another Medi-Cal managed care plan, DHCS will provide the member's risk tier to the new Medi-Cal managed care plan.

The IRA questions will align with the DHCS-specified criteria for high, medium/rising, and low risk tiers. It is DHCS's intent that the structure of the IRA will meet NCQA requirements for a Health Appraisal.

- The IRA will include 10-15 questions, which seek to identify preliminary risk information for the following elements: Behavioral, developmental, physical, Long Term Services and Supports, and oral health needs;
- Emergency department visits within the last six months;
- Self-assessment of health status and functional limitations;
- Adherence to medications as prescribed;
- Assessment of health literacy and cultural and linguistic needs;
- Desire or need for case management;
- Ability to function independently and address his/her own health needs;
- Access to basic needs such as education, food, clothing, household goods, etc.;
- Use or need for long-term services and supports;
- Availability of social supports and caregiver;
- Access to private and public transportation;
- Social and geographic isolation; and
- Housing and housing instability assessment;

4. Reassessment

At a minimum, the Medi-Cal managed care plan shall reassess risk and need, including rising risk, of all members annually both the DCHS risk tiering and its own risk stratification/segmentation process. Individual members' risk and need may need to be re-evaluated throughout the year based on a change in condition or level of care, such as an inpatient admission or new diagnosis, the availability of new data, or a case management interaction.

Medi-Cal managed care plans must describe what events or data trigger the re-evaluation process for individual members. In the population health management program description, the Medi-Cal managed care plan must inform DHCS what minimum risk groups would require regular assessment in between the annual risk stratification process. However, this does not limit the Medi-Cal managed care plan from conducting additional assessments beyond what is defined as required by DHCS.

5. Provider Referrals

Medi-Cal managed care plans must establish a process by which providers may make referrals for members to receive case management or services for other emerging needs. Referrals for case management should lead to a re-evaluation of risk stratification and DHCS risk tier assignment. Medi-Cal managed care plans must consider and integrate information received through referrals when determining members' risk stratification.

Actions to Support Wellness and Address Risk and Need

1. General Requirements and Services

The Medi-Cal managed care plan shall integrate required activities with the population health management program as appropriate including, but not limited to member services, utilization management, referrals, transportation, health/plan/benefit education, appointment assistance, warm-handoffs to community-based organizations or other delivery systems, system navigation, primary care provider member assignment, community outreach, preventive services, and screenings for all members.

The Medi-Cal managed care plan shall provide a toll-free line for primary care providers and specialists who seek technical and referral assistance when any physical or behavioral condition requires further evaluation or treatment. Available information shall include assistance in arranging for referrals, including mental health and SUD treatment referrals, developmental services referrals, dental referrals, referrals to home-based medical/social services for people with serious illness, and referrals to long-term services and supports. Communication about the availability of this consultation service shall be found on the front-page of the Medi-Cal managed care plan's website and in materials supplied to providers.

The Medi-Cal managed care plan shall provide a 24-hours-a-day, 7-days-a-week, toll-free nurse advice line for members who seek technical, clinical, and referral assistance for physical, oral, and behavioral health services to address urgent needs.

The Medi-Cal managed care plan shall demonstrate how they support practice change activities, the deployment of evidence-based tools for providers, and models of service delivery that optimize health care and coordinated health care and social services. Finally, the Medi-Cal managed care plan shall develop or provide access to a current and updated community resource directory for case managers and contracted providers.

2. Wellness and Prevention Services

The Medi-Cal managed care plan shall provide wellness and prevention services in accordance with NCQA and contractual requirements. The population health management program shall integrate wellness and prevention services for all members, regardless of risk tier, according to the benefits outlined in the managed care contract including, but not limited to, the following:

- Provide preventive health visits, developmental screenings, and services for:
  - All children (under 21 years of age) in accordance with the American Academy of Pediatrics Bright Futures periodicity schedule.
  - All adults in accordance with US Preventive Services Task Force Grade "A" and "B" recommendations.
- Monitor the provision of wellness and preventive services by primary care providers as part of the Medi-Cal managed care plan Facility Site Review process.
- Provide health educational materials about topics such as disease management, preventive services, Early and Periodic Screening, Diagnostic, and Treatment services, how to access benefits, and other managed care plan health promotion materials.

3. Managing Members with Medium/Rising Risks

The population health management program shall:

- Provide screening for Adverse Childhood Experiences (ACEs) for children and adults, based on the recommended periodicity schedule as specified in the Medi-Cal managed care contract.
- Ensure members receive appropriate follow-up for behavioral, developmental, physical, and oral health needs including preventive care, care for chronic conditions, and referrals to long-term services and supports, as appropriate;

- Refer members identified, through assessment or re-assessment, as needing care coordination or case management to the member's case manager for follow-up care and needed services within 30 calendar days; and

- Assess individual social care needs and deploy appropriate community resources and strategies to mitigate the adverse childhood experiences (ACEs) toxic stress and impacts of social determinants of health in partnership with providers and community organizations.

Additionally, Medi-Cal managed care plans will be required to use predictive analytics to inform them about which patients, communities or populations are emerging as high risk as well as identify and address the needs of outliers with more specific services and supports. To address this focus, Medi-Cal managed care plans shall incorporate the DHCS Population Needs Assessment and NCQA Population Health program requirements on this topic into their population health management strategy. Identifying and addressing the needs of specific high-risk communities and populations – sometimes referred to as "hot spotting" – will be a focus of the population health management learning collaborative and DHCS will continue to assess best practices in this area.

4. Case Management

Case management services actively assist at-risk members in navigating health delivery systems and acquiring self-care skills to improve functioning and health outcomes, slow the progression of disease or disability or prepare for the progression of a serious illness. Case management services are intended for members who are medium- or high-risk or may have rising risks that would benefit from case management services. Members determined to be low risk should continue to receive wellness and prevention services as well as other medically necessary services.

Case management services include the following, as needed and appropriate:

- Screening beyond the IRA to identify and prioritize goals and needs for case management, including both health issues, ACEs and toxic stress, and health-related social needs
- Documentation in an electronic format of the individual care plan and assigned case manager for each member (required for all case management).
- Utilization of evidence-based practices in screening and intervention.
- Ongoing review of the member's goals and care plan as well as identifying and addressing gaps in care.
- Support from an inter-professional team with one primary point of contact for the member.

- Access to person-centered planning, including advanced care planning regarding preferences for medical treatment, and education and training for providers and families.
- Continuous information sharing and communication with the member and their providers.
- Ensuring a person-centered and family-centered approach by identification of member's circle of support or caregiver(s).
- Coordination and access to medically necessary health services and coordination with entities that provide mental health, substance use disorder services, and developmental and oral health services.
- Ensuring coordination and access to community-based services, such as home care, personal care services, and long-term services and supports.
- Developing relationships with local community organizations to implement interventions that address social determinants of health (e.g. housing support services, nutritional classes, etc.).
- Coordinating authorization of services including timely approval of and arranging for durable medical equipment, pharmacy, private duty nursing, palliative care, and medical supplies.
- Promoting recovery using community health workers, peer counselors, and other community supports.
- Requesting modifications to treatment plans to address unmet service needs that limit progress.
- Assisting members in relapse and/or crisis prevention planning that includes development and incorporation of recovery action plans, and advance directives for individuals with a history of frequent mental health readmissions or crisis system utilization.
- Assisting members in care planning related to cognitive impairment, traumatic brain injury, Alzheimer's disease, and dementia.
- Performance measurement and quality improvement using feedback from the member and caregivers.
- Delivery of services in a culturally competent manner that addresses the cultural and linguistic needs by interacting with the member and his or her family in the member's primary language (use of interpreter allowed), with appropriate consideration of literacy and cultural preference.
- If the Medi-Cal managed care plan assigns a case manager outside the plan, written agreements shall define the responsibility of each party in meeting case management requirements to ensure compliance and non-duplication of services. If situations arise where a member may be receiving care coordination from multiple entities, the Medi-Cal managed care plan shall identify a lead care coordinator.

If a member changes enrollment to another Medi-Cal managed care plan, the Medi-Cal managed care plan shall coordinate transition of the member to the new plan's case management system to ensure services do not lapse and are not duplicated in the transition. The Medi-Cal managed care plan must also ensure member confidentiality and member rights are protected.

Members may be assigned to one of three types of case management based on assessment of risk and need.

The three types of case management include:

- **Basic Case Management:** Basic case management would be appropriate for members who require planning and coordination that is not at the highest level of complexity, intensity, or duration. These services are provided by the Medi-Cal managed care plan, clinic-based staff, or community-based staff, and may be provided by non-licensed staff. These services may include assignment to a certified patient-centered medical home, participation in a Medi-Cal managed care plan disease management program or participation in another Medi-Cal managed care plan population health management program.

- **Complex Case Management:** The Medi-Cal managed care plan shall provide complex case management in accordance with NCQA requirements. NCQA defines complex case management as "a program of coordinated care and services for members who have experienced a critical event or diagnosis that requires extensive use of resources." NCQA allows organizations to define "complex." Complex case management generally involves the coordination of services for high-risk members with complex conditions.

- **Enhanced Care Management:** The proposed Enhanced Care Management benefit is designed to provide a whole-person approach to care that addresses the clinical and non-clinical needs of high-cost and/or high-need Medi-Cal beneficiaries enrolled in Medi-Cal managed care plans. Enhanced care management is a collaborative and interdisciplinary approach to providing intensive and comprehensive care management services to targeted individuals. Through collaborative leadership and systematic coordination among public and private entities, the enhanced care management benefit will serve target populations, benefit from data sharing between systems, and coordinate care in real time for beneficiaries. DHCS will evaluate individual and population progress — all with the goal of providing comprehensive care and achieving better health outcomes.

The population health management program description shall describe how and when the services are utilized in conjunction with the risk stratification process, as members with changing risk and needs may require changing levels of case management. If the Medi-Cal managed care plan delegates or contracts with a provider for case management or transition of care services, it must do so in accordance with the NCQA's population health management delegation requirements.

5. In Lieu of Services

"In lieu of services" are flexible wrap-around services that the Medi-Cal managed care plan will integrate into their population health management programs. These services are provided as a substitute or to avoid utilization of other services such as hospital or skilled nursing facility admissions, discharge delays, or emergency department use. In lieu of services should be integrated with case management for members at medium-to-high levels of risk and may fill gaps in Medi-Cal State Plan benefits to address medical or other needs that may arise due to social determinants of health. DHCS is proposing the initial use of in lieu of services to serve as a transition of the work done through existing pilots (e.g. Whole Person Care, the Health Homes Program, the Coordinated Care Initiative, etc.), as well as inform the development of future potential statewide benefits that may be instituted.

Examples of the in lieu of services that DHCS proposes to cover include many of the services currently provided in the Whole Person Care Pilot program that are not covered as Medi-Cal State Plan benefits. Some of these include, but are not limited to, respite, recuperative care, medically tailored meals, supplemental personal care services, housing tenancy navigation and sustaining services, and sobering centers. Medi-Cal managed care plans will develop a network of providers of allowable in lieu of services with consideration for which community providers have expertise and capacity regarding specific types of services. See **Appendix J: In Lieu of Services Options** for more detail.

6. Coordination between Medi-Cal Managed Care Plans and External Entities

The Medi-Cal managed care plan shall describe in the population health management program description how they will coordinate with, and refer members to, health care and social services/programs including, behavioral health services, dental, and home and community-based services. Referrals must be culturally and linguistically appropriate for the member. The Medi-Cal managed care plan must coordinate with competent external entities to provide all necessary services and resources to the member. These entities should be listed as part of the population health management program description identifying specific services each named entity will provide plan members. The Medi-Cal managed care plan's population health management

program description shall include assurance of payment to Indian Health Care Providers.

7. Transitional Services

The Medi-Cal managed care plan shall ensure transitional services are provided to all members who are transferring from one setting, or level of care, to another. The Medi-Cal managed care plan shall work with appropriate staff at any hospital that provides services to its members, whether contracted or non-contracted in the case of emergency services, to implement a safe, comprehensive discharge plan. The plan must provide continued access to medically necessary covered services that will support the member's recovery and prevent readmission.

The Medi-Cal managed care plan shall have in place operational agreements or shall incorporate transitional language into existing network arrangements with the Medi-Cal managed care plan's contracted community physical and behavioral health hospitals, residential treatment facilities and long-term care facilities, as applicable, to ensure smooth transitions. Transition services shall include tribal consultation/outreach for protections involving American Indians and Indian Health Clinic providers. The operational agreements shall define the responsibility of each party in meeting the following requirements:

- Completion of a standardized discharge risk assessment tool. The tool shall assess risk for re-institutionalization, re-hospitalization, and/or substance use disorder treatment recidivism. Each Medi-Cal managed care plan's discharge screening tool must be approved by DHCS;
- Development of a written discharge plan, shared with the beneficiary and all treating providers, to mitigate the risk of readmission and other negative health outcomes;
- Obtain the member's permission to share information with clinical and non-clinical providers to facilitate care transitions;
- Develop discharge planning policies and procedures in collaboration with all hospitals;
- Process all hospital prior authorization requests for clinic services within two business days. Such services shall include authorizations for therapy, home care services, equipment, medical supplies, and pharmaceuticals;
- Educate hospital discharge planning staff on the clinical services that require pre-authorization to facilitate timely discharge from the hospital; and
- Prevent delayed discharges from a hospital due to Medi-Cal managed care plan authorization procedures or transition to a lower level of care.

8. Skilled Nursing Facility Coordination

The Medi-Cal managed care plan shall coordinate with hospital or other acute care facility discharge planners and nursing facility case managers or social workers to ensure a smooth transition to or from a skilled nursing facility or nursing facility. The Medi-Cal managed care plan shall coordinate with the facility to provide case management and transitional care services and ensure coverage of all medically necessary services not included in the negotiated daily rate. This includes, but is not limited to, prescription medications, durable medical equipment, intravenous medications, and any other medically necessary service or product.

- If the Medi-Cal managed care plan, in coordination with the nursing facility or skilled nursing facility, anticipates the member will be in the facility after a member no longer meets criteria for medically necessary skilled nursing care or rehabilitative care, the Medi-Cal managed care plan shall assist the member in exploring all available care options. This includes potential discharge to a home or community residential setting, or to remain in the skilled nursing facility for long-term services and supports.
- If the member is discharged to a home or to a community residential setting, the Medi-Cal managed care plan shall coordinate with the facility to ensure the member is in a safe location. The plan shall ensure medically necessary services are available including, but not limited to, home health services, durable medical equipment and supplies, outpatient rehabilitation services, and any other services necessary to facilitate the member's recovery. The Medi-Cal managed care plan shall also ensure follow-up care is provided consistent with the transitional service requirements listed above.

Population Health Management Oversight

The Medi-Cal managed care plan shall have internal monitoring processes in place to ensure compliance with the population health management program requirements. Quality assurance reviews of documented population health management activities shall include:

- Case identification and assessment according to established risk stratification system;
- Electronically documented treatment plans and care plans with evidence of periodic revision as appropriate to emerging member needs;
- Referral management;
- Effective coordination of care, including coordination of services that the member receives through the fee-for-service system; and

- Identification of appropriate actions for the case manager to take in support of the member, and the case manager's follow-through in performing the identified tasks.

The Medi-Cal managed care plan shall document quality assurance reviews on an annual basis or upon DHCS' request and submit them to DHCS for review. Medi-Cal managed care plans are responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including All Plan Letters, Policy Letters, and Dual Plan Letters. These requirements must be communicated by each Medi-Cal managed care plan to all delegated entities and sub-Medi-Cal managed care plans. The Medi-Cal managed care plan must submit a population health management oversight plan in accordance with NCQA requirements for any entities to which they delegate population health management functions. Such plans would need to be reviewed and approved by the state.

Health Information Technology to Support Integrated Care and Care Coordination

The Medi-Cal managed care plan will work to implement health information technology to support population health principles, integrated care, and care coordination across the delivery system. Examples of health information technology include, but are not limited to, electronic health records, emergency department information exchange, clinical data repositories, registries, decision support and reporting tools that support clinical decision-making, and case management. An overarching goal of the population health management program is to expand interoperable health information technology and health information exchange infrastructure, so that relevant data (including clinical and non-clinical) can be captured, analyzed, and shared to support provider integration of behavioral health and medical services, case management oversight and transitional planning, value-based payment models, and care delivery redesign.

The Medi-Cal managed care plan shall develop data exchange protocols, including member information sharing protocols, before initiating services with any subcontracted entity. Protocols must support integrated behavioral health-physical health coordination including, but not limited to, sharing of claims and pharmacy data, treatment plans or care plans, and advance directives necessary to coordinate service delivery and care management for each member in accordance with applicable privacy laws.

Improved data collection, specifically of encounter data at the provider level, is a critical component of achieving the goals of this proposal, and DHCS will be working with plans and providers to achieve this goal.

Accountability and Oversight of Medi-Cal Managed Care Plans

In order to hold Medi-Cal managed care plans accountable for the activities proposed here, DHCS will increase its oversight and assessment of the plans to include changes

to its audit procedures and the imposition of corrective action plans and financial sanctions, when appropriate. DHCS recognizes that, through this and the other CalAIM proposals, the responsibility of Medi-Cal managed care plans will increase over time, and therefore DHCS' approach to oversight and accountability must also grow and change in conjunction with these proposals. DHCS is committed to providing Medi-Cal managed care plans technical assistance to support the smooth adoption of these changes.

Future Policy Development and Technical Assistance

As technical assistance for Medi-Cal managed care plans in development of their population health management programs, DHCS will provide submission templates and best practice examples of Medi-Cal managed care plan population health management programs from California and other states. DHCS will also create a DHCS-operated learning collaborative for Medi-Cal managed care plans to share information and promising practices. The learning collaborative will foster information sharing and address promising practices in all the DHCS-required population health management activities. The following topics that have been identified by stakeholders:

- Medi-Cal managed care plan coordination and partnerships with external entities that provide carved-out services, such as specialty mental health, Drug Medi-Cal, Regional Centers, schools, public health departments, and community-based organizations that provide social services;
- Engaging with consumers who have health and social needs but are unidentified, unengaged, and are underutilizing services, including methods to engage with these members, build trust, and obtain information from the member about their needs;
- Care transition coordination including sharing discharge risk assessment tools;
- Incorporating social determinants of health and health-related social care needs into case management and community-level population improvement activities;
- Collection of social determinants of health information for risk stratification and segmentation, and for state-level data collection for strategic planning purposes;
- Best practices in how to use population health management programs to support specific populations of interest, such as children and pregnant women, in ways that align with other DHCS initiatives;
- Use of population data for "hot spotting" and other population analysis promising practices;

- Use of general beneficiary medical record release consent to allow Medi-Cal managed care plans and providers to share data broadly for the purposes of care coordination;
- Learning best practices from California Accountable Communities for Health Initiative activities, including opportunities for partnership and elements that may be appropriate to integrate into the population health management strategies;
- Data exchange protocols and the development of health information technology/health information exchange policies; and
- Submission of housing status data to DHCS via ICD-10 coding, in alignment with the current DHCS Value-Based Payment incentive program for these codes.

The best method to advance promising practices in these areas may be to allow them to emerge through a learning collaborative and assessment of Medi-Cal managed care plan outcomes. DHCS may also standardize certain requirements after further research and consultation with stakeholders.

Continuing areas of DHCS policy development will include:

- DHCS Risk Tiering criteria;
- DHCS IRA to gather individual member information for risk tiering and stratification;
- Detailed review of alignment with NCQA Population Health program requirements, in coordination with NCQA and Medi-Cal managed care plans;
- Continued exploration into what guidance DHCS can provide regarding what can be allowed for different types of information sharing between providers and Medi-Cal managed care plans to facilitate care coordination;
- Voluntary guidance from DHCS regarding Medi-Cal managed care plan collection of social determinants of health data from ICD-10 encounter coding. The guidance, and Medi-Cal managed care plan collection of this data in accordance with the guidance, will become mandatory on January 1, 2024; and
- Setting prospective, prioritized goals to improve Medi-Cal managed care population health management over five years from the implementation date. To do this, DHCS will review of population health management program outcomes goals and measures, and their relation to the broader DHCS managed care quality metric strategy, which may be used to assess each Medi-Cal managed care plan's population health management program.

2.1.3 Rationale

The population health management program requirement will ensure that there is a cohesive plan to address beneficiary needs across the continuum of care, from prevention and wellness to complex case management. This proposal will work in conjunction with other CalAIM proposals to meet the overarching CalAIM goals of improving coordination and quality, while reducing unnecessary administrative burden and redundancy. The following CalAIM elements of the population health management program will magnify the positive impact on member outcomes:

- **NCQA Accreditation** will provide a foundation of quality best practices and an oversight structure for the population health management program and other Medi-Cal managed care plan activities;
- The new **enhanced care management** benefit will provide a critical new set of services as well as an effective case management tool to integrate within the population health management program;
- The adoption of a menu of **in lieu of services** – flexible wrap-around services designed to fill medical and social determinants of health gaps – will similarly integrate within the population health management program; and
- Making **shared risk/savings and incentive payments** available to Medi-Cal managed care plans and providers will maximize the effectiveness of the population health management program and new service options.

2.1.4 Proposed Timeline

The population health management program would be implemented as part of the new Medi-Cal managed care plan contracts, with an effective date of January 1, 2023. The date for the first population health management program description submission and other required submissions from Medi-Cal managed care plans to DHCS is to be determined.

2.2 Enhanced Care Management Benefit

2.2.1 Background

Depending on the needs of the beneficiary, some individuals may need to access six or more separate delivery systems (managed care, fee-for-service, mental health, substance use disorder, developmental, dental, In Home Supportive Services, etc.). Given the similarities in target populations across Medi-Cal delivery systems, beneficiaries are likely to be eligible for multiple programs that include some level of care management, depending on the efforts that are underway in their county of residence.

Additionally, as one would expect, the need for care coordination increases with greater system fragmentation, greater clinical complexity, and/or decreased patient capacity for coordinating their own care. The Health Homes Program and many of the Whole Person Care pilots provide such services. DHCS is proposing the implementation of a single, comprehensive enhanced care management benefit within Medi-Cal managed care. Lessons learned from the Whole Person Care pilots and the Health Homes Program will be incorporated to ensure that the new enhanced care management benefit is designed to meet the clinical and non-clinical needs for the highest cost/highest need beneficiaries in Medi-Cal and is available as a statewide benefit.

2.2.2 Proposal

The proposed enhanced care management benefit will replace the current Health Homes Program and elements of the Whole Person Care pilots, building on positive outcomes from those programs over the past several years. Based on extensive stakeholder engagement, DHCS will require that beneficiaries receiving Health Homes or Whole Person Care services are seamlessly transitioned to continue receiving care coordination services by way of the new enhanced care management benefit. Medi-Cal managed care plans will be mandated to contract with all existing local providers offering Health Homes and Whole Person Care services, with a few contractual exceptions. Medi-Cal managed care plans will be required to contract with community-based providers that have experience serving the enhanced care management target populations, and who have expertise providing the core enhanced care management services. Further, to allow non-Whole Person Care or Health Homes Program counties additional time to develop an adequate local infrastructure, a phased-in approach for implementing enhanced care management will be adopted.

It is the state's intention to implement this new initiative in a complementary, rather than duplicative manner that will build upon the strengths and foundations of these existing programs. DHCS recognizes the significant investment the Whole Person Care entities made over the past five years in building the capacity for these services. The intention is to build on those investments and infrastructure to continue the positive outcomes achieved by the Whole Person Care pilots. Additionally, as a result of extensive stakeholder feedback, DHCS has determined that Medi-Cal managed care plans will be required to coordinate enhanced care management services with county Targeted Case Management programs to ensure non-duplication of services and provide a holistic approach to care for Medi-Cal's most vulnerable beneficiaries.

The proposed enhanced care management benefit is designed to provide a whole-person approach to care that addresses the clinical and non-clinical needs of high-cost and/or high-need Medi-Cal beneficiaries enrolled in Medi-Cal managed care plans. Enhanced care management is a collaborative and interdisciplinary approach to

providing intensive and comprehensive care management services to targeted individuals.

Medi-Cal managed care plans will proactively identify members who meet the target population criteria and can benefit from enhanced care management services. The enhanced care management providers will be taking on the responsibility for coordinating services across all delivery systems. They are the primary responsible entity for coordinating across multiple medical and social service domains of care. Authorized members will be assigned a lead care manager that will have responsibility for interacting directly with the member and coordinating all primary, behavioral, developmental, oral health, and long-term services and supports, any in lieu of services, and services that address social determinants of health needs, regardless of setting.

Through collaborative leadership and systematic coordination among public and private entities, the enhanced care management benefit will serve target populations, benefit from data sharing between systems, and coordinate care in real time for beneficiaries. DHCS will evaluate individual and population progress — all with the goal of providing comprehensive care and achieving better health outcomes.

The overarching goals for enhanced care management are:

- Improving care coordination;
- Integrating services;
- Facilitating community resources;
- Improving health outcomes;
- Addressing social determinants of health; and
- Decreasing inappropriate utilization.

The enhanced care management target populations include: (see **Appendix I: Enhanced Care Management Target Population Descriptions** for more detailed definitions):

- Children or youth with complex physical, behavioral, developmental, and/or oral health needs (e.g. California Children Services, foster care, youth with Clinical High-Risk syndrome or first episode of psychosis).
- Individuals experiencing homelessness, chronic homelessness or who are at risk of becoming homeless.
- High utilizers with frequent hospital admissions, short-term skilled nursing facility stays, or emergency room visits.

- Individuals at risk for institutionalization who are eligible for long-term care services.
- Nursing facility residents who want to transition to the community.
- Individuals at risk for institutionalization with Serious Mental Illness (SMI), children with Serious Emotional Disturbance (SED) or Substance Use Disorder (SUD) with co-occurring chronic health conditions.
- Individuals transitioning from incarceration who have significant complex physical or behavioral health needs requiring immediate transition of services to the community.

Enhanced Care Management Design and Services

The enhanced care management benefit, which will be delivered by community-based providers (”ECM Providers”) contracting with Medi-Cal managed care plans, will provide multiple opportunities to engage beneficiaries by stratifying risk and need, developing care plans and strategic interventions to mitigate risk and help clients achieve improved health and well-being. Enhanced care management services extend beyond standard care coordination and disease management activities and are concentrated on the coordination and monitoring of cost-effective, quality direct care services for the individual, as well as connections to needed community supports for indirect care needs.

The enhanced care management benefit is fundamentally person-centered, goal-oriented, and culturally relevant to assure that, as a primary goal of the program, members receive needed services in a supportive, effective, efficient, timely, and cost-effective manner. Enhanced care management will emphasize prevention, health promotion, continuity and coordination of care to link members to services as necessary across providers and settings and with emphasis on identifying the least restrictive and most integrated setting that will meet the needs of the beneficiary.

The role of enhanced care management is, through face-to-face visits, to coordinate all primary, acute, behavioral, developmental, oral, and long-term services and supports for the member, including participating in the care planning process, regardless of setting. Enhanced care management activities shall become integrated with other care coordination processes and functions and shall assume primary responsibility for coordination of the member’s physical health, behavioral health, oral health, developmental, and long-term care needs.

Enhanced care management will be provided at a level dictated by the complexity of the health and social needs of the member. The approach to enhanced care management will be high-touch, on-the-ground, and face-to-face, with frequent contacts for persons residing in community settings and nursing facilities. Enhanced care management care managers are expected to develop relationships with members and their families, engage

members and families in needs assessment and care planning processes, and work with the primary care provider to address the member's needs in coordinating physical and behavioral health care.

The enhanced care management care managers will operate within the member's community, serve as the members' primary point of contact and are responsible for ensuring that applicable physical, behavioral, long-term care, developmental, oral, social, and psychosocial needs are met in the safest, least restrictive way possible while considering the most cost-effective way to address those needs. Care managers meet members where they are, both literally, and from a medical management and plan of care perspective. Community health workers can also be used to improve outreach and provide care coordination services for beneficiaries.

Required programmatic elements to be implemented include, but are not limited to, care coordination, health promotion, comprehensive transitional care, member and family supports and referral to community and social services. These elements include helping beneficiaries navigate, connect to and communicate with providers and social service systems; coaching beneficiaries on how to monitor their health and identify and access helpful resources; identifying and coordinating available in lieu of services such as housing services; helping beneficiaries move safely and easily between different care settings and reducing avoidable hospital admissions and readmissions; educating beneficiaries and their family/support system about their conditions to improve treatment adherence and medication management; providing referrals to community and social services; and follow-up to help ensure that beneficiaries are connected to the services they need.

Program Administration

Enhanced care management will be administered by the Medi-Cal managed care plans, who will have direct responsibility for establishing the enhanced care management benefit and criteria for their members, subject to contractual requirements and programmatic guidance provided by DHCS. DHCS intends for Medi-Cal managed care plans to build upon the expertise and infrastructure of the existing Whole Person Care pilots and Health Homes Program to achieve these outcomes and, with some exceptions, to contract directly with existing Whole Person Care providers and Health Homes Program community-based care management entities, as well as other necessary contracting with public and private providers to deliver such services.

In addition, DHCS expects that plans will work in coordination and collaboration, and even contract when appropriate, with county behavioral health systems who often are the primary providers of services to a subset of Medi-Cal beneficiaries. This proposal requests that managed care plans determine the service design and intensity based on the parameters established by DHCS. DHCS will build enhanced funding into the

capitation rates to enable Medi-Cal managed care plans to successfully provide enhanced care management benefit. The Medi-Cal managed care plans will have strong oversight and will perform regular auditing and monitoring activities to ensure that all requirements are met. If a plan proposes to keep some level of enhanced care management in-house instead of contracting with direct providers, the plan will need to demonstrate to the state that their enhanced care management benefit is appropriately community-based and provide a rationale for not contracting with existing WPC and HHP providers (per the exceptions outlined in the enhanced care management and in lieu of services Model of Care Template and managed care plan contract language.)

For individuals with a primary SMI diagnosis, SUD, children with SED, or children involved in child welfare, county behavioral health staff should be considered to serve as the enhanced care management provider through a contractual relationship, provided they agree to coordinate all the services (physical, developmental, oral health, long-term care and social needs) needed by those target populations, not just their behavioral health needs. These staff will focus on the behavioral health needs and interventions for the Medi-Cal beneficiary, act as a resource for the Medi-Cal managed care plan in managing the needs of this population and ensuring that beneficiaries are linked to appropriate county resources; as well as other resources that have more experience and documented success in working with those living with these conditions.

Targeted Case Management

Furthermore, Medi-Cal managed care plans will be expected to work with Local Governmental Agencies to ensure that members receiving enhanced care management services do not receive duplicative Targeted Case Management services; this approach will also help support the Department's goal of strengthening the connections across California's delivery systems. The Targeted Case Management program is an optional Medi-Cal Program funded by federal and local funds. See **Appendix B: Targeted Case Management** for which counties currently participate in the Targeted Case Management program.

DHCS may need to review and discuss other potential county funding interactions with this benefit to ensure there is no duplication of services or funding.

Transition and Coordination Plan

Medi-Cal managed care plans currently operating a Health Homes Program or operating in a county with a Whole Person Care pilot or Targeted Case Management program, will be required to submit a transition and coordination plan to DHCS by July 1, 2021. Through the transition and coordination plan, managed care plans will demonstrate how they will translate the existing programs into the enhanced care management benefit and in lieu of services and coordinate with existing Targeted Case Management programs. The

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plans must also demonstrate a good faith effort to contract for enhanced care management and in lieu of services with existing Health Homes providers and Whole Person Care entities already providing such services. If the Medi-Cal managed care plan and existing provider cannot come to agreement, the Medi-Cal managed care plans will need to provide DHCS information as to why such entities were not able to come to a contractual agreement.

Medi-Cal managed care plans in counties with Targeted Case Management programs will be required to submit information in the transition and coordination plan describing how they will work with the Local Government Agency to ensure that members receiving enhanced care management services do not receive duplicative Targeted Case Management services.

A transition and coordination plan will not be required for Medi-Cal managed care plans in counties that do not have Whole Person Care pilots, Health Homes Programs, or Targeted Case Management.

Implementation

January 1, 2022: All Medi-Cal managed care plans in counties with Whole Person Care pilots and/or Health Homes Programs will begin implementation of the enhanced care management benefit, for those target populations currently receiving Health Homes Program and/or Whole Person Care services.

July 1, 2022:

- Medi-Cal managed care plans in counties with Whole Person Care pilots and/or Health Homes Programs will implement additional mandatory enhanced care management target populations.
- All Medi-Cal managed care plans in counties without Whole Person Care pilots and/or Health Homes Programs must begin implementation of select enhanced care management target populations.

January 1, 2023: All Medi-Cal managed care plans in all counties must implement enhanced care management for all target populations.

Medi-Cal managed care plans that begin implementing on January 1, 2022 will submit an enhanced care management Model of Care proposal to DHCS for review by July 1, 2021. Draft contract provisions will be shared with plans in February 2021. Medi-Cal managed care plans that will implement enhanced care management on July 1, 2022, will submit an enhanced care management Model of Care by January 1, 2022. All plans must complete readiness activities for the mandatory target populations. Medi-Cal managed

care plans can submit to DHCS additional optional target populations, in addition to the mandatory target populations.

Federal regulations require that Medi-Cal managed care plan implementation activities shall include tribal consultation/outreach for protections involving American Indians and Indian Health Clinic providers. Through the enhanced care management Model of Care, managed care plans must demonstrate that there are sufficient Indian Health Clinics participating in their provider network to ensure timely access to services available under the contract from such providers for American Indian enrollees who are eligible to receive services. Medi-Cal managed care plans will provide a description of their coordination with tribal partners within the enhanced care management transition and coordination plan.

By July 1, 2022, all Medi-Cal managed care plans will need to submit to DHCS an enhanced care management Model of Care proposal for serving individuals transitioning from incarceration for implementation on January 1, 2023 in all counties. Re-entry transitions involve working closely with corrections departments, including probation, courts and the local county jail system to ensure connections to care once individuals are released from jail. While there is some infrastructure in place for this enhanced care management target population due to Whole Person Care Pilots, these types of arrangements require significant planning and coordination between the managed care plan, counties, sheriff, probation, and other key stakeholders.

DHCS is also looking to leverage the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act provisions that may make it possible to begin providing enhanced care management for individuals exiting from incarceration with known medical and behavioral health needs 30 days prior to release.

This aspect of enhanced care management will support the scaling of diversion efforts aimed at keeping some of the most acute and vulnerable individuals with serious medical or behavioral health conditions out of jail/prison and in their communities. In this case, Medi-Cal managed care plans can contract with county and non-profit entities that work to meet the health care needs of those who are involved in pre- or post-booking diversion behavioral health and criminogenic treatment programs and, thus, are at risk for incarceration and could, through care coordination and service placement, have a treatment plan built to avoid incarceration and get into community-based care and services.

Furthermore, to complement this enhanced care management benefit, DHCS is proposing to mandate that all counties implement a county inmate pre-release Medi-Cal application process by January 1, 2023.

Mandated County Inmate Pre-Release Application Process

In 2004, the Centers for Medicare & Medicaid Services (CMS) issued a State Medicaid Director letter, entitled "Ending Chronic Homelessness," that encouraged states to ensure that applications for Medicaid are processed in a timely manner so that individuals can receive Medicaid-covered services immediately upon release from a public institution.

On May 6, 2014, DHCS provided guidance in All-County Welfare Directors Letter #14-24, on the pre-release application process for state inmates who apply for Medi-Cal coverage. Subsequently, on June 25, 2014, DHCS clarified in All County Welfare Directors Letter #14-24E, that the guidance issued in the May 2014 letter is also applicable to county inmates. However, a specific pre-release process to facilitate the applications for county inmates was not defined and implementation of such process was voluntary.

The current pre-release application process varies from county to county. From a survey of some counties, DHCS learned that relatively larger counties with pre-release programs, such as Orange County and Stanislaus County, have agreements with third-party entities (e.g., community-based organizations or vendors) to streamline the pre-release application process and to provide dedicated application intake staff that visit individuals at the county jail while still in custody. Of the smaller counties surveyed, Yolo County has an agreement with the Sheriff's Department to establish communication channels and set up physical stations at the correctional facility, as well as security clearances for designated county staff to speak with the county inmate applicant directly. **Appendix C: County Inmate Pre-Release Application Process sample contracting Models** includes the three main models currently being used for various county inmate pre-release application programs.

DHCS is proposing to mandate that all counties implement a county inmate pre-release Medi-Cal application process by January 1, 2023, which would include juvenile facilities. The goal of the proposal is to ensure the majority of county inmates/juveniles that are eligible for Medi-Cal and are in need of ongoing physical or behavioral health treatment receive timely access to Medi-Cal services upon release from incarceration.

Additionally, DHCS is proposing to mandate that all county jails and juvenile facilities implement a process for facilitated referral and linkage from county release to county specialty mental health, Drug Medi-Cal, Drug Medi-Cal Organized Delivery Systems, and Medi-Cal managed care providers when the inmate was receiving behavioral health services while incarcerated to allow for continuation of behavioral health treatment in the community. DHCS will look to counties to implement medical record release processes that would allow medical records to be shared with the county behavioral health and Medi-Cal managed care providers, prior to or upon release from jail or county juvenile facility.

The mandated county inmate pre-release application process will standardize policy, procedures, and collaboration between California's county jails, county sheriff's departments, juvenile facilities, county behavioral health and other health and human services entities. This collaboration will ensure that eligible individuals are enrolled in Medi-Cal prior to release and will establish a continuum of care and ongoing support that may ultimately help to reduce the demand for costly and inappropriate services.

2.2.3 Rationale

DHCS continues to strengthen integration within the state's health care delivery system and is working with health promotion partners to achieve better care and better health outcomes at lower cost to the Medi-Cal program. Creating a statewide enhanced care management benefit with required target populations is consistent with the CalAIM objective of reducing variation and complexity across the delivery system, as well as identifying and managing member risk and need. The benefit will comprise an intensive set of services for Medi-Cal members who require coordination at the highest levels. Targeted individuals are beneficiaries who may be challenged with medical and behavioral conditions, access to care issues, chronic illnesses, disabilities, multiple social determinants of health, and require multidisciplinary care to regain health and function.

The enhanced care management benefit will provide Medi-Cal managed care plans with opportunities to help beneficiaries achieve improved health and well-being through stratifying risk and need and developing care plans and strategic interventions. Enhanced care management services will extend beyond standard care coordination and disease management activities. They will be concentrated on the coordination and monitoring of cost-effective, high quality, direct care services, as well as connections to needed community supports for non-direct care needs.

2.2.4 Proposed Timeline

DHCS is proposing a phased statewide implementation of the enhanced care management benefit and inclusion in Medi-Cal managed care contracts. Medi-Cal managed care plans in counties with Whole Person Care Pilots and/or Health Homes Programs will implement enhanced care management on January 1, 2022 for those target populations currently receiving Health Homes and/or Whole Person Care services. On July 1, 2022, Medi-Cal managed care plans in those counties will implement additional required target populations and counties without Whole Person Care pilots and/or Health Homes Programs will begin implementing select populations on July 1, 2022. The benefit must be implemented for in all counties all target populations, including individuals transitioning from incarceration, by January 1, 2023.

DHCS is proposing an effective date of January 1, 2023 for counties to implement a county inmate/juvenile pre-release application process. To ensure the necessary data

sharing agreements and communication plans are in place, below is detailed timeline for planning and implementation of this proposal:

- **March 1, 2021:** Establish workgroup with County Welfare Director's Association and counties to develop and vet implementation plan
- **May 1, 2021:** All county guidance development
- **November 1, 2021:** County and stakeholder feedback process
- **January 1, 2022:** Publish All County Welfare Director Letter
- **January – December 2022:** County implementation planning and technical assistance
- **January 1, 2023:** Implementation of county inmate pre-release application process

2.3 In Lieu of Services

2.3.1 Background

The Whole Person Care pilots and Health Homes Program built a foundation for an integrated approach to coordinating medical care, behavioral health, and social services to improve beneficiary health outcomes. The implementation of these programs, however, has varied across California and did not provide a statewide platform to comprehensively address the needs of beneficiaries with the most complex health challenges.

According to federal Medicaid program rules, "in lieu of services" are medically appropriate and cost-effective alternatives to services that can be covered under the State Plan. They are typically delivered by a different provider or in a different setting than traditional State Plan services. An in lieu of service can only be covered if:

- The state determines that the service is a medically appropriate and cost-effective substitute or setting for the State Plan service;
- The services are optional for the managed care plan to provide;
- The services are optional for beneficiaries and they are not required to use the in lieu of service; and
- The in lieu of services are authorized and identified in the state's Medi-Cal managed care plan contracts.

Once adopted, Medi-Cal managed care plans will integrate in lieu of services into their population health management plans – often in combination with the new enhanced care

management benefit – to address gaps in State Plan benefit services. In lieu of services may be focused on addressing combined medical and social determinants of health needs to avoid higher levels of care. For example, in lieu of services might be provided as a substitute for, or to avoid, hospital or nursing facility admissions, discharge delays, and emergency department use. Based on extensive stakeholder feedback, DHCS has updated the in lieu of services menu of services. The feedback enhanced the overall design of in lieu of services, allowing beneficiaries receiving Health Homes or Whole Person Care services to continue receiving optional plan services. Furthermore, the additional feedback optimized the depth and capacity for serving eligible beneficiaries.

2.3.2 Proposal

DHCS is proposing to include the following fourteen (14) distinct services as in lieu of services under Medi-Cal managed care. Details regarding each proposed set of services are provided in **Appendix J: In Lieu of Services Options**:

- Housing Transition/Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Short-Term Post-Hospitalization Housing
- Recuperative Care (Medical Respite)
- Respite Services
- Day Habilitation Programs
- Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly and Adult Residential Facilities
- Community Transition Services/Nursing Facility Transition to a Home
- Personal Care and Homemaker Services
- Environmental Accessibility Adaptations (Home Modifications)
- Meals/Medically Tailored Meals
- Sobering Centers
- Asthma Remediation

The provision of in lieu of services is voluntary for Medi-Cal managed care plans and beneficiaries have the option to accept the in lieu of services or receive the State Plan services instead. Each service will have defined eligible populations, code sets, potential providers, restrictions, and limitations. However, individual in lieu of services may be used

together with other complementary in lieu of services based on individual needs and may be combined with enhanced care management services for high-risk, complex-need individuals. ILOS can be offered as an appropriate EPSDT service. Other appropriate EPSDT services should be offered in conjunction with any ILOS.

Transition and Coordination Plan

Since DHCS is building on the infrastructure developed for the Health Homes Program and parts of the Whole Person Care pilots, Medi-Cal managed care plans in counties with these programs will be required to submit a Transition and Coordination Plan to the state by July 1, 2021 demonstrating how they will transition existing programs into their enhanced care management benefit and in lieu of services. The plans must also demonstrate a good faith effort to come into agreement with and contract for enhanced care management and in lieu of services with Health Homes providers and Whole Person Care entities providing such services. DHCS recognizes the significant investment in infrastructure, as well as the existing expertise in providing these types of services, by our local county and other public/private partners and expects Medi-Cal managed care plans to partner with these entities to continue providing these critical services. If the Medi-Cal managed care plan and existing provider cannot come to agreement, the Medi-Cal managed care plans will need to provide DHCS a justification as to why the plan has not contracted with such entities.

2.3.3 Rationale

Adoption of this set of in lieu of services will provide additional support to beneficiaries with complex medical and behavioral health needs who experience socio-economic conditions that impede their ability to achieve their health goals. These circumstances put them at risk of hospitalization, institutionalization, and/or in need of other higher cost services.

Currently, Medi-Cal strategies to address beneficiaries' social determinants of health vary across the state, depending on the initiatives underway in different regions. Consistent with the CalAIM objective of reducing variation and complexity across the delivery system, as well as identifying and managing member risk and need, establishing coverage of a set of in lieu of services will make a statewide offering of these critical interventions for Medi-Cal beneficiaries.

The in lieu of services framework allows for regions that do not currently have a sufficient infrastructure to provide the full array of services to build network capacity in a way that meets the unique needs of their residents. This may include partnerships to develop physical infrastructure, as well as collaborations with new provider types who have not historically worked with Medi-Cal. This will also set the stage for Medi-Cal managed care

plans to be prepared to have long-term services and supports integrated into their care program by 2027.

The stakeholder feedback was critical to ensuring that the identified services will adequately address the critical needs of beneficiaries. The final policy incorporates feedback received regarding strategies for building the necessary service infrastructure in a cost-effective manner, finalizing the eligible populations, potential restrictions and limitations, and appropriate provider types to deliver this new set of services.

2.3.4 Proposed Timeline

January 1, 2022: DHCS is proposing statewide implementation and inclusion of in lieu of services in Medi-Cal managed care plan contracts. DHCS will provide technical assistance to plans as they prepare to implement this new set of services.

2.4 Shared Risk, Shared Savings, and Incentive Payments

2.4.1 Background

The combination of carving in long-term care statewide, enhanced care management and in lieu of services provides a number of opportunities, including an incentive for building an integrated, managed long-term services and supports program by 2027 and building the necessary clinically-linked housing continuum for our homeless population.

In order for the state to be equipped with the needed MLTSS and clinically linked housing continuum infrastructure, it is important to consider potential incentives and shared savings/risk models that could be established to encourage Medi-Cal managed care plans and providers to fully engage. Incentive funding will be focused on building a pathway for Medi-Cal managed care plans to invest in the necessary delivery and systems infrastructure, build appropriate and sustainable enhanced care management and in lieu of services capacity, and achieve improvements in quality performance that can inform future policy.

2.4.2 Proposal

DHCS proposes to create a series of incentives through a multi-pronged risk strategy. Potential approaches include:

- A blended capitation rate to account for the addition of seniors and persons with disabilities and long-term care beneficiaries into managed care. The rate will be subject to a blend true-up, which will provide financial protections in case of significant differences between actual long-term care beneficiary enrollment and assumptions used during capitation rate development.

- A time-limited, tiered, and retrospective shared savings/risk financial calculation performed by DHCS. This tiered model would be available for three calendar years – 2023, 2024 and 2025.

- A prospective model of shared savings/risk incorporated via capitation rate development. DHCS proposes to implement this approach beginning in calendar year 2026, once historical cost and utilization experience is available that would reflect the implementation of in lieu of services, long-term care services, and enhanced care management benefits statewide in managed care.

DHCS will establish plan incentives linked to delivery system reform through an investment in enhanced care management and in lieu of services infrastructure. The incentive payments will also be based on quality and performance improvements and reporting in areas such as LTSS and other cross-delivery system metrics. The target of incentive payments is to drive change at the managed care plan and provider levels. DHCS anticipates managed care plans will partner and share the incentive dollars with on-the-ground providers, including our critical partners that operate Federally Qualified Health Centers, Rural Health Centers, Indian Health Service clinics, public hospital safety net systems, and county behavioral health systems and providers to work collaboratively to meet the defined targets of incentive program.

2.4.3 Rationale

In recognition of the financial uncertainties that accompany the implementation of enhanced care management, in lieu of services, and MLTSS statewide, DHCS is committed to implementing strategies that will limit excessive financial risk (losses) for Medi-Cal managed care plans, as well as for the state and federal governments. At the same time, DHCS supports the use of strategies that will result in financial gains that can be shared between Medi-Cal managed care plans and the state and federal governments. DHCS' goal is to establish financial mechanisms that will ensure a mutual commitment to the success of the proposed short- and long-term reforms and innovations within the Medi-Cal managed care program.

DHCS' proposed risk approaches are intended to strengthen financial incentives for Medi-Cal managed care plans to:

- Divert or transition beneficiaries from long-term institutional care to appropriate home and community-based alternatives, supported by the availability of in lieu of services and enhanced care management;

- Make the necessary infrastructure investments to support the goal of transitioning to an integrated long-term services and supports program; and

- Improve quality, performance measurement, and data reporting as a pathway toward realizing better health outcomes for Medi-Cal beneficiaries.

2.4.4 Proposed Timeline

Rate setting, including associated risk strategies, is a dynamic process. Therefore, DHCS will engage and collaborate with Medi-Cal managed care plans and make future refinements as determined appropriate.

- **January – December 2021:** Develop shared savings/risk and plan incentive methodologies and approaches with appropriate stakeholder input.
- **January 1, 2022:** Begin implementation of managed care plan incentives.
- **No sooner than January 1, 2023:** Begin implementation of a seniors and persons with disabilities/long-term care blended rate.

2.5 Serious Mental Illness/Serious Emotional Disturbance Demonstration Opportunity

2.5.1 Background

On November 13, 2018, CMS issued a State Medicaid Director letter that outlines opportunities for states to design innovative service delivery systems to improve care for adults with serious mental illness (SMI) and children with serious emotional disturbance (SED) who are enrolled in Medicaid.

This SMI/SED demonstration opportunity allows states to receive federal matching funds for services provided to Medicaid beneficiaries during short-term stays for acute care in psychiatric hospitals or residential treatment settings that qualify as an institution for mental disease (IMD) (e.g., psychiatric hospitals or psychiatric health facilities that have more than 16 beds), as long as it is part of a broader effort to build a robust continuum of care allowing care in the least restrictive, community-based settings. Due to the long-standing federal exclusion of Medicaid matching funds for services provided in these settings, California's counties have historically paid the full cost of inpatient mental health services provided to Medi-Cal beneficiaries in these settings.

2.5.2 Proposal

DHCS proposes that California pursue this SMI/SED demonstration opportunity to receive federal financial participation for services provided to Medi-Cal beneficiaries in an IMD. DHCS heard from stakeholders both positive and negative feedback regarding this proposal. Stakeholders in favor of the demonstration opportunity stated the additional federal funds could provide opportunities to improve service delivery and outcomes

across the continuum of care from inpatient to community-based settings, and the availability of additional matching funds would free up other local resources that counties could reinvest in strengthening other mental health services and further build the continuum of care in the community.

Proponents suggested that the demonstration opportunity is a critical component of solutions for the state hospital crisis (with long wait lists for people found incompetent to stand trial, as the state hospitals are full) and for achieving health equity, since increasing the number of short-term, crisis stabilization resources can divert people with mental illness to treatment instead of entering the justice system. People of color are disproportionately placed in justice settings instead of in mental health treatment, and lack of bed availability is a contributing factor. Stakeholders also expressed opposition based on concerns that the presence of the existing IMD exclusion is the primary safeguard in inhibiting county mental health departments from expanding the use of institutional settings and an important incentive to develop alternatives to those settings, and that using federal dollars to fund IMDs could divert resources from community-based services, undermining progress toward increased community integration and a community-based continuum of care.

On balance, DHCS believes the benefits outweigh the risks, and proposes that California submit an application to CMS using the usual process for submitting a Section 1115 waiver demonstration application. Similar to the state's existing 1115 demonstration to provide residential and other SUD treatment services under Medi-Cal, county participation would be voluntary.

2.5.3 Rationale

If California is approved to participate in the SMI/SED demonstration opportunity, federal financial participation would become available for mental health services provided to Medi-Cal beneficiaries in an IMD if all requirements are met. This additional funding would provide opportunities to improve service delivery and outcomes across a well-developed and robust continuum of care from inpatient to community-based settings, which is a requirement of this waiver. Availability of additional federal matching funds would free up other local resources, such as realignment funds, that counties may then reinvest in strengthening other mental health services and further build the continuum of care in the community.

The SMI/SED demonstration opportunity comes with many federal milestones and requirements. As of October 2020, Washington DC, Vermont, Indiana, and Idaho have approved applications, and Massachusetts, Oklahoma and Utah have pending 1115 waiver application to CMS. Below is a summary of key requirements, some of which may pose feasibility challenges:

- **Average Length of Stay:** The state would be required to achieve a statewide average length of stay of no more than 30 days for beneficiaries residing in IMDs. CMS developed guidance regarding calculations of average length of stay, clarifying that a short-term stay for acute care is limited to no more than 60 consecutive days, as long as the state continues to meet the statewide average length of stay of 30 days or less, and that states may not claim for *any* part of a stay (days 0 to 60) that exceeds 60 days.

- **Improving Community-based Services**: States participating in the SMI/SED demonstration opportunity will be expected to commit to taking several actions to improve community-based mental health care. These actions are linked to a set of goals for the SMI/SED demonstration opportunity and will milestones for ensuring quality of care in IMDs, to improve connections to community-based care following stays in acute care settings, to ensure a continuum of care is available to address more chronic, on-going mental health care needs of beneficiaries, to provide a full array of crisis stabilization services, and to engage beneficiaries with SMI/SED in treatment as soon as possible.

- **Maintenance of Effort:** According to the guidance, CMS will be examining the commitment to ongoing maintenance-of-effort on funding outpatient community-based mental health services and states must provide an assessment of current availability of mental health services. The purpose of the maintenance-of-effort requirement is to ensure that resources are not disproportionately drawn into increasing access to treatment in inpatient and residential settings at the expense of community-based services.

- **Data Collection & Required Measures:** The state would need to report on a common set of measures and agree to additional measures and concepts specific to the state's demonstration parameters.

- **Health Information Technology:** The state would be required to develop and submit a health information technology plan that describes the ability to leverage technology, advance health information exchange(s), and ensure interoperability in support of the demonstration's goals. The health information technology plan would address electronic care plan sharing, care coordination, and behavioral and physical health integration.

- **Staffing and Resource Considerations:** Since DHCS does not currently pay for IMD services for this target population, pursuing the demonstration and ensuring compliance with requirements would require additional staffing and resources. Similarly, counties would likely need additional resources to implement and comply with elements required by the demonstration.

For additional information about the demonstration goals and milestones, federal application requirements, and other relevant requirements, please refer to the **Appendix E: CalAIM Benefit Changes Chart** of this proposal.

2.5.4 Proposed Timeline

The SMI/SED demonstration proposal would be developed no sooner than July 1, 2022. If the waiver proposal is approved by CMS, DHCS would work with interested counties to develop a formal implementation plan, with expected launch of the demonstration in 2023-24.

2.6 Full Integration Plans

2.6.1 Background

Currently, Medi-Cal beneficiaries must navigate multiple complex managed care and fee-for-service delivery systems to meet all of their health care needs. Beneficiaries enrolled in Medi-Cal managed care plans receive physical health care and treatment for mild-to-moderate mental health conditions from their Medi-Cal managed care plan, care for SMI/SED and SUD from the county delivery system, and dental care from a separate fee-for-service delivery system or a dental managed care plan. This fragmentation can lead to gaps in care and disruptions in treatment, cost inefficiencies, and generally fails to be patient-centered and convenient for most beneficiaries. The longevity gap among individuals with serious and persistent mental illness, and the fact that this group suffers and dies from un-or under-treated chronic physical health conditions, demonstrates the need to pilot the concept of a fully integration delivery system.

2.6.2 Proposal

DHCS would like to test the effectiveness of full integration of physical health, behavioral health, and oral health under one contracted entity. Multiple Medi-Cal delivery systems (Medi-Cal managed care, county mental health plans, county Drug Medi-Cal and DMC-ODS programs) would be consolidated under one contract with DHCS. To further develop this concept, DHCS will be engaging in stakeholder conversations to inform the development of the various components associated with fully integrating health care services. Topics will include contractor selection criteria, strategies for consolidating contract requirements, subcontracting and network requirements, and delivery system administration issues such as care coordination, utilization management, quality monitoring, and external quality review organization functions.

2.6.3 Rationale

In alignment with CalAIM, fully integrating all or most of the Medi-Cal health care delivery systems under one contract would improve the beneficiary experience as well as health outcomes by eliminating fragmentation, duplication, and the need to navigate multiple systems. In addition, integration will improve access to health data/data sharing among providers and between the plan and DHCS. Full integration would also result in overall administrative simplification by consolidating and streamlining system infrastructure. An integrated delivery system would allow for more efficient coordination of care and create opportunities to identify and manage the risks and needs of the beneficiaries in a more holistic way.

As part of the CalAIM workgroup process, DHCS sought stakeholder feedback to understand the benefits, risks and considerations for plans and counties interested in participating in a full integration model. Discussion included realignment (county behavioral health participation would need to be voluntary), how non-Medi-Cal funding streams would be managed (such as MHSA), criteria for participation, the need for adequate planning and preparation, the importance of clearly defined outcome measures, and other considerations.

2.6.4 Proposed Timeline

DHCS acknowledges the complexity of this proposal, and for this reason, is proposing a go-live of no sooner than January 2027, to allow sufficient time for planning and preparation, in partnership with counties, plans and other stakeholders.

2.7 Long-Term Plan for Foster Care

2.7.1 Background

Children and youth in foster care often present with complex medical, behavioral, oral and developmental health problems rooted in their history of childhood trauma and adverse childhood experiences (ACEs) Navigating multiple systems of care can create inherent challenges. Under the Medi-Cal program, beneficiaries receive services through various delivery systems, including Medi-Cal managed care, fee-for-service, California Children's Services, regional centers, dental county mental health plans, Drug Medi-Cal, and DMC-ODS programs. While children and youth in foster care typically have a comprehensive team to help facilitate and oversee their care including social workers, public health nurses, and the judicial system; many challenges remain in navigating Medi-Cal delivery systems, especially if there are multiple placements that may result in the child moving from one county to another or between homes in a single county.

In recent years, California has placed a greater emphasis on the behavioral health care needs of child welfare-involved children and families through major reforms such as the

Continuum of Care Reform, Family Urgent Response System, development of short-term residential treatment providers and coordinated efforts to implement the new federal Family First Prevention Services Act in California.

2.7.2 Proposal

In assessing the challenges foster care children and youth face, in June 2020 DHCS launched a workgroup of interested stakeholders to consider whether DHCS should develop a different model of care for children and youth in foster care, including the former foster youth and youth transitioning out of foster programs and services. To facilitate this discussion and develop meaningful recommendations, DHCS invited participation from key partners including but not limited to: the Department of Social Services, the Department of Education, child welfare county representatives and state-level associations, Medi-Cal managed care plans, behavioral health managed care plans, juvenile justice and probation, foster care consumer advocates, regional centers, and judicial entities involved with matters pertaining to children who are placed into the foster care system. DHCS also commissioned focus groups with foster youth and foster parents, to hear directly from those most affected by the challenges in the current system.

2.7.3 Proposed Timeline

DHCS launched the workgroup in June 2020, and will meet every other month through June 2021. DHCS and CDSS then will take lessons learned from the workgroup and the input from stakeholders and develop a comprehensive set of recommendations and plan of action, which may involve budget recommendations, waiver amendments, State Plan changes or other activities.

3. Moving Medi-Cal to a More Consistent and Seamless System by Reducing Complexity and Increasing Flexibility

This section will walk through the proposals aimed at standardizing and reducing complexity across all delivery systems.

Managed Care

- Managed Care Benefit Standardization
- Mandatory Managed Care Enrollment
- Transition to Statewide Long-Term Services and Supports, Long-Term Care & Duals-Special Needs Plans
- NCQA Accreditation of Medi-Cal Managed Care Plans
- Regional Managed Care Capitation Rates

Behavioral Health

- Behavioral Health Payment Reform
- Medical Necessity Criteria and Other Related Changes
- Administrative Integration of Specialty Mental Health and Substance Use Disorder Services
- Behavioral Health Regional Contracting
- DMC-ODS Renewal and Policy Improvements

Dental

- New Dental Benefits and Pay for Performance

County Partners

- Enhancing County Eligibility Oversight and Monitoring
- Enhancing County Monitoring and Oversight: California Children's Services and Child Health and Disability Prevention
- Improving Beneficiary Contact and Demographic Information

Managed Care

3.1 Managed Care Benefit Standardization

3.1.1 Background

Medi-Cal delivers services through a variety of delivery systems today including fee-for-service, managed care, county mental health, Drug Medi-Cal Organized Delivery System, and Drug Medi-Cal. Most full-scope Medi-Cal beneficiaries receive their physical health

services through a Medi-Cal managed care plan. While Medi-Cal managed care exists statewide, it is operated under six different model types that currently differ based on whether certain benefits are part of the Medi-Cal managed care plan's responsibility or provided through a different delivery system.

3.1.2 Proposal

Under CalAIM, DHCS is proposing to standardize the benefits that are provided through Medi-Cal managed care plans statewide. Regardless of the beneficiary's county of residence or the plan they are enrolled in, they will have the same set of benefits delivered through their Medi-Cal managed care plan as they would in another county or plan.

DHCS is proposing the following changes:

Carved Out Benefits

- Effective April 1, 2021, all pharmacy benefits or services by a pharmacy billed on a pharmacy claim will be carved out from Medi-Cal managed care plans (pursuant to the Governor's Executive Order N-01-19 from January 7, 2019). This applies to all Medi-Cal managed care plans, including AIDS Healthcare Foundation, but does not apply to SCAN Health Plan, Programs of All-Inclusive Care for the Elderly (PACE) organizations, Cal MediConnect health plans, and Major Risk Medical Insurance Program (MRMIP).

- Effective January 1, 2022, the following benefits that are currently within the scope of some or all the Medi-Cal managed care plans will be carved out:

    - Specialty mental health services that are currently carved in for Medi-Cal members enrolled in Kaiser in Solano and Sacramento counties; and

    - The Multipurpose Senior Services Program which is currently included in the Medi-Cal managed care plans in the seven Coordinated Care Initiative counties.

Carved In Benefits

- Effective January 1, 2022, all major organ transplants, currently not within the scope of many Medi-Cal managed care plans, will be carved into all plans statewide for all Medi-Cal members enrolled in a plan.

- Effective January 1, 2023, institutional long-term care services (i.e. skilled nursing facilities, pediatric/adult subacute care, intermediate care facilities for individuals with developmental disabilities, disabled/habilitative/nursing services, specialized rehabilitation in a skilled nursing facility or intermediate care facilities), currently

not within the scope of many Medi-Cal managed care plans will be carved into all plans statewide for all Medi-Cal members enrolled in a plan.

In order to provide a smooth transition from fee-for-service to managed care, promote access and maintain affordability, DHCS proposes to require that long-term care and transplant providers accept as payment in full and require the Medi-Cal managed care plan to pay the applicable Medi-Cal fee-for-service rate, unless the provider and plan mutually agree upon an alternative payment. This is consistent with how these transitions to managed care have occurred in the past, such as with the Coordinated Care Initiative and the Whole Child Model.

3.1.3 Rationale

The standardization of benefits delivered through Medi-Cal managed care plans statewide has two main purposes and benefits:

- Beneficiaries will no longer have to deal with the confusion that may arise when moving counties/plans and to find that different benefits are covered by their new plan or that they need to access another delivery system; and
- DHCS will be able to implement a change to Medi-Cal managed care plan rate setting. Currently, the capitation payment rates are developed on a county-by-county and plan-by-plan basis, resulting in excessive administrative work and challenges. With the standardization of the benefits and populations, DHCS will be able to move to a regional rate setting process that will reduce the number of rates being developed and allow DHCS to work with the managed care plans to explore different rate setting methodologies and adjustments to reward improved quality and outcomes.

3.1.4 Proposed Timeline

The benefit standardization will be effective and included in Medi-Cal managed care plan contracts by January 2023, according to **Appendix F: Managed Care Enrollment Proposed Aid Code Group Coverage**.

3.2 Mandatory Managed Care Enrollment

3.2.1 Background

Currently, the Medi-Cal program provides benefits through both a fee-for-service and managed care delivery system. Enrollment into the fee-for-service delivery system or the managed care delivery system is based upon specific geographic areas, the health plan model, and/or the aid code that the beneficiary is determined to qualify for. In some cases, enrolling in managed care is optional for beneficiaries. However, more than 80 percent of Medi-Cal beneficiaries are currently served through the managed care delivery system.

3.2.2 Proposal

In an effort to enhance coordination of care, increase standardization, and reduce complexity across the Medi-Cal program, DHCS is proposing to standardize which aid code groups will require mandatory managed care enrollment versus mandatory fee-for-service enrollment, across all models of care and aid code groups, statewide. Under this proposal, beneficiaries in a voluntary or excluded from managed care enrollment aid code that are currently accessing the fee-for-service delivery system, would be required to choose a Medi-Cal managed care plan and will not be permitted to remain in fee-for-service. DHCS completed extensive data analytics to inform this proposal, for example, 73% of beneficiaries with other health coverage are already enrolled in managed care today and of non-long-term care share of cost beneficiaries, on average only 5.4% of beneficiaries meet their monthly share of cost.

DHCS is proposing implementation of this change in two phases, transitioning non-dual eligible populations in 2022 and dual eligible populations in 2023. A non-dual member is defined as a Medi-Cal member without any Medicare coverage. A dual beneficiary is defined as a Medi-Cal member with any Medicare coverage. This would include Medi-Cal members with Medicare A only or Part B only (partial duals) and members with Medicare Part A and B (full duals) regardless of enrollment in Medicare Part C or Part D. See below for a summary of changes and **Appendix F: Managed Care Enrollment Proposed Aid Code Group Coverage** for more details.

Given the ability and directive of Medi-Cal managed care plans to provide case and care management not available in a fee-for-service environment, DHCS firmly believes that Medi-Cal managed care is a delivery system we should continue to invest in and rely upon. In conjunction with these new and increased responsibilities, DHCS plans to increase oversight of the plans and their delegated entities to ensure that current requirements being met but also that the additional benefits and requirements contained in CalAIM are truly being provided statewide.

Mandatory Managed Care Enrollment

Below are the populations that currently receive benefits through the fee-for-service delivery system that would transition to Medi-Cal managed care upon implementation of this proposal in 2022:

- Trafficking and Crime Victims Assistance Program (except share of cost)
- Individuals participating in accelerated enrollment
- Child Health and Disability Prevention infant deeming
- Pregnancy-related Medi-Cal (Pregnant Women only, 138-213% citizen/lawfully present)
- American Indians
- Beneficiaries with other health care coverage

- Beneficiaries living in rural zip codes

Below are the populations that currently receive benefits through the fee-for-service delivery system except in COHS and CCI counties that would transition to the Medi-Cal managed care system upon implementation of this proposal in 2023:

- All dual and non-dual individuals eligible for long-term care services (includes long-term care share of cost populations)
- All partial and full dual aid code groups, except share of cost or restricted scope, will be mandatory Medi-Cal managed care, in all models of care starting in 2023

Mandatory Fee-for-Service Enrollment

This proposal would also move the following populations from mandatory managed care enrollment into mandatory fee-for-service enrollment upon implementation of this proposal in 2022:

- Omnibus Budget Reconciliation Act (OBRA): This population was previously mandatory managed care in Napa, Solano, and Yolo counties.
- Share of Cost: beneficiaries in county organized health systems (COHS) and Coordinated Care Initiative counties excluding long-term care share of cost.

Therefore, beneficiaries in the following aid code groups will have mandatory fee-for-service enrollment:

- Restricted scope
- Share of cost (including Trafficking and Crime Victims Assistance Program share of cost, excluding long-term care share of cost)
- Presumptive eligibility
- State medical parole, county compassionate release, and incarcerated individuals
- Non-citizen pregnancy-related aid codes enrolled in Medi-Cal (not including Medi-Cal Access Infant Program enrollees)

DHCS recommends keeping enrollment requirements for foster care children and youth in place until the Foster Care Workgroup makes recommendations on the future delivery system for foster care children and youth.

3.2.3 Rationale

Moving to mandatory managed care enrollment will standardize and reduce the complexity of the varying models of care delivery in California. Populations moving between counties will have the same experience when it comes to receiving services through a managed care plan. Transitioning current populations to mandatory managed care enrollment will also allow for Medi-Cal managed care plans to provide more

coordinated and integrated care and provide beneficiaries with a network of primary care providers and specialists.

Additionally, DHCS will be able to implement a change to Medi-Cal managed care plan rate setting. Currently, the capitation payment rates are developed on a county-by-county and plan-by-plan basis, resulting in excessive administrative work and challenges. With the standardization of the benefits and populations, DHCS will be able to move to a regional rate setting process that will reduce the number of rates being developed and allow DHCS to work with the managed care plans to explore different rate setting methodologies and adjustments to reward improved quality and outcomes.

3.2.4 Proposed Timeline

- **January 1, 2022:** Non-Dual and pregnancy related aid code group, and population-based transitions, except for LTC aid codes.
- **January 1, 2023:** Dual aid code group transition, including LTC aid codes for both non-dual and dual beneficiaries.

3.3 Transition to Statewide Long-Term Services and Supports, Long-Term Care, & Dual Eligible Special Needs Plans

3.3.1 Background

Under CalAIM, DHCS is proposing to transition CMC and the CCI to a statewide MLTSS and dual eligible special needs plan (D-SNP) structure. This policy is intended to help meet the statewide goals of improved care integration and person-centered care, under both CalAIM and the California Master Plan for Aging.

The Coordinated Care Initiative has been underway in seven California counties and is comprised of two parts: 1) Cal MediConnect, a demonstration project that combined acute, primary, institutional, and home and community-based services into a single benefit package for individuals who are fully or partially eligible for Medicare and Medicaid; 2) mandatory Medi-Cal managed care enrollment for dual eligibles for all Medi-Cal benefits, including managed long-term services and supports.

The Governor's 2017-2018 budget determined that the Coordinated Care Initiative was not cost-effective due to the financing of the In-Home Supportive Services benefit, which was carved out to fee-for-service effective January 1, 2018. DHCS will carve out Multipurpose Senior Services Program services to fee-for-service effective January 1, 2022 for all Medi-Cal members. CMS approved an extension for the remaining program elements – Cal MediConnect and mandatory managed long-term services and supports enrollment – until December 31, 2022.

While the Coordinated Care Initiative and Cal MediConnect offer the promise of better integrated care for California's dual eligibles, the program is only available in seven out of 58 counties. Additionally, Cal MediConnect has been a complex program to administer.

DHCS is implementing a new approach to take the key lessons learned and innovative strategies from these programs and make them more broadly available across the State.

3.3.2 Proposal

Aligned Enrollment

DHCS will use selective contracting to move toward aligned enrollment in D-SNPs; beneficiaries will enroll in a Medi-Cal managed care plan and D-SNP operated by the same parent company to allow for greater integration and coordination of care.

- In CCI counties, aligned enrollment will begin in 2023. Cal MediConnect members will transition to aligned D-SNPs and managed care plans operated by the same organization as their Cal MediConnect product.
- Aligned enrollment will phase-in in non-CCI counties as plans are ready. DHCS will require managed care plans to apply for aligned D-SNPs to be effective no later than contract year 2025.
- Dual eligible beneficiaries already enrolled in a non-aligned D-SNP (a D-SNP that is not affiliated with their managed care plan) when aligned enrollment takes effect in their county will be in that D-SNP (allowing the beneficiary to stay in the non-aligned D-SNP). New enrollment in those non-aligned D-SNPs will be closed.

In conjunction with the aligned enrollment approach, starting in 2022 CMS will limit enrollment into Medicare Advantage (MA) plans that are D-SNP “look-alikes.” These are MA plans that offer the same cost sharing as D-SNPs, but do not offer integration and coordination with Medi-Cal or other benefits targeted to the dual eligible population, such as risk assessments or care plans.

As outlined in the CMS Contract Year 2021 Medicare Advantage and Part D Final Rule:

- CMS will not enter into contracts with new MA plans that project 80 percent or more of the plan's enrollment will be entitled to Medicaid starting in 2022; and
- CMS will not renew contracts with MA plans (except SNPs) that have enrollment of 80 percent or more enrollees who are entitled to Medicaid (unless the MA plan has been active for less than one year and has enrollment of 200 or fewer individuals).

DHCS will also allow plans in CCI counties with managed care plan contracts, existing D-SNPs, and existing MA D-SNP look-alike plans to transition their dual eligible populations enrolled in the MA look-alike into an existing D-SNP in 2022, prior to the end of CCI. This will provide better coordination of care, without reducing enrollment in Cal MediConnect plans, and is in alignment and preparation for the CMC transition to D-SNP aligned enrollment in 2023.

D-SNP Integration Requirements

DHCS will require that all D-SNPs use a model of care addressing both Medicare and Medi-Cal services to support coordinated care, high-quality care transitions, and information sharing. DHCS will work with CMS to incorporate new CalAIM model of care requirements into the D-SNP model of care, as appropriate.

As DHCS implements aligned enrollment, DHCS will require D-SNPs to:

- Develop and use integrated member materials.
- Include consumers in their existing advisory boards.
- Work with CMS to establish quarterly joint contract management team meetings for aligned D-SNP and managed care plans.
- Include dementia specialists in their care coordination efforts.
- Coordinate carved-out LTSS benefits including IHSS, MSSP, and other HCBS waiver programs.

Additionally, DHCS will work with CMS to coordinate audit timing, to avoid a D-SNP/managed care plan being audited by both agencies at the same time.

Long-Term Care Carve In

In conjunction with mandatory Medi-Cal managed care enrollment, DHCS will require statewide integration of LTC into managed care for Medi-Cal populations by 2023. This means that full- and partial-benefit duals in LTC facilities in counties or plans that do not already include LTC will be enrolled in Medi-Cal managed care by 2023.

D-SNP Transitions and Enrollment Policies

DHCS will encourage aligned enrollment of dual eligibles into matching managed care plans and D-SNPs to promote more integrated care. During all transitions, DHCS will work with CMS to ensure beneficiaries receive continuity of care protections.

Mandatory Enrollment into Medi-Cal Managed Care Plans

DHCS is committed to providing beneficiary and provider education, as well as technical assistance around Medi-Cal managed care plan requirements, for mandatory enrollment of dual eligibles into Medi-Cal managed care. As part of this work, DHCS will:

- Review and make any needed updates to education and enrollment materials used to assist dual eligibles in enrolling into a managed care plan or PACE for their Medi-Cal benefits.

- Help educate providers about necessary billing practices as well as the processes that will not change, building on materials and best practices previously developed under CCI.

3.3.3 Rationale

Individuals dually eligible for Medicare and Medi-Cal are among the highest need populations. However, lack of coordination between Medicare and Medi-Cal can make it difficult for individuals enrolled in both programs to navigate these separate systems of care. California has made significant progress in building integrated systems through the implementation of CCI and CMC in seven counties (Los Angeles, Orange, San Diego, San Mateo, Riverside, San Bernardino and Santa Clara). As part of the CalAIM initiative, DHCS is leveraging the lessons and success of CCI to develop policies to promote integrated care through D-SNPs and MLTSS across California. This includes mandatory enrollment for dual eligibles into managed care plans for their Medi-Cal benefit and increasing the availability of aligned D-SNPs. This will allow duals to voluntarily enroll for their Medicare benefits into the D-SNP that is aligned with their managed care plan.

In addition, to promote integrated, person-centered care, the D-SNP and MLTSS policies will rely on California's robust and diverse array of HCBS providers across the state who serve older Californians and people with disabilities. In support of this effort, DHCS plans to submit a request for supplemental funding through the federal Money Follows the Person grant to accelerate LTSS system transformation design and implementation, and to expand HCBS capacity. The one-time supplemental funding would be used to develop a multi-year roadmap for implementing strategies and solutions for strengthening HCBS and MLTSS programs and provider networks. DHCS' intent is that the roadmap will provide a unified vision to integrate CalAIM MLTSS, D-SNP policy and the related in lieu of services policy, other components of the Master Plan on Aging, and all of HCBS, to expand and better link those HCBS to Medi-Cal managed care and D-SNP plans.

3.3.4 Proposed Timeline

- **January 1, 2021:** All existing D-SNPs must meet new regulatory integration standards effective 2021.

- **January 1, 2022**: Voluntary in lieu of services in all Medi-Cal managed care plans and CMC plans. Multipurpose Senior Services Program (MSSP) carved out of managed care in CCI counties. Plans in CCI counties with existing managed care plan contracts, existing D-SNPs, and existing MA D-SNP look-alike plans may transition their dual eligible populations enrolled in the MA look-alike into an existing D-SNP.

- **December 31, 2022**: Discontinue CMC and CCI.

- **January 1, 2023**: Statewide mandatory enrollment of full- and partial- benefit dual eligible beneficiaries into managed care plans for Medi-Cal benefits, including dual and non-dual eligible LTC residents and statewide integration of LTC into Medi-Cal managed care. Aligned enrollment begins in CCI counties and managed care plans in those counties must stand up D-SNPs. All CMC members cross-walked to matching D-SNP and managed care plans, subject to CMS and state requirements.

- **January 1, 2025**: Aligned enrollment begins in non-CCI counties; All managed care plans required to begin operating D-SNPs (voluntary enrollment for dual eligibles' Medicare benefit).

- **January 1, 2027**: Implement MLTSS statewide in Medi-Cal managed care.

3.4 NCQA Accreditation of Medi-Cal Managed Care Plans

3.4.1 Background

The National Committee for Quality Assurance (NCQA) is a private, not-for-profit organization that offers accreditation to health plans and other health care-related entities (e.g., accountable care organizations) in the areas of quality improvement, population health management, network management, utilization management, credentialing and re-credentialing, and member experience. NCQA also develops quality performance measures known as the Healthcare Effectiveness Data and Information Set (HEDIS) measures, which provide a standardized method for comparing health plan performance. Currently, 26 states require NCQA accreditation for their contracted Medicaid managed care plans.

DHCS conducts annual medical audits of all Medi-Cal managed care plans, but does not currently "deem," or use information obtained from a national accreditation review, to satisfy mandatory external quality review activities, with the exception of the credentialing requirement of the annual medical audit. Federal regulations permit the state to deem this information for credentialing purposes.

DHCS does not currently require Medi-Cal managed care plans to be accredited by NCQA. Out of 24 full scope Medi-Cal managed care plans in the state, 17 health plans currently have NCQA accreditation. Medi-Cal managed care plans that provide private coverage through Covered California are required to be accredited by either NCQA, the Utilization Review Accreditation Commission (URAC), or the Accreditation Association for Ambulatory Health Care (AAAHC).

3.4.2 Proposal

To streamline Medi-Cal managed care plan oversight and to increase standardization across plans, DHCS recommends requiring all Medi-Cal managed care plans and their

health plan subcontractors to be NCQA accredited by 2026. DHCS may use NCQA findings to certify or deem that Medi-Cal managed care plans meet particular state and federal Medicaid requirements. However, numerous stakeholders have shared with DHCS their concerns around DHCS deeming any elements of its current oversight of the managed care plans. Before DHCS recommends deeming of elements of its annual medical audits of the plans, DHCS will solicit feedback on the proposed deemable elements. If deeming does occur, DHCS will post information on the deeming elements and the corrective action plan for NCQA oversight findings on its website. DHCS will not accept accreditation from entities other than NCQA (e.g. URAC). Additional information on proposed deeming is below.

DHCS will also require Medi-Cal managed care plan NCQA accreditation to include the LTSS Distinction Survey subsequent to all health plans operating a D-SNP by 2027; the exact effective date for the LTSS Distinction Survey will be determined at a later date. Requiring the LTSS Survey will align with the state's effort to carve-in long-term care services and expand in lieu of services to make MLTSS a statewide benefit.

While DHCS is interested in the potential future addition of the Medicaid (MED) module to routine NCQA health plan accreditation, as it could potentially maximize the opportunity for streamlining state compliance and deeming, DHCS has determined that it is premature to require the MED module at this point, given how new it is for NCQA.

Finally, DHCS had considered requiring Medi-Cal managed care plans to ensure any non-health plan subcontractors to whom certain contractual elements are delegated are NCQA accredited for that function. DHCS will not require this in its contracts with the Medi-Cal managed care plans at this time; Medi-Cal managed care plans will need to determine if they will require any accreditation of their non-health plan subcontractors. If DHCS decides to deem particular elements of NCQA health plan accreditation standards, and any Medi-Cal managed care plans elect to require NCQA accreditation of their subcontractors, the Medi-Cal managed care plans will have the option to offer deeming on those same elements, if applicable, with their subcontractors.

3.4.3 Rationale

One of the three objectives of CalAIM is to reduce variation and complexity across Medi-Cal delivery systems, including standardization of the Medi-Cal managed care benefit. requiring NCQA accreditation of its managed care plans and following the NCQA framework, DHCS can potentially increase standardization throughout the state and reduce redundancies in various processes and assessments, in areas such as care coordination, which DHCS currently requires. Further, NCQA accreditation can assist in streamlining DHCS monitoring and oversight of managed care plans, particularly with regard to the annual medical audits, by increasing the number of elements in which DHCS may consider deeming Medi-Cal managed care plans. This would allow the annual medical audits to focus on other DHCS priority areas not reviewed by NCQA.

The addition of the LTSS Distinction Survey aligns with DHCS' goal of making LTSS a statewide benefit. DHCS recognizes that the addition of this survey to routine NCQA accreditation may be difficult for Medi-Cal managed care plans that are not already NCQA accredited, so DHCS will determine a timeframe for requiring the LTSS Distinction Survey that falls after all managed care plans have achieved routine NCQA plan accreditation.

3.4.4 Proposed Timeline

DHCS will require all Medi-Cal managed care plans and their health plan subcontractors to be NCQA accredited by 2026.

- DHCS will review and consider elements of NCQA health plan accreditation standards for deeming in relation to the annual A&I compliance audits.
    - DHCS will ensure that a complete crosswalk of federal and state Medicaid requirements and NCQA health plan accreditation standards is available online for comment prior to finalizing any deeming decisions.
    - DHCS will ensure that any NCQA health plan accreditation elements selected for potential deeming are vetted with stakeholders prior to finalizing any deeming decisions.
- DHCS may consider implementing deeming of the select elements sooner than 2026 for Medi-Cal managed care plans that already have NCQA accreditation. DHCS will align all applicable processes in its Medi-Cal managed care plan contract and All Plan Letters with the following six NCQA health plan accreditation categories to correspond with the requirement for accreditation by 2026:
    - Quality Improvement;
    - Population Health Management;
    - Network Management;
    - Utilization Management;
    - Credentialing; and
    - Member Experience.

3.5 Regional Managed Care Capitation Rates

3.5.1 Background

DHCS currently develops, certifies, and implements managed care capitation rates on an annual basis for contracted Medi-Cal managed care plans. DHCS develops distinct rates for each contracted managed care plan by county/region and population group. Due to the complexities of the Medi-Cal managed care program, which includes varied and intricate financing mechanisms, DHCS calculates multiple rating components for each capitation rate for a total of more than 4,000 rating components on an annual basis as of

state fiscal year 2018-19. The excessively large number of rating components DHCS must develop on an annual basis is administratively burdensome and contributes to lengthy annual federal review and approval timeframes. It also limits DHCS' ability to advance value-based and outcomes-focused rate setting methodologies. With the changes contemplated in CalAIM, DHCS views the need for simplified methodologies with a reduced number of components as necessary to achieving our broader goals of improving care delivery, access, quality and outcomes for our Medi-Cal beneficiaries.

3.5.2 Proposal

A regional rate-setting methodology provides a pathway toward simplification of the rate-setting process for the Medi-Cal managed care program. The proposed simplification will afford DHCS the flexibility to continue to pursue strategies that support advancements and innovations within the program.

To ensure a successful transition, DHCS proposes a two-phased approach:

Implement Regional Rates in Targeted Counties (Phase I)

- DHCS would implement Phase I for calendar years 2022 and 2023 (at a minimum) for targeted counties and Medi-Cal managed care plans;
- DHCS would advance new regional rate-setting approaches and streamline rate processes and methodologies;
- DHCS would utilize Phase I as a means of identifying strategies and further improvements that will support a seamless transition to regional rate setting statewide; and
- DHCS would engage and collaborate with contracted Medi-Cal managed care plans and industry associations as part of this process.

Fully Implement Regional Rates Statewide

- DHCS proposes to fully implement regional rates statewide no sooner than calendar year 2024, to align with the end of Phase I; and
- DHCS will consider health care market dynamics, including but not limited to health care cost and utilization data, across counties when determining regional boundaries.

3.5.3 Rationale

The proposed transition to regional rates statewide offers four main benefits:

- Regional rates would reduce the number of distinct rating components that DHCS must develop on an annual basis, and thereby permit DHCS to utilize a more flexible rate structure model. This flexibility is essential to DHCS' ability to pursue

advancements and innovations in the Medi-Cal managed care program, including CalAIM, and to explore new, innovative ideas.

- Regional rates would simplify the presentation of rates to CMS, which may expedite federal review and approval of the Medi-Cal managed care capitation rates. DHCS could implement rate-setting approaches that promote efficiency, including cost-averaging processes, across Medi-Cal managed care plans.
- These approaches would continue to incentivize Medi-Cal managed care plans to operate efficiently as rates will be based upon costs across the multi-county region. In effect, each Medi-Cal managed care plan will be incentivized to compete to be more efficient than other plans in their region.
- Regional rates would provide a larger, multi-county base for averaging, and thereby alleviate some of the criticisms regarding the process currently used by DHCS.

3.5.4 Proposed Timeline

Rate setting is a dynamic process. Therefore, DHCS will proceed methodically, engage and collaborate with Medi-Cal managed care plans, and make future refinements as determined actuarially appropriate.

- **Calendar Year 2020 and 2021:** Develop regional rate-setting methodologies and approaches with appropriate stakeholder input.
- **January 1, 2022:** Implement Phase I for targeted counties and Medi-Cal managed care plans.
- **Calendar Year 2023:** Evaluate and continue to refine the rate-setting process prior to the implementation of regional rates statewide.
- **No sooner than January 1, 2024:** Fully implement regional rates statewide.
- **Post-implementation:** Continue to evaluate and refine the rate-setting process and regions.

Behavioral Health

3.6 Behavioral Health Payment Reform

3.6.1 Background

Through realignment efforts in 1991 and 2011, funding for the majority of the non-federal share of costs associated with the specialty mental health and substance use disorder (SUD) services became the responsibility of the counties. Currently, counties are reimbursed for the federal and state portion of costs for services and administration of these programs via Medicaid Certified Public Expenditure (CPE) methodologies. Under

CPE methodologies, reimbursements to counties are limited to costs incurred by the counties and are subject to a lengthy and labor-intensive cost reconciliation process.

For specialty mental health services, counties pay with non-federal funds at the time of service and when incurring costs to administer the programs. The counties then submit CPEs to DHCS so that the state can draw down eligible federal Medicaid matching funds. In accordance with the CMS-approved CPE protocol, mental health plans receive interim reimbursement of federal financial participation on a fee-for-service basis, pursuant to interim rates approved by the state on an annual basis for approved units of service for allowable procedure codes. The state completes the interim reconciliation of interim Medicaid payments no later than 24 months after the close of each state fiscal year. The final cost reconciliation of mental health plan interim Medicaid payments occurs within 36 months after the certified, reconciled, state-developed cost reports are submitted.

The Drug Medi-Cal portions of the State Plan establishes the interim payment methodology for both Narcotic Treatment Program and non-Narcotic Treatment Program services. Generally, this methodology requires an interim reimbursement at the statewide maximum allowable or uniform statewide daily dosing rate. DHCS also provides an interim reimbursement to counties for costs incurred to administer DMC-ODS or DMC programs. After the fiscal year ends, DHCS performs a settlement with counties for the cost of administering the SUD services (either through DMC State Plan or through DMC-ODS). These cost reconciliations occur years after the close of the state fiscal year to allow time for claims run out as well as for DHCS to complete its cost reconciliation audits.

To incentivize additional investment in the delivery systems and reduce overall burden on counties and the state, DHCS is proposing to reform behavioral health payment methodologies for counties. Under the current CPE methodology, counties are not able to retain revenue when implementing cost-reduction efforts, thereby limiting the ability to fully invest in the delivery system to improve access and quality. These reforms will allow not only for more timely review and final payment, but will enable the county behavioral health system, for the first time, to participate in and design true outcomes and value-based reimbursement structures that reward better overall results and quality of life for Medi-Cal beneficiaries.

3.6.2 Proposal

The state is proposing to reform its behavioral health payment methodologies via a multi-phased approach with the goal of increasing available reimbursement to counties for services provided and to incentivize quality objectives. This proposal would move reimbursement for all inpatient and outpatient specialty mental health and substance use disorder services from CPE-based methodologies to other rate-based/value-based structures that instead utilize intergovernmental transfers to fund the county-supplied non-federal share. DHCS proposes to implement the shift in methodology in two initial phases:

- In order to establish appropriate payment rates, DHCS proposes to transition specialty mental health and SUD services from existing Healthcare Common Procedure Coding System (HCPCS) Level II coding to Level I coding, known as Current Procedural Terminology (CPT) coding, when possible; and
- DHCS will establish reimbursement rates, as well as an ongoing methodology for updating rates, for the updated codes with non-federal share being provided by counties via intergovernmental transfer instead of CPEs, eliminating the need for reconciliation to actual costs.

Transition from HCPCS Level II Coding to CPT Coding

DHCS is proposing to transition from existing HCPCS Level II coding to CPT coding in all cases where a suitable CPT code exists. If a suitable CPT code does not exist, DHCS would identify an appropriate HCPCS Level II code.

For specialty mental health services, DHCS would identify a mix of HCPCS Level II codes and CPT codes for the following service functions: therapy, assessments, treatment planning, rehabilitation, prescribing medication, administering medication, patient education, and crisis intervention. DHCS would establish a rate for each of the HCPCS Level II codes and CPT codes identified within each service function. Counties would receive payment for each service rendered based upon the rate established for the specific HCPCS Level II code or CPT code. Services that currently receive a bundled rate, such as psychiatric inpatient hospital services, adult residential treatment, crisis residential treatment, psychiatric health facility services, crisis stabilization, day treatment, and day rehabilitation, would continue to be reimbursed using a bundled rate.

For SUD services, DHCS would identify a mix of HCPCS Level II codes and CPT codes for the following service functions: assessment, case management, crisis intervention, discharge planning, group counseling, individual counseling, medical psychotherapy, prescribing medication, administering medication, recovery services, and treatment planning. DHCS would establish a rate for each of the HCPCS Level II codes and CPT codes identified within each service function. Counties would receive payment for each service rendered based upon the rate established for the specific HCPCS Level II code or CPT code. Narcotic Treatment Programs would continue to be reimbursed a daily rate for each encounter.

Rate Setting Methodology

For the establishment of reimbursement rates, DHCS is proposing to set rates by peer grouping. Each peer group would be made up of counties with similar costs of doing business to best reflect local needs. Rates would include a service component as well as an administrative component and a utilization management/quality assurance component, which would be percentages on top of the service component. Additionally,

DHCS is proposing to establish a methodology to provide, at a minimum, an annual update to established rates to ensure that reimbursement continues to reflect the cost of providing services, administration, and required utilization management/quality assurance activities.

To start, DHCS is proposing to process intergovernmental transfers and make payments to counties on a monthly basis. Eventually, DHCS plans to transition to quarterly intergovernmental transfers and payments to reduce the administrative burden tied to processing intergovernmental transfers and payments for 58 counties on a monthly basis. The state will discuss with the counties the appropriate time to transition from monthly to quarterly payments.

3.6.3 Rationale

Under CPE-based methodologies, all reimbursement is limited to the actual cost of providing services, which does not allow for value-based arrangements or incentives to reduce costs and share in the savings. The shift from CPE to intergovernmental transfer-based methodologies will allow DHCS, in collaboration with county partners, to:

- Establish rates for reimbursement that are not limited to cost and instead focus on the quality and value of services;
- Provide more flexibility to counties to explore provider reimbursement arrangements that incentivize quality and value;
- Create opportunities for improved coordination of care by simplifying options for contracts and payments between Medi-Cal managed care plans and counties, without limiting financial benefits for the county; and
- Reduce state and county administrative burden and allow counties to close their accounting records closer to the end of a fiscal year by eliminating the lengthy and labor-intensive cost-reconciliation process.

Finally, the shift from HCPCS Level II coding to HCPCS Level I coding will allow for more granular claiming and reporting of services provided, creating the opportunity for more accurate reimbursement to counties/providers. The shift in coding will also allow counties and DHCS to better report performance outcomes and measures. In turn, the increased reporting will provide counties and DHCS with more accurate, useful information on health care quality to inform policy decisions.

3.7.4 Proposed Timeline

Given the need to ensure county readiness for this change in approach, DHCS is looking forward to working with counties and stakeholders to establish the timeline for adoption of the HCPCS Level I. DHCS proposes to work with counties and stakeholders to evaluate county readiness and develop a strategy to support them in making this transition. However, the earliest date the shift would occur would be July 1, 2022.

The transition from cost-based reimbursement to an established rate schedule would take place concurrently with the adoption of the HCPCS Level I coding. DHCS would, initially, establish separate rate schedules for specialty mental health and substance use disorder services, with the goal of aligning rate schedules when these services are administratively integrated into a single behavioral health managed care program. DHCS would begin the intergovernmental transfer-based reimbursement at the start of a state-county fiscal year to ease the transition.

3.7 Medical Necessity Criteria

3.7.1 Background

Current medical necessity criteria for specialty mental health services are outdated and confusing and can lead to challenges for beneficiaries in accessing appropriate care. Current diagnosis requirements can prevent beneficiaries from receiving urgently needed care, especially for children, who are entitled to care before developing a mental health condition, or for people with a co-occurring substance use disorder whose diagnosis may not be immediately clear. DHCS requirements for provider documentation are confusing and may lead to provider burden and risk of payment disallowance during audits.

Currently, DHCS does not standardize screening practices to determine where a beneficiary should initially seek mental health care. As a result, counties and plans have a variety of approaches to determine where beneficiaries should initially access care, whether with county Mental Health Plans (for specialty mental health services) or with Medi-Cal Managed Care or Fee for Service delivery systems (for beneficiaries not meeting criteria for specialty mental health services). DHCS does not currently standardize how beneficiaries transition across these delivery systems when their status changes, leading to inconsistent practices. In addition, the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) protection for beneficiaries under age 21 is inconsistently interpreted and leads to confusion and variation in practice.

3.7.2 Proposal

With the CalAIM initiative, DHCS aims to design a coherent plan to address beneficiaries' needs across the continuum of care, ensure that all Medi-Cal beneficiaries receive coordinated services, and improve health outcomes. The goal is to ensure beneficiary access to the right care in the right place at the right time.

In CalAIM, DHCS proposes to update and clarify medical necessity criteria for specialty mental health services for both adults and children, including allowing reimbursement of treatment before diagnosis and clarifying that treatment in the presence of a co-occurring SUD is appropriate and reimbursable when medical necessity is met.

DHCS proposes to clarify EPSDT protections for beneficiaries under age 21, and create criteria for children to access specialty mental health services based on experience of trauma and risk of developing future mental health conditions, such as involvement in child welfare or experience of homelessness.

DHCS proposes to develop a standardized screening tool to facilitate accurate determinations of when care would be better delivered in the specialty mental health delivery system or in the Medi-Cal managed are or fee for service system. In addition, DHCS proposes to develop a standardized transition tool, for when a beneficiary's condition changes, and they would be better served in the other delivery system.

DHCS proposes to implement a "no wrong door" policy to ensure beneficiaries receive medically necessary treatment regardless of the delivery system where they seek care. This policy would allow beneficiaries who directly access a treatment provider to receive an assessment and mental health services, and to have that provider reimbursed for those services, even if the beneficiary is ultimately transferred to the other delivery system due to their level of impairment and mental health needs. In certain situations, beneficiaries may receive non-duplicative services in multiple delivery systems, such as when a beneficiary has an ongoing therapeutic relationship with a therapist or psychiatrist in one delivery system while requiring medically necessary services in the other.

DHCS also proposes to simplify and streamline mental health documentation requirements, to align with medical provider requirements, improve efficiency, and decrease provider burnout.

With respect to inpatient specialty mental health services, DHCS proposes to update the criteria for psychiatric inpatient medical necessity currently provided in Title 9 of the California Code of Regulations. To facilitate improved communication between mental health plans and hospitals, and to decrease variation in clinical documentation requests across counties, DHCS will develop, in consultation with hospital and county stakeholders, documentation standards and concurrent review protocols to allow efficient and streamlined communication of clinical information during concurrent review.

Division of Services Between Mental Health Plans and Medi-Cal Managed Care Plans

To ensure beneficiaries with behavioral health needs are guided to the most appropriate delivery system to address their needs, DHCS is proposing to update its medical necessity criteria and processes, which would be organized as described below:

California provides Medi-Cal mental health services through Managed Care Plans, Fee for Service (FFS), and county mental health plans. The delivery system responsible to provide the mental health service depends on the degree of a beneficiary's impairment from the mental health condition and other criteria described below. Beneficiaries may receive mental health services prior to diagnosis in any of these delivery systems under certain conditions, even if ultimately the beneficiary is determined not to have a mental disorder. Beneficiaries may initiate medically necessary mental health services in one delivery system and receive ongoing services in another system. Beneficiaries whose degree of impairment changes may transition between the delivery systems, or under some circumstances may receive medically necessary mental health services in more than one delivery system. Care shall be coordinated between the delivery systems and services shall not be duplicated.

Medi-Cal Managed Care Plan responsibilities:

The following nonspecialty mental health services are covered by managed care plans:

a) Individual and group mental health evaluation and treatment (including psychotherapy and family therapy);
b) Psychological testing, when clinically indicated to evaluate a mental health condition;
c) Outpatient services for the purposes of monitoring drug therapy;
d) Psychiatric consultation; and,
e) Outpatient laboratory, drugs, supplies and supplements (note: the pharmacy benefit will be carved out of managed care plans contracts and transitioned to fee for service delivery under Medi-Cal Rx as of 4/1/2021).

Medi-Cal managed care plans are responsible to provide the above nonspecialty mental health services to adult beneficiaries with mild to moderate distress or mild to moderate impairment of mental, emotional or behavioral functioning resulting from mental health disorders, as defined by the current Diagnostic and Statistical Manual of Mental Disorders. Managed care plans are also required to provide non-specialty mental health services to children under the age of 21. Managed care plans are also responsible to provide mental health services to beneficiaries with potential mental health disorders

These services are also available in the FFS mental health delivery system for beneficiaries not enrolled in Medi-Cal managed care.

County Mental Health Plan responsibilities:

For beneficiaries 21 years and over, Mental health plans are responsible to provide specialty mental health services for beneficiaries who meet (A) and (B) below:

(A): The beneficiary must have one of the following:

(i) Significant impairment ("impairment" is defined as distress, disability or dysfunction in social, occupational, or other important activities), OR
(ii) A reasonable probability of significant deterioration in an important area of life functioning.

(B): The beneficiary's condition in (A) is due to:

(i) A diagnosed mental health disorder (according to the current Diagnostic and Statistical Manual of Mental Disorders and International Statistical Classification of Diseases and Related Health Problems criteria), OR

(ii) A suspected mental disorder that has not yet been diagnosed.

For beneficiaries under age 21[1],
Mental health plans are responsible to provide specialty mental health services to beneficiaries who meet either Criteria 1 **or** Criteria 2:

Criteria 1: The beneficiary is at high risk for a future mental health disorder due to experience of trauma, evidenced by: scoring in the high-risk range on a DHCS-approved trauma screening tool, or involvement in the child welfare system, or experience of homelessness.

Criteria 2: The beneficiary must meet both (A) and (B), below:

(A): The beneficiary must have at least one of the following:

I. Significant impairment, or
II. A reasonable probability of significant deterioration in an important area of life functioning, or
III. iii. A reasonable probability a child will not progress developmentally as appropriate, or
IV. Less than significant impairment, but requires mental health services that are not included within the mental health benefits that managed care plans are required to provide.

(B): The beneficiary's condition in (A) is due to:
I. A diagnosed mental health disorder (according to the current Diagnostic and Statistical Manual of Mental Disorders and International Statistical Classification of Diseases and Related Health Problems criteria), or
II. A suspected mental disorder that has not yet been diagnosed.

Mental health plans provide the following specialty mental health services

1. Crisis Residential Treatment Services
2. Adult Residential Treatment Services
3. Crisis Interventions
4. Crisis Stabilization
5. Day Rehabilitation
6. Day Treatment Intensive
7. Medication Support Services
8. Psychiatric Health Facility Services

[1] The Early and Periodic Screening, Prevention and Treatment protection entitles beneficiaries under age 21 to services necessary to correct or ameliorate a mental illness and condition recommended by a qualified provider operating within his or her scope of practice, whether or not the service is in the state plan.

9. Psychiatric Inpatient Hospital Services
10. Targeted Case Management/Intensive Care Coordination
11. Mental Health Services and Intensive Home-Based Services (including the following service interventions: Assessment, Plan Development, Therapy, Rehabilitation, and Collateral)
12. Therapeutic Behavioral Services
13. Therapeutic Foster Care Services

Substance Use Disorder Services

As with the current SMHS medical necessity criteria, the current Section 1115 waiver for SUD services requires beneficiaries to be diagnosed with a SUD to meet criteria for reimbursement, preventing the provision of treatment services prior to a definitive diagnosis.

As for mental health, DHCS proposes that substance use disorder treatment services may be provided and reimbursed prior to the determination of a diagnosis, including providing services to beneficiaries with co-occurring mental health disorders.

In addition, DHCS heard many comments from stakeholders about how to improve the Drug Medi-Cal Organized Delivery System, which are reflected in the "DMC-ODS Program Renewal and Policy Improvements" section of this proposal.

Documentation Requirements for Specialty Mental Health and Substance Use Disorder Services

Documentation requirements for SUD and SMHS are currently stringent. Stakeholders report that concern about disallowances result in providers spending an excessive amount of time "treating the chart instead of treating the patient." With the goal of aligning standards across physical and behavioral health programs, DHCS is proposing to update documentation requirements for specialty mental health and substance use disorder treatment to simplify and streamline requirements. For example, DHCS proposes to eliminate the requirement for a point-in-time treatment plan signed by the client, with progress notes tying to the treatment plan. Evidence does not show that shared decision-making is achieved through signature requirements, and the requirement that every note and every intervention must tie to a treatment plan is inefficient and inconsistent with documentation requirements in the medical (physical health) system. DHCS proposes to align behavioral health and medical documentation requirements in Medi-Cal by requiring problem lists and progress notes to reflect the care given and to align with the appropriate billing codes. DHCS also proposes to revise the clinical auditing protocol, to use disallowances when there is evidence of fraud, waste, and abuse, and to use quality improvement methodologies (such as oversight from the External Quality Review Organization) for minor clinical documentation concerns. These documentation changes will align with behavioral health payment reform, as the use of Level 1 HCPCS codes comes with national documentation standards and expectations.

Technical Corrections

DHCS proposes to make other technical corrections to address outdated references to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV), rather than the more current DSM-V, and reflect federal diagnostic coding requirements related to use of International Classification of Diseases (ICD) code sets.

3.7.3 Rationale

Updates to medical necessity criteria for specialty mental health and SUD services, and related policy proposals, are required to achieve more up-to-date clinical practices and better clarity for oversight.

3.7.4 Proposed Timeline

DHCS recommends making changes to the specialty mental health and substance use disorder medical necessity criteria and related processes, as applicable, effective January 1, 2022 with the approval of the Section 1115 and 1915(b) waivers.

3.8 Administrative Integration of Specialty Mental Health and Substance Use Disorder Services

3.8.1 Background

California's mental health plans operate under the authority of a Section 1915(b) waiver, while DMC-ODS plans operate under the authority of a Section 1115 demonstration, and Drug Medi-Cal fee-for-service programs are authorized through California's Medicaid State Plan.

For mental health plans and DMC-ODS plans, DHCS contracts with counties to act as prepaid inpatient health plans to provide, or arrange for the provision of, specialty mental health services and DMC-ODS treatment services to beneficiaries. While the specialty mental health services program is a statewide benefit, the DMC-ODS managed care program is only covered in counties that have "opted-in" and are approved to participate by DHCS and CMS.

Fifty-six mental health plans administer the SMHS program, including two joint arrangements in Sutter/Yuba and Placer/Sierra. For SUD services, 37 counties administer the DMC-ODS program, covering more than 90 percent of the Medi-Cal population. Seven of these counties contract with a local Medi-Cal managed care plan to provide an alternative regional model for DMC-ODS. The remaining 21 counties provide SUD treatment services through Drug Medi-Cal.

Medi-Cal specialty mental health and SUD treatment services are currently administered through separate, unique structures at the county level. Beneficiaries with co-occurring mental health and SUD treatment needs must navigate multiple systems to access care.

Beneficiaries must review multiple handbooks and provider directories, navigate separate intake and assessment processes, and often travel to multiple locations to receive care. Counties and providers face challenging documentation and coding requirements, especially for beneficiaries with both SUDs and mental health conditions.

At the system level, counties must demonstrate compliance with two sets of requirements and are subject to multiple reviews. For DMC-ODS counties, administering two distinct prepaid inpatient health plans must demonstrate compliance with federal managed care requirements twice, essentially running two almost entirely separate managed care programs with duplicative processes for quality improvement and performance measurement, beneficiary appeals, and program integrity.

3.8.2 Proposal

DHCS is proposing administrative integration of specialty mental health and SUD services into one behavioral health managed care program. This proposal is distinct from the Full Integration Plan which will integrate physical, behavioral and oral health care into comprehensive managed care plans. The goal is to improve outcomes for beneficiaries through coordinated treatment across the continuum of care. An additional goal and benefit would be to reduce administrative and fiscal burdens for counties, providers, and the state.

For counties participating in DMC-ODS managed care, DHCS is interested in working toward integrating the two behavioral health programs/prepaid inpatient health plans into a single behavioral health plan structure. The result would be a single prepaid inpatient health structure in each county or region responsible for providing, or arranging for the provision of, specialty mental health and SUD treatment services for all Medi-Cal beneficiaries in that county or region. Participating counties would benefit from streamlined state requirements and the elimination of redundancy. Consolidating operations and resources into one behavioral health managed care plan would allow counties to successfully meet state and federal requirements and significantly decrease their administrative burden.

Additionally, Drug Medi-Cal fee-for-service counties will also be able to integrate such services; however, slight variations may apply due to the differences of federal requirements for fee-for-service verses prepaid inpatient health plans.

Clinical Integration

1. Access Line

Counties are required to have a 24-hour access line for mental health plans and for DMC-ODS. Some Drug Medi-Cal counties may also have 24-hour access lines, although it is not a requirement. Many counties already use their access lines in an integrated manner to triage, screen, and refer beneficiaries for both specialty mental

health and SUD treatment services; however, some counties maintain separate lines. Under an integrated model, the goal would be for all counties to have an integrated, 24-hour access line for beneficiaries seeking either specialty mental health and/or SUD services.

2. Intake/Screening/ Referrals

Processes for intake, screening, and referral vary by county. Optimally, counties would have standardized and streamlined intake processes that are timely, emphasize a positive beneficiary experience, and use a "no wrong door" approach to help beneficiaries access mental health and substance use disorder services. While assessments are performed by clinicians and tailored to the needs of the client, and may vary based on setting, DHCS proposes to move forward with a standardized statewide screening tool for beneficiaries 21 and over, and one for beneficiaries under 21, to ensure beneficiaries receive prompt care in the right delivery system.

3. Assessment

Assessment processes and tools for specialty mental health and SUD services also vary by county. For example, the American Society of Addiction Medicine placement tool is used to make level of care determinations DMC-ODS. However, an assessment tool is not required in Drug Medi-Cal counties. For SMHS, the Child and Adolescent Needs and Strengths tool is required for children and youth; however, there is not a required tool for adults. More research will be needed to determine which aspects, authorities, or requirements need to be addressed to integrate clinical assessments for mental health and SUDs.

4. Treatment Planning

Currently, treatment planning for specialty mental health and SUD treatment services is conducted separately and is not integrated. Beneficiaries receiving both types of services can have multiple treatment plans that include different documentation requirements. To improve efficiency, counties would integrate treatment planning for both specialty mental health and substance use disorder services with simplified and aligned documentation requirements. The goal would be to develop a new, simplified, more client-centered and strength-based approach to behavioral health treatment planning and to align treatment planning and documentation standards with physical health care. Additionally, DHCS will provide counties with relevant Medi-Cal services data, which may include managed care encounter and pharmacy claims data, to allow for better coordination of care and treatment planning.

5. Beneficiary Informing Materials

Currently, beneficiaries who receive services through mental health plans and DMC-ODS receive two beneficiary handbooks. The handbooks are not the same, but both

address elements that are required by federal managed care regulations, such as language regarding the grievance, appeals and state fair hearing processes. The goal is to consolidate beneficiary information materials to streamline them into one user-friendly handbook, reduce confusion, increase access, and achieve administrative efficiencies.

Consideration would need to be given to implementing this element in Drug Medi-Cal counties, since they are not currently required to have a beneficiary handbook.

Administrative Integration

1. Contracts

Currently, there are three separate contract types between DHCS and counties: mental health plans, DMC-ODS and Drug Medi-Cal counties. Under an integrated system, the goal would be to have only one contract in every county that would cover both all Medi-Cal specialty mental health and SUD treatment services.

2. Data Sharing / Privacy Concerns

Counties are responsible for managing data-sharing at two levels: within and across county plans, and at the provider level. Data sharing and privacy concerns need to be explored to determine what areas can be addressed, since there are different considerations and regulations pertaining to data sharing for SMHS and SUD services. Addressing these concerns will be critical in determining whether and when counties can integrate assessments, treatment plans, and electronic health records, among other processes. A thorough assessment of the various barriers and solutions to stringent patient privacy protections will be required. There will need to be a thorough assessment by the state and counties to identify the various barriers and solutions to stringent patient privacy protections built into federal regulations.

3. Electronic Health Record Integration and Re-Design

Many counties currently operate separate electronic health records (EHRs) or maintain differently configured and separate records for specialty mental health and substance use disorder services. This is largely in response to federal regulations, but also due to historical bifurcation of the two programs and different documentation and data-reporting requirements for the specialty mental health and substance use disorder programs. Timelines for integrating different components of administrative integration will depend on counties' ability to arrive at a record design that is compliant and then collaborate with their vendors to make multiple, timely modifications to their electronic health records.

4. Cultural Competence Plans

Mental health plans are required to have a plan for culturally responsive care for specialty mental health services. DMC-ODS plans are also required to have a culturally responsive care plan. Under an integrated system, counties would have only one integrated plan for culturally responsive care instead of two, separate plans.

Considerations would need to be given to how this element would be implemented in Drug Medi-Cal counties since they are currently not subject to these same requirements.

Integration of DHCS Oversight Functions

1. Quality Improvement

Some counties have integrated quality improvement and performance measurement programs for specialty mental health and substance use disorder services. However, most programs – or components of them – are still separate. Under an integrated system, counties would develop and operationalize a consolidated quality improvement plan, have a single quality improvement committee, and develop a comprehensive list of performance measures for specialty mental health services and substance use disorder services.

2. External Quality Review Organizations

Pursuant to federal Medicaid managed care requirements, an external quality review is required for both mental health plans and DMC-ODS. Currently, Behavioral Health Concepts is the contractor that acts as the External Quality Review Organization for both programs. However, there are separate contracts, review processes, timelines, and protocols. In addition, counties must develop separate performance improvement plans for each program. The goal is to implement a combined external quality review process, which would result in one external review and integrated performance improvement plans, and ultimately having one single External Quality Review Organization (EQRO) report for each county. Since an external quality review is not required for Drug Medi-Cal counties, further exploration will be needed to determine the extent to which these elements would play a role under an integrated model.

3. Compliance Reviews

Current compliance reviews conducted by DHCS for mental health plans, DMC-ODS, and Drug Medi-Cal counties are separate. Under an integrated model, the goal would be to consolidate compliance reviews into a single review with an integrated protocol. A particular focus of this effort will be on streamlining documentation requirements for behavioral health providers to allow integrated behavioral health care.

4. Network Adequacy

Network adequacy certification processes are separate for specialty mental health plans and DMC-ODS. Under an integrated model, DHCS would certify one network for specialty mental health and substance use disorder managed care services for each county, instead of certifying two networks as currently required.

5. Licensing & Certification

Existing requirements and processes for licensing and certification are different and separate for specialty mental health and substance use disorder providers. The goal is to streamline licensing and certification requirements, processes, and timeframes across the behavioral health managed care system, where appropriate. Successful implementation of integrated care models would also necessitate a discussion on non-administrative changes that may be needed, such as workforce development, cross-training of existing providers, and adoption of new evidence-based practices.

3.8.3 Rationale

About half of individuals with a SMI have a co-occurring substance use and those individuals benefit from integrated treatment. Since the state provides Medi-Cal-covered substance use disorder and specialty mental health services through two separate county-operated delivery systems, it is difficult for counties to provide integrated treatment to individuals who have co-occurring disorders. For example, counties with both DMC-ODS and mental health plans are subject to two separate annual quality assessments, two separate post-payment chart audits, and two separate reimbursement and cost reporting methods. The purpose of this proposal is to make changes to streamline the administrative functions for SUD and SMHS.

3.8.4 Proposed Timeline

The goal would be to submit for a single, integrated behavioral health plan in each county or region responsible for providing, or arranging for the provision of, specialty mental health and SUD services under the next 1915(b) waiver in 2027. Both state-level and county-level activities will be required to achieve this goal. Successful implementation will require careful sequencing and planning and a phased-in approach where cohorts are considered.

3.9 Behavioral Health Regional Contracting

3.9.1 Background

State law allows two or more counties acting jointly to deliver or subcontract for the delivery of specialty mental health services. Furthermore, participating DMC-ODS counties are permitted to develop regional delivery systems for required modalities or to act jointly to deliver covered services, with approval from DHCS and CMS, as applicable.

3.9.2 Proposal

DHCS encourages counties to develop regional approaches to administer and deliver specialty mental health and substance use disorder services to Medi-Cal beneficiaries. There are a variety of options available to counties, including a Joint Powers Authority to operate such services for a multi-county region (e.g., Sutter/Yuba). Counties could also pool resources to contract with an administrative services organization/third-party administrator or other entity, such as the County Medical Services Program or the local Medi-Cal managed care plan, to create administrative efficiencies across multiple counties.

Small counties, rural/frontier counties, and counties with shared population centers or complementary resources should consider opportunities for regional partnership. DHCS is interested in discussing how counties not currently seeking DMC-ODS participation may be more interested in doing so through a regional approach and/or how services provided under Drug Medi-Cal might also be provided through a regional approach. DHCS is committed to working with counties to offer technical assistance to help develop regional contracts and establish innovative partnerships.

3.9.3 Rationale

Acting jointly through regional contracts would allow counties to pool their resources, which can improve access and availability of services for Medi-Cal beneficiaries in their region and allow for increased county administrative efficiencies. Although regional contracting is currently allowed under state law, only a few counties have taken advantage of this opportunity. Regional contracting would give counties opportunities to share workforce and jointly invest in administrative infrastructure such as electron health records, billing and claiming systems, and oversight/quality assurance and improvement.

Regional contracts offer numerous potential advantages. For example, network adequacy certification requires significant administrative infrastructure to develop and maintain policies and procedures for tracking network resources, and counties must identify and contract with additional qualified providers when network gaps are identified. Both functions (tracking and finding new providers) can prove challenging in some counties that may have fewer local providers. Through regional contracts, counties could reduce duplication and standardize administrative processes, such as beneficiary handbooks, provider directories, and grievance and appeal processes.

For Drug Medi-Cal counties, regionalization could potentially enable smaller counties to participate in DMC-ODS, providing a broader set of services to their residents when it would not be otherwise feasible. By participating in DMC-ODS, these counties could then create a single, integrated behavioral health plan, as described in the CalAIM Administrative Integration of Specialty Mental Health and Substance Use Disorder Services proposal.

In addition, Medi-Cal managed care plans, mental health plans, and DMC-ODS plans must meet the full array of state and federal requirements applicable to prepaid inpatient health plans under the federal Medicaid managed care regulations. Among these are network adequacy, quality assessment and performance improvement, beneficiary rights and protections, and program integrity. For individual counties, entering into regional contracting agreements would reduce the administrative burden of meeting Medicaid managed care requirements. Counties could better utilize resources to focus on improving access, quality of care, and beneficiary outcomes, while mitigating the risk of audit exceptions and administrative and financial sanctions.

3.9.4 Proposed Timeline

DHCS seeks input from county partners and other stakeholders regarding an estimated timeframe for establishing regional contracting agreements.

3.10 Drug Medi-Cal Organized Delivery System Renewal and Policy Improvements

3.10.1 Background

One of the key goals of the Drug Medi-Cal Organized Delivery System (DMC-ODS) was to treat more people more effectively by reorganizing the delivery system for substance use disorder (SUD) treatment through Medi-Cal. California's Drug Medi-Cal Organized Delivery System (DMC-ODS) was the nation's first SUD treatment demonstration project under Section 1115, approved by CMS in 2015. Since then, more than 20 other states have received approval for similar substance use disorder treatment demonstrations. The program has established a continuum of care modeled after the American Society for Addiction Medicine (ASAM) criteria. These criteria are the most widely used and comprehensive set of guidelines for placement, continued stay, and transfer/discharge of patients with addiction.

The benefits under the DMC-ODS, which counties administer as pre-paid inpatient health plans (PIHPs), include all of the standard SUD treatment services covered in California's Medicaid State Plan (outpatient, intensive outpatient, perinatal residential, narcotic treatment programs and naltrexone), plus case management, multiple ASAM levels of residential substance use disorder treatment, withdrawal management services, recovery services, physician consultation and if the county chooses, additional medication assisted treatment, and partial hospitalization.

Also included in the current program is the expenditure authority to allow federal Medicaid reimbursement for short-term residential SUD treatment stays in an Institution for Mental Disease (IMD). The IMD exclusion has historically prohibited federal reimbursement for residential and inpatient mental health and SUD treatment for Medicaid enrollees age 21-64, in facilities with more than 16 beds. This exclusion deterred most providers in the State who found it financially unviable to operate facilities with so few beds. Allowing for reimbursement of residential SUD treatment services through the Medi-Cal program, with

no limitation on the number of beds, means that counties can receive federal matching funds for services that were previously unavailable.

Currently, DMC-ODS is not a statewide benefit since the program operates only in counties that "opt in" to participate and are approved to do so by both DHCS and CMS. There are currently 37 counties participating in the DMC-ODS demonstration, providing access to SUD treatment services for 96 percent of the Medi-Cal population. Seven of these counties are working with a local managed care organization to implement a regional model. Medi-Cal beneficiaries in the 21 counties not participating in the program provide their SUD treatment services through fee-for-service as authorized through the Drug Medi-Cal State Plan. The fee-for-service benefit is more limited than the DMC-ODS benefit in terms of covered services and that it is not a managed care program.

3.10.2 Proposal

DHCS proposes to update and improve the DMC-ODS, based on experience from the first several years of implementation. Accordingly, DHCS proposes to clarify or change policies to support the goal of improved beneficiary care and administrative efficiency.

DHCS aims to design a cohesive plan to address beneficiaries' SUD treatment needs across the continuum of care, ensure that all Medi-Cal beneficiaries receive coordinated services, and to promote long-term recovery. This requires developing new approaches to care delivery and system administration that will improve the beneficiary experience, increase efficiency, ensure cost-effectiveness, and achieve positive health outcomes.

The 37 counties that have implemented the DMC-ODS have made tremendous strides in improving the continuum of care for Medi-Cal beneficiaries with SUD treatment needs. Implementation across 37 California counties has also yielded lessons learned and opportunities to clarify or change policies to support the goal of improved beneficiary care and administrative efficiency. DHCS also acknowledges that for many counties, the DMC-ODS model of care is still very new since implementation was phased in over several years.

Accordingly, DHCS solicited input from stakeholders on the following proposed policy clarifications and changes, which have been thoughtfully constructed to balance system improvements while minimizing disruptions at the local level.

DHCS also intends to provide counties with another opportunity to opt-in to participate in the DMC-ODS in hopes of promoting DMC-ODS participation across the state. While participation in DMC-ODS will not be mandatory for counties, DHCS would like to work with counties not currently participating in the DMC-ODS to explore ways to encourage the remaining counties to opt-in.

Residential Treatment Length-of-Stay Requirements

Currently, within a 365-day period, adult residential SUD treatment services may be authorized for two non-continuous stays, for up to 90 days for each stay, with one 30-day extension permitted for one of the stays. Similarly, within a 365-day period, adolescent residential treatment services may be authorized for two non-continuous stays; however, stays for adolescents are limited to 30 days each stay, with one up to 30-day extension allowed for one of the stays.

Residential length-of-stay should be determined based on the individual's condition, medical necessity, and treatment needs. Given that the two-episode limit is inconsistent with the clinical understanding of relapse and recovery from SUDs, DHCS proposed in the 12-month extension request to remove this limitation and base treatment on medical necessity.[2] DHCS will further propose that there be no distinction between adults and adolescents for these particular requirements.

Note: DHCS must obtain approval from CMS regarding all components of the Section 1115 extension and renewal. CMS is currently only approving SUD 1115 demonstrations with a residential benefit average length-of-stay of 30 days. While some states may show average lengths of stay that are close to the 30-day target, these are likely to include numerous treatment episodes that may have terminated prematurely, before the client achieved positive clinical outcomes. Including these shorter stays in the calculation may lower the average and give the impression that shorter lengths of stay are universally feasible and appropriate.

As such, DHCS will examine the possibility of tracking and documenting the average length-of-stay for only those DMC-ODS enrollees that achieve positive treatment outcomes. Furthermore, with the substantial rise in methamphetamine usage and overdose deaths in California, DHCS will work closely with CMS to negotiate a residential treatment benefit that accounts for the increased clinical needs of individuals utilizing stimulants.

[2] Proposed changes to the DMC-ODS program included in the Medi-Cal 2020 12-month extension request: 1) Remove the limitation on the number of residential treatment episodes that can be reimbursed in a one-year period, 2) Clarify that reimbursement is available for SUD assessment and appropriate treatment even before a definitive diagnosis, 3) Clarify that recovery services benefit, 4) Expand access to MAT, and 5) Increase access to SUD treatment for American Indians and Alaska Natives.

Residential Treatment Definition

The current definition of residential treatment in California does not clearly define the amount, duration, and scope of covered services, and there are different treatment standards and limitations for adults and adolescents.

DHCS proposes that the definition of residential treatment be updated to remove the adolescent length-of-stay limitations, and to add mandatory provisions for referral to medication assisted treatment. DHCS would also propose to remove the distinction between adults and adolescents for these requirements, with the exception of Early and Periodic Screening, Diagnostic, and Treatment services.

Recovery Services

As part of Dimension 6 (Recovery Environment) of the ASAM criteria, during the transfer/transition planning process, beneficiaries shall be linked to applicable recovery services. Beneficiaries may access recovery services after completing their course of treatment whether they are triggered, have relapsed, or as a preventive measure to avoid relapse.

DHCS proposed in the 12-month extension to clarify the following policies related to recovery services:

- Specify the services included in the benefit (e.g., group, education sessions, and assessment);
- Establish when and how beneficiaries may access these services, including language to encourage the use of recovery services for justice-involved individuals: and
- Define the term “after completing their course of treatment,” to not inadvertently prohibit beneficiaries receiving long-term medication assisted treatment from having access to recovery services.

If these proposed changes are not ultimately approved in the 12-month extension, they will be included in the demonstration renewal request that DHCS will submit in 2021, for a five year renewal from January 1, 2022-December 31, 2026.

Additional Medication Assisted Treatment

Counties are required to cover opioid treatment program services, also called Narcotic Treatment Programs. Currently counties may elect to cover additional medication assisted treatment, which includes the ordering, prescribing, administering, and monitoring of all medications for SUD treatment.

DHCS proposed in the 12-month extension request to keep the additional medication assisted treatment (MAT) services as an optional benefit but clarified the coverage provisions to require that all substance use disorder managed care providers demonstrate that they either directly offer, or have referral mechanisms to medication assisted treatment. The goal is to have a county-wide multi-delivery system of coverage.

Clinician Consultation Services

Currently, physician consultation services cover time spent by the DMC-ODS physicians consulting with addiction medicine physicians, addiction psychiatrists, or clinical pharmacists. The name of the benefit will change to Clinician Consultation Services and be expanded to include consultation services for, and by, licensed clinicians including Nurse Practitioners and Physician Assistants. Coverage of consultation services is designed to help clinicians seek expert advice on designing treatment plans for beneficiaries. Clinician consultation services can only be billed and reimbursed by providers in DMC-ODS provider sites.

DHCS proposes to clarify the terms of clinician consultation, particularly with regard to how and who can claim this activity. DHCS proposes to remove the limitation that clinician consultation services can only be billed by certified Drug Medi-Cal providers. Counties may contract with SUD clinicians not certified by Drug Medi-Cal. DHCS' telehealth policy will be used to guide this effort.

Evidence-Based Practice Requirements

Currently, providers are required to implement at least two of the following evidence-based treatment practices based on a timeline established in the county implementation plan: Motivational Interviewing, Cognitive Behavioral Therapy, Relapse Prevention, Trauma-Informed Treatment, and Psycho Education. The two evidence-based practices are a per-provider per-service modality.

DHCS proposes to retain the five (5) current evidence-based practices and add Contingency Management to the renewal proposal. Providers are not limited to providing only the six evidence-based practices.

DHCS Provider Appeals Process

Following a county's protest procedure, a provider may currently appeal to DHCS if it believes that the county erroneously rejected the provider's solicitation for a contract.

DHCS proposes removing this process from as it is convoluted, has rarely been used, and it is already addressed by the network adequacy requirements. All providers have a right to appeal under the federal 438 requirements.

Tribal Services

DHCS proposed in the 12-month extension to take several actions to increase access to SUD treatment for American Indians and Alaska Natives, including:

- Providing an allowance for specific cultural practices for Tribal 638 and Urban clinics, reimbursement, and definitions of scope of practice for the workforce of traditional healers and natural helpers, and culturally specific evidence-based practices.

- Requiring Indian health care providers to use at least two evidence-based practices as defined in the DMC-ODS and/or from a list developed by DHCS in consultation with Tribal and Urban partners.

These changes are requested to ensure American Indians and Alaska Natives have access to culturally appropriate and evidence-based substance use disorder treatment.

Treatment after Incarceration

The current language requiring the ASAM criteria, may be underestimating the level of care necessary to serve individuals being released from incarceration, since their substance use was either not possible during incarceration or because individuals under parole/probation supervision are likely hesitant to admit to substance use.

Because inmates are at a high risk of relapse and overdose upon release from incarceration, whether or not there was active use in the last 12 months, DHCS plans to clarify access language for individuals leaving incarceration who have a known substance use disorder.

Billing for Services Prior to Diagnosis

Currently, counties may not begin billing for SUD services until a beneficiary has been diagnosed (i.e., counties may not bill for time spent conducting substance use disorder assessments). Since it takes time for clinicians to evaluate a beneficiary for a substance use disorder, and sometimes presenting symptoms are due to a combination of mental illness, substance use disorder, or both, DHCS proposed in the Medi-Cal 2020 extension to clarify the waiver Special Terms and Conditions to allow reimbursement for SUD assessments (even if it takes multiple visits) before a final diagnosis is determined, which aligns with requirements around assessments for specialty mental health services.

Medical Necessity for Narcotic Treatment Programs (NTPs)

DHCS proposes to update and align the STCs with best practices to allow a physician's history and physical to determine medical necessity for NTP services as required by

federal licensing laws. In addition, DHCS would clarify requirements for the initial assessment and medical necessity determinations in other settings.

Early Intervention (Level 0.5)

DHCS proposes to add ASAM 0.5 level of care for beneficiaries under 21, to allow early intervention as an organized service that may be delivered in a wide variety of settings. This service is designed to explore and address problems or risk factors related to substance use, and to help the individual recognize the harmful consequences of high-risk substance use. This includes engagement activities (including screening, assessment, brief interventions such as motivational interviewing and counseling) for beneficiaries at high-risk for developing substance-related or addictive behavior problems, or those for whom there is not yet sufficient information to document a substance use disorder.

3.10.3 Proposed Timeline

The following changes would go into effect on January 1, 2021, subject to federal approval of the Medi-Cal 2020 12-month extension request:

- Remove the limitation on the number of residential treatment episodes that can be reimbursed in a one-year period
- Clarify that reimbursement is available for SUD assessment and appropriate treatment even before a definitive diagnosis
- Clarify that recovery services benefit
- Expand access to MAT
- Increase access to SUD treatment for American Indians and Alaska Natives.

The remaining changes outlined above would go into effect January 1, 2022, subject to federal approval.

Dental

3.11 New Dental Benefits and Pay for Performance

3.11.1 Background

DHCS is committed to improving the accessibility of Medi-Cal dental services and improving oral health outcomes for Medi-Cal members. To demonstrate that commitment, three initiatives and policy changes have been implemented in recent years:

- The Dental Transformation Initiative under the current Medi-Cal 2020 Section 1115 demonstration;
- Proposition 56 supplemental provider payments; and

- Restoration of the optional adult dental benefit under Medi-Cal.

These efforts have been successful in increasing preventive dental service utilization for children, as well as increasing adult utilization of dental care. While two of the initiatives share a common theme – financial incentives for positive outcomes – they are time-limited. DHCS has included a chart (see **Appendix H: Dental in Proposition 56 vs. CalAIM**) that reflects the dental codes with financial incentives available under CalAIM and Proposition 56.

3.11.2 Proposal

The Department set a goal to achieve at least a 60 percent dental utilization rate for Medi-Cal eligible children. In order to progress toward achieving that goal and based on lessons learned from the Dental Transformation Initiative, DHCS proposes the following reforms for Medi-Cal dental be made statewide provide better care and align with national dental care standards. The proposed new benefits include:

- Caries Risk Assessment Bundle for young children; and
- Silver Diamine Fluoride for young children; and specified high-risk and institutional populations; and
- Expanded pay-for-performance initiatives that a) reward increasing the use of preventive services and b) reward establishing/maintaining continuity of care through a dental home. These expanded initiatives would be available statewide for children and adult enrollees.

These expanded initiatives would be available statewide for children and adult enrollees.

New Dental Benefits

DHCS proposes adding coverage of a Caries Risk Assessment Bundle for children ages 0 to 6 years. The Caries Risk Assessment bundle would include nutritional counseling (D1310) to educate and influence behavior change. Based on risk level associated with each individual Medi-Cal beneficiary ages 0 to 6, the benefit would allow the following frequency of services:

- Low – comprehensive preventive services 2x/year (D0601)
- Moderate – comprehensive preventive services 3x/year (D0602)
- High – comprehensive preventive services 4x/year (D0603)

Additionally, DHCS proposes to add coverage of Silver Diamine Fluoride for children ages 0 to 6 years and persons with underlying conditions such that nonrestorative caries treatment may be optimal, which may include adults living in a Skilled Nursing Facility/ Intermediate Care Facility (SNF/ICF) or part of the Department of Developmental Services (DDS) population. The Silver Diamine Fluoride benefit would provide two visits per member per year, for up to ten teeth per visit, at a per tooth rate and a maximum of four treatments per tooth.

Pay for Performance

To increase statewide preventive service utilization for children and adults, DHCS is proposing to provide a flat rate performance payment for each paid preventive service rendered by a service office location.

Additionally, the state proposes to provide an annual flat rate performance payment to a dental service office location that maintains dental continuity of care by establishing a dental home for each patient and perform at least one annual dental exam/evaluation (D0120/D0150/D0145) for two or more years in a row.

3.11.3 Rationale

These policy proposals align with the legislature's charge to achieve at least a 60 percent dental utilization rate for Medi-Cal eligible children, CMS Oral Health Initiative goals for Medicaid (increase by ten percentage points the proportion of Medicaid and CHIP children ages one to 20 who receive a preventive dental service), and our lessons learned from the Dental Transformation Initiative (DTI).

For example, in the DTI - Domain 1, incentive payments were made to service office locations that increased the utilization of the top eleven preventive services available to children. As a result, not only has utilization of preventive services continued to increase year after year, but since the baseline year of 2014, the number of services has increased eight percent and the number of services per member has also increased by seven percent.

Furthermore, data comparing a control group of children in Dental Transformation Initiative counties who did not receive Caries Risk Assessment with children who did receive Caries Risk Assessment over two calendar years yielded staggering results. The Medi-Cal children who had a Caries Risk Assessment received over 300 percent more preventive services compared to 189 percent for non-Caries Risk Assessment children. Additionally, in this same period, the number of restorative services was almost half that of the control group. Medi-Cal children receiving Caries Risk Assessment had a 263 percent increase in restorative services while the control group with no Caries Risk Assessment had a 475 percent increase in restorative services.

3.11.4 Proposed Timeline

DHCS is currently evaluating a timeline for implementation as funding for Designated State Health Programs (DSHP) is not approved in extension of the Medi-Cal 2020 demonstration.

County Partners

3.12 Enhancing County Eligibility Oversight and Monitoring

3.12.1 Background

The implementation of the Affordable Care Act (ACA) marked a monumental overhaul of the Medi-Cal program by financing a coverage expansion to populations that previously did not qualify, in addition to streamlining eligibility requirements for some populations. County social service agencies strived to acclimate to the vast changes in regulations while managing an unprecedented surge in Medi-Cal applications submitted statewide. To afford counties the opportunity to modify business processes to effectively administer the Medi-Cal program post Affordable Care Act, counties were held harmless by DHCS for performance standards.

Federal, state, and DHCS audits of Medi-Cal eligibility determinations conducted since the implementation of the Affordable Care Act in 2014 have identified several issues that must be addressed and resolved. Audit findings include performance issues related to timeliness of application processing and timeliness of annual eligibility renewal processing. Discrepancies between the Medi-Cal Eligibility Data System (MEDS), and the county Statewide Automated Welfare System (SAWS) also resulted in audit findings, which in part were caused by system-related issues connected to the implementation of the California Healthcare, Eligibility, Enrollment and Retention System (CalHEERS).

Audit findings, recommendations, and corrective action plans imposed upon DHCS require the State to implement additional oversight activities needed to increase the administrative integrity of the Medi-Cal program. Federal audit findings have also levied fiscal penalties upon DHCS, requiring the state to repay the federal matching funds that were claimed because of erroneous Medi-Cal eligibility determinations.

3.12.2 Proposal

DHCS recommends a phased-in approach to working with the counties to increase program integrity with respect to eligibility and enrollment.

- **Reinstate County Performance Standards**: In response to audit findings, DHCS will reinstate the county performance standards required under state law as a means of addressing and correcting error rates and issues which may have a future impact on the timeliness and accuracy of Medi-Cal eligibility determinations. DHCS plans to implement a series of oversight programs throughout the course of the next 24 months. This includes the implementation of a statewide MEDS alerts monitoring program.

- **Develop an Updated Process for the Monitoring and Reporting of County Performance Standards**: In collaboration with CWDA, SAWS and the counties, DHCS will define roles, responsibilities, and develop an updated written process for the monitoring and reporting of the existing county eligibility performance standards. This process will clearly outline DHCS' performance expectations, taking into consideration the issues that are beyond the counties' control, but including potential consequences if standards are not met.

- **Ensure DHCS/County Partnership through Regular Meetings and Open Lines of Communication:** DHCS will work collaboratively with CWDA, counties, and SAWS to develop a communications plan that articulates a process for receiving and responding to county requests for technical guidance and assistance as necessary and appropriate to support counties through this transition. DHCS will look at leveraging existing meetings, and/or developing dedicated meetings to further open lines of communication related to county oversight and monitoring. DHCS will continue to encourage county feedback in identifying gaps or needed clarifications in policy guidance and automation issues. DHCS will also work closely with counties, SAWS and CalHEERS to identify and pursue needed automation changes to support counties in the effective administration of the Medi-Cal program.

- **Develop a Tiered Corrective Action Approach**: DHCS will work with county partners to establish a tiered corrective action approach that would require the submission of a Corrective Action Plan for counties that do not meet established performance expectations. DHCS remains committed to supporting counties and providing timely policy guidance, along with technical assistance, as needed, in addressing and correcting error trends.

- **Incorporate Fiscal Penalties as Part of the Tiered Corrective Action Approach**: For counties that do not demonstrate sufficient improvement in performance, DHCS will take disciplinary action that could range from technical assistance to requiring corrective action plans to imposing financial penalties on counties that fail to show significant improvement and/or are unresponsive to CAPs.

- **Incorporate Findings/Actions in Public Facing Report Cards**: DHCS will work with CWDA, counties and the SAWS to further develop county performance reports that are publicly posted on the California Health and Human Services (CHHS) Open Data Portal and increase accountability by issuing annual public-facing report cards to all 58 counties.

3.12.3 Rationale

This proposal is envisioned to be a crucial step toward achieving DHCS' larger vision for CalAIM by ensuring Medi-Cal enrollment processes are applied in a standardized and consistent manner statewide. This proposal will help to improve DHCS' oversight and monitoring of various aspects of Medi-Cal eligibility and enrollment and the activities of its contracted partners. This includes implementing additional county oversight activities to increase the integrity of the administration of the Medi-Cal program, as well as implementing the recommendations of the California State Auditor's Office. This proposal will also ensure that DHCS is compliant with federal and state requirements.

3.12.4 Proposed Timeline

Given the Executive Order to halt all county renewal processes and negative actions through the duration of the Public Health Emergency (PHE), the implementation timeline reflected for this initiative will shift if the PHE is extended. The dates noted are based on the PHE ending and normal county business processes resuming January 2021, allowing 12 months from the end of the PHE for counties to process and clean-up the resulting backlog. Dates are subject to change once the end of the PHE is established.

- **June 1 – August 31, 2021**: DHCS will reinstate County Performance Standards, including incorporation of MEDS alert monitoring statewide.

- **September 1 – December 30, 2021:** DHCS will develop and publish an updated process for the monitoring and reporting of County Performance Standards, incorporating an outline of the tiered Corrective Action steps which will include disciplinary action ranging from CAPs for counties that do not meet performance expectations, to potential fiscal penalties for unresponsive counties.

- **January 1 – March 31, 2022:** DHCS will begin assessing County Performance Standards, in keeping with the aforementioned updated process.

- **April 1 – June 30, 2022:** DHCS will implement the county performance monitoring dashboard (a public facing report card). The dashboard is envisioned to represent county performance in application processing, renewal processing, and MEDS alert processing, and could potentially include other measures to be mutually agreed upon in the future.

- **July 1 – September 30, 2022:** DHCS will begin publishing the county performance monitoring dashboard on the CHHS Open Data Portal.
- **July 1 – December 31, 2023:** DHCS will begin taking steps toward fiscal sanctions for counties who do not demonstrate sufficient improvement in meeting performance expectations or are unresponsive.

3.13 Enhancing County Oversight and Monitoring: CCS and CHDP

3.13.1 Background

The California Children's Services program serves as a proxy of Medi-Cal for case management services and provides diagnostic and treatment services, physical and occupational therapy services to children and youth with eligible medical conditions. The Child Health and Disability Prevention program delivers periodic health assessments and services to low-income children and youth; and provides care coordination to assist families with medical appointment scheduling, transportation, and access to diagnostic and treatment services.

California Children's Services and Child Health and Disability Prevention beneficiaries are best served when their care is delivered in a standardized and consistent manner. It is the State's responsibility to ensure that the same high-quality standard of care is compliant with federal and State guidelines for all beneficiaries. To remain proactive with emerging trends, technology, medical advances, and interventions, it is essential the State continue to evolve its efforts accordingly.

3.14.2 Proposal

DHCS intends to provide enhanced monitoring and oversight of all 58 counties and three (3) cities (Berkeley, Pasadena, and Long Beach) to ensure continuous, and unwavering optimal care for children. To implement the enhanced monitoring and oversight of California Children's Services and Child Health and Disability Prevention in all counties, DHCS will develop a robust strategic compliance program. Effective compliance programs begin with ascertainable goals, performance measures, and metrics capturing all federal and State requirements. Ongoing quality assurance and data reviews are fundamental to ensuring compliance and continued improvements in program operations and beneficiary care.

Initial efforts will entail a review of all current standards and guidelines for both programs. Once the internal policy review is complete, DHCS will develop initial auditing tools to assess current county/city operations and compliance. DHCS will then evaluate and analyze the findings gathered during audits to identify gaps and vulnerabilities across the State within the programs. The information gathered will be the cornerstone for future efforts, and the basis for the development of the strategic compliance program.

County/City variances in program operations and compliance with federal and State laws are also identified by tracking trends. DHCS will refine and update oversight policies and procedures and implement best practices. DHCS, along with input from our county partners and other stakeholders, will establish goals, metrics, performance measures, and milestones to ensure counties/cities are providing the necessary provider oversight and medical/ dental care for beneficiaries. DHCS will provide training and technical assistance with internal and external partners to achieve statewide consistency of the compliance requirements and goals. In addition, DHCS will conduct ongoing quality assurance reviews, develop, and create county/city program specific dashboards, as necessary to meet internal and external reporting needs.

In alignment with technology trends, the State plans to shift counties/cities from annual hardcopy submission of Plan and Fiscal Guidelines budgets to a more efficient and streamlined automated electronic submission process. Training and overview of the electronic submission process conducted for the counties ensures understanding prior to implementation of the automated system. More rigorous annual review of all county budgets will further efficiencies, contain costs, and improve outcomes.

To better manage this population's health care and ensure targeted interventions are implemented, each county/city and state will enter into a Memorandum of Understanding (MOU) with DHCS. The MOU, in conjunction with other supportive policies (information notices, numbered letters, etc.), will detail how the state will monitor county/city activities, policies and procedures, conduct audits, and implement corrective action plans. This MOU will be developed utilizing information obtained during the audits with the intent of having signed agreements with all counties/cities.

After initial deployment of the enhanced monitoring and oversight, DHCS will continue to conduct ongoing audits, stay proactive with emerging developments, and monitor trends to ensure high-quality consistent care. DHCS will allow sufficient time for counties to implement and adjust to this new structure prior to engaging in any sort of progressive action. DHCS will continue compliance oversight to preserve and improve the overall health and well-being of these vulnerable populations.

3.13.3 Rationale

Enhancing monitoring and oversight will eliminate disparities in care to beneficiaries and reduce vulnerabilities to the state, thereby preserving and improving the overall health and well-being of California's vulnerable populations.

3.13.4 Proposed Timeline

- **Phase I: August 2020 – June 2021**
    - Review of current standards, policies, and guidelines

  - Development of goals, performance measures, and metrics
  - Revision of current Plan and Fiscal Guidelines guidance document
  - Continuation of the establishment of an electronic submission portal for the annual county/city budgets.

- **Phase II: July - September 2021**
  - Development of auditing tools
- **Phase III: October 2021 – September 2022**
  - Shift to an electronic automated PFG submission by the counties/cities
  - Develop training documents
  - Evaluate and analyze findings and trends
  - Identify gaps and vulnerabilities
- **Phase IV: October 2022- Ongoing**
  - Initiate Memorandum of Understanding between State and counties
  - Continuous monitoring and oversight
  - Continuous updates to standards, policies, and guidelines

3.14 Improving Beneficiary Contact and Demographic Information

3.14.1 Background

Medi-Cal has approximately 13 million enrolled beneficiaries; approximately 80 percent are enrolled in the managed care delivery system and 20 percent are enrolled in the fee-for-service delivery system. County social services departments are delegated by DHCS to process Medi-Cal applications and renewals, as well as to generally provide case management services. Counties use Statewide Automated Welfare Systems (SAWS_ to support and maintain Medi-Cal enrollment processes. The SAWS, of which there are currently three, contain contact and demographic information on enrolled individuals. The systems maintain electronic interfaces with the state-level eligibility and enrollment system (California Healthcare Eligibility, Enrollment, and Retention System) and the state-level eligibility database, the Medi-Cal Eligibility Data System. The Medi-Cal Eligibility Data System is the system of record for purposes of Medi-Cal eligibility information, claims payment, and health plan assignment, among other things.

When a beneficiary has a change in circumstances that affects their eligibility, the beneficiary is required to report changes to their county eligibility worker within ten calendar days of the change. Such changes include but are not limited to address and contact information updates, family size (increases or decreases), access to other health insurance, changes in income, and death. County eligibility workers are then responsible

for ensuring the data maintained in the local county eligibility system is accurate and up to date. Under current state law, Medi-Cal managed care plans have the ability to report updated contact information to the county when they have obtained consent from the beneficiary for such reporting.

Accurate contact and demographic information is critical for purposes of ongoing program enrollment and care management for beneficiaries. This information is used by Medi-Cal fee-for-service providers and Medi-Cal managed care plans, as well as other providers of care, for purposes of effective communication and interaction with Medi-Cal beneficiaries, including deploying care management strategies based on individual needs.

Given the substantial volume of individuals in the process of enrolling in or renewing Medi-Cal coverage, it is critical that DHCS, counties and plan and provider partners have accurate contact and demographic information. A more effective and efficient process for keeping this information up to date in California's systems is needed.

3.14.2 Proposal

DHCS intends to convene a workgroup of interested stakeholders to provide feedback and recommendations on ways in which contact and demographic information can be updated by other entities and the means to accomplish this while maintaining compliance with all applicable state and federal privacy laws. The goal of the workgroup will be to determine the best pathway for ensuring that reported updated data is accurate and can be used in eligibility and enrollment systems/databases without creating unintended consequences for other social services program, Medi-Cal beneficiaries, managed care plans, and the provider community.

3.14.3 Rationale

As DHCS seeks to make improvements in its approach to population-based health care and drive innovation in health care delivery, it is critical that our Medi-Cal providers, managed care plans, county partners, and others have access to accurate, up-to-date contact and demographic information for beneficiaries. County eligibility workers play a key role in ensuring contact information is current; however, there are other entities that interact with Medi-Cal beneficiaries on a regular basis who may have access to more current information. As a result, DHCS would like to leverage and explore the possibility of other entities having the opportunity to also update contact and demographic information about Medi-Cal beneficiaries.

3.14.4 Proposed Timeline

DHCS proposes to engage with key partners during 2022-23 to develop thoughtful and realistic recommendations for implementing improvements in how contact and demographic information can be updated by other entities in addition to county eligibility

workers. Such changes may be effectuated through updates to the Medi-Cal application, use of eligibility online portals and/or other means. As part of the workgroup effort, DHCS will also seek input in terms of timing of implementation, taking into consideration current system migrations, consolidations and/or modernization efforts.

4. Conclusion

DHCS developed these CalAIM proposals with a view toward the future and what will be necessary to more effectively and positively impact Medi-Cal beneficiaries' quality of life. These proposals were drawn from more than a year-long effort by DHCS leadership and staff, as well as engagement with critical partners and experts across the State and the nation. These ambitious proposals represent a long-term vision for advancing and improving the Medi-Cal program in fundamental ways that build upon the foundations established in prior waivers and expansion efforts. The success of the thinking behind CalAIM will fundamentally rest on the collaboration and coordination of DHCS, our plan, provider, county, and legislative partners, and the entire stakeholder community. DHCS recognizes that these proposals will likely require significant time and fiscal investment and look forward to working with our partners and through the budget process to most effectively implement the concepts proposed in this initiative. These efforts are not limited to a single year, but represent DHCS' current vision for what Medi-Cal might be able to achieve over the next five to ten years, and beyond.

5. From Medi-Cal 2020 to CalAIM: A Crosswalk

California is embarking on a new and system-wide initiative to transform how beneficiaries' access Medi-Cal services. As the Medi-Cal program has expanded under the Affordable Care Act and through other state-led initiatives, and with over 80% of beneficiaries now being served through managed care plans, it is an opportune time to consider the patient experience from an even more global perspective. Currently, beneficiaries may need to access six or more separate delivery systems (managed care, fee-for-service, specialty mental health, substance use disorder, dental, In Home Supportive Services, etc.) in order to receive the care they need. This combination of system fragmentation and clinical complexity, and the likelihood of decreased beneficiary capacity, makes access to effective care coordination even more critical.

As such, the state is undertaking a more targeted approach to consolidating its Medi-Cal benefit package to achieve better alignment across the system. While Section 1115 waiver authority has historically been the mechanism of choice for states interested in building and expanding managed care delivery systems, the use of the authority has evolved in recent years. The federal government no longer considers the "savings" generated from the shift from fee-for-service to managed care that occurred 15 years ago in Medicaid as relevant in calculating budget neutrality for waivers. CMS, in recent

guidance, has also discontinued approval of traditional financing mechanisms in the Section 1115 context, namely the availability of federal funds for Designated State Health Programs and Safety Net Care Pools. These factors, combined with new federal managed care regulations, have encouraged DHCS to shift its focus away from the Section 1115 waiver authority to instead leverage other available pathways for innovation in the Medi-Cal program.

In the spring of 2020, in response to the COVID-19 public health emergency, DHCS determined that additional time would be needed to prepare Medi-Cal managed care plans, counties, and a wide array of stakeholders for the transition from the Section 1115 waiver to the CalAIM structure. As such, the state prepared a 12-month extension request for the Medi-Cal 2020 Section 1115 demonstration. The request was posted for public comment in June 2020 and submitted to CMS on September 16, 2020. The 12-month extension is meant to serve as a bridge to a 5-year Section 1115 waiver renewal, primarily to continue key programs that require the authority, including the Global Payment Program (GPP) and the Drug Medi-Cal Organized Delivery System (DMC-ODS). In addition, DHCS is designing a comprehensive Section 1915(b) managed care waiver request for CMS that would also be for a 5-year period.

The following table outlines the proposed approach under CalAIM for each of the key Medi-Cal 2020 waiver elements:

Crosswalk of Medi-Cal 2020 Waiver Components to CalAIM Proposals

Medi-Cal 2020 Waiver Component	Included in Waiver Extension Through 12/31/21	Planned for CalAIM	Description	Timeline
Medi-Cal Managed Care	X	Transition to new 1915(b) waiver.	The general authority for various Medi-Cal managed care will be shifted from 1115 to 1915(b). This would include PACE models needing waiver approval and Whole Child Model.	January 1, 2022
Whole Person Care Pilots	X	Transition to new 1915(b) waiver and managed care plan contract authority.	Medi-Cal managed care plans would provide a new enhanced care management benefit. Additionally, Medi-Cal managed care plans will have the option to provide a menu of approved in lieu of services. The majority of Whole Person Care services will continue to be available as both enhanced care management and in lieu of services via Medi-Cal managed care plans, and ultimately will be expanded to Medi-Cal managed care plans in non-Whole Person Care counties.	January 1, 2022
PRIME		Transition to managed care directed payment under the Quality Incentive Pool (QIP) Program.	The existing PRIME funding structure was transitioned into QIP directed payments effective July 1, 2020. Network Designated Public Hospital (DPH) systems and the District/Municipal Public Hospitals (DMPHs) will have the opportunity to participate in and receive directed QIP payments from their contracted Medi-Cal managed care plans for reporting on a set of quality improvement measures through the QIP program.	Phase I: July 1 – December 31, 2020 Phase II: January 1, 2021
Health Homes Program	X	Transition to new 1915(b) waiver as Enhanced Care Management.	Medi-Cal managed care plans would provide a new enhanced care management benefit similar to the benefits included in the Health Homes Program. Medi-Cal managed care plans will have the option of providing a menu of approved in lieu of services. Services currently provided to populations with complex health needs under the HHP will become available under the managed care delivery system structure.	January 1, 2022

Crosswalk of Medi-Cal 2020 Waiver Components to CalAIM Proposals

Medi-Cal 2020 Waiver Component	Included in Waiver Extension Through 12/31/21	Planned for CalAIM	Description	Timeline
Coordinated Care Initiative and Cal MediConnect	X	Managed care authority to new 1915(b) waiver; Extension of 1115A demonstration for Cal MediConnect through 2022; eventual Medicare-Duals Special Needs Plans (D-SNPs).	Transition to standardized mandatory enrollment of dual eligibles into Medi-Cal managed care plans. Multipurpose Senior Services Programs will be carved out; long-term care will be carved in statewide. All Medi-Cal managed care plans will be required to offer coverage through D-SNPs for care coordination and integration of benefits.	CCI program with end date of December 31, 2022
Drug Medi-Cal Organized Delivery System (DMC-ODS)	X	Expenditure authority for residential SUD treatment remains in 1115 waiver; Services and delivery system move to new 1915(b) waiver.	The Drug Medi-Cal Organized Delivery System (DMC-ODS) provides a continuum of care for substance use disorder treatment.	Implementation continues January 1, 2022
Global Payment Program	X	1115 waiver renewal.	Continuation of existing program, with discontinuation of Safety Net Care Pool funds, using only Medicaid Disproportionate Share Hospital (DSH) allotment funds.	January 1, 2022.

Crosswalk of Medi-Cal 2020 Waiver Components to CalAIM Proposals

Medi-Cal 2020 Waiver Component	Included in Waiver Extension Through 12/31/21	Planned for CalAIM	Description	Timeline
Dental Transformation Initiative	X	Transition authority to Medi-Cal State Plan.	New dental benefits and provider payments: • Caries Risk Assessment Bundle for ages 0-6; • Silver Diamine Fluoride for ages 0-6, and specified high-risk and institutional populations Pay for Performance incentives for preventive services and establishing continuity of care through dental homes	January 1, 2022
Community-Based Adult Services (CBAS)	X	1115 waiver renewal.	Services for eligible older adults and those with disabilities to restore or maintain their optimal capacity for self-care. The goal is to delay or prevent inappropriate or personally undesirable institutionalization.	January 1, 2022
Eligibility Authorities	X	1115 waiver renewal.	Full Scope Benefit for Pregnancy Related Beneficiaries with FPL 109-138% and Out of State Former Foster Care Youth.	January 1, 2022
Rady CCS Pilot	X	Not included.	The demonstration project tested two healthcare delivery models for children enrolled in the California Children's Services (CCS) Program.	Expires December 31, 2021
Designated State Health Programs (DSHP)	X	Not included.	Financing mechanism under 1115 waiver which has permitted federal funding for certain State health programs not traditionally allowed for federal funding	Expires December 31, 2020
Tribal Uncompensated Care	X	Not included.	The state makes supplemental payments to Indian Health Service (IHS) and tribal 638 facilities to take into account their responsibility to provide uncompensated care. DHCS will work to implement Tribal FQHCs by January 1, 2021, which will account for the remaining services being billed for under Tribal Uncompensated Care.	Expires December 31, 2021

5.1 Transition of PRIME to Quality Incentive Program

5.1.1 Background

The California Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program built on other delivery system transformation efforts focused on strengthening patient-centered primary and specialty outpatient care, improving care coordination, and providing the right care in the most appropriate settings. A total of 17 Designated Public Hospitals and 34 District and Municipal Public Hospitals participated in PRIME. PRIME was designed to accelerate efforts by participating entities to change care delivery, maximize health care value, and strengthen their ability to successfully perform under risk-based alternative payment models. PRIME was intentionally designed to be ambitious in scope and time limited. Using evidence-based quality improvement methods, the initial work required the establishment of performance baselines followed by target-setting, and the implementation and ongoing evaluation of quality improvement interventions.

In 2017, California created a Quality Incentive Program (QIP) – a managed care directed payment program – for the state's Designated Public Hospitals. The state directs Medi-Cal managed care plans to make QIP payments tied to designated performance metrics in four strategic categories: primary care, specialty care, inpatient care, and resource utilization. The QIP measures do not directly overlap with any of the quality measures being used in PRIME, rather they are designed to be complementary. The QIP promote access to care, value-based purchasing, and to tie funding to quality outcomes, while at the same time further aligning state, Medi-Cal managed care plan, and hospital system goals. The QIP also creates incentives to build data and quality infrastructure and ties funding directly to these goals, allowing the state to pay for quality and build capacity.

5.1.2 Proposal

DHCS is in the process of transitioning the quality improvement work and funding that has been available through PRIME into the QIP and permitting the District and Municipal Public Hospitals to begin participating in the program, which has enabled hospitals to continue quality improvement efforts underway at all 51 PRIME entities after PRIME expired on June 30, 2020. This transition promotes value-based purchasing, ties funding to quality outcomes, and aligns PRIME entities' transition to the QIP with California's transition to the calendar year rating period for Medi-Cal managed care plans.

There are two key phases in the PRIME-to- QIP transition:

- **Phase I:** Alignment with the calendar year health plan rating period, July 1, 2020 through December 31, 2020

- **Phase II:** Merge to QIP, January 1, 2021 through December 2021, and beyond.

Phase I: Alignment with Calendar Year Rating Period

All 51 PRIME entities transitioned into a six-month transitional program on July 1, 2020 to calibrates the new program to end on the same date as Bridge Period 2019-20, an 18-month rate year for Medi-Cal managed care plans that ended on December 31, 2020. For performance on both the original QIP quality metrics (for Designated Public Hospitals) and the PRIME transition metrics (for Designated Public Hospitals and 34 District and Municipal Public Hospitals) during this period, the 51 entities will be paid through Medi-Cal managed care plans, via state-directed Medi-Cal managed care plan payments. CMS approval for this six-month program was obtained on September 14, 2020.

To earn funds for PRIME transition metrics, all 51 PRIME entities will continue to report to DHCS on quality improvement projects and measures from PRIME. The six-month transition will use a twelve-month measurement period to ensure that performance can be fairly compared to benchmarks set by DHCS. Due to the COVID-19 public health emergency, entities will use the March 1, 2019 to February 29, 2020 measurement period and be held to achieving the minimum performance benchmark established by DHCS from PRIME Demonstration Year 15. The Designated Public Hospitals will also continue activities on the original QIP quality metrics during this six-month period, utilizing the same modifications due to the COVID-19 public health emergency outlined for PRIME above.

Phase II: Merge to QIP

Subject to obtaining the necessary federal approvals, January 1, 2021 will be the start of QIP Year 4 and will include the Designated Public Hospitals and 34 District and Municipal Public Hospitals, totaling 51 QIP entities. Similar to Phase I, payments to the 51 QIP entities will be directed payments through the Medi-Cal managed care plans. Program Year 4 will align with Rate Year 2021, corresponding to calendar year 2021.

PRIME Policy Letters and associated PRIME reporting guidance will no longer apply to QIP. DHCS will review all prior PRIME Policy Letters and QIP Policy Letters for relevance and issue updated Policy Letters and reporting guidance to Designated Public Hospitals and District and Municipal Public Hospitals.

DHCS worked with stakeholders to develop a revised metric set for Program Year 4 that prioritizes CMS Adult and Child Core Set measures, HEDIS measures, other nationally vetted and endorsed measures, and measures in wide use across Medicaid quality initiatives. The measures align with well-established benchmarks and State, Medi-Cal managed care plan, and hospital system goals. The Program Year 4 metric set meaningfully reflects the goals and priorities of CalAIM.

5.1.3 Rationale

The QIP Program is intended to promote access to care, value-based payments, and tie funding to quality outcomes, while at the same time further aligning state, Medi-Cal managed care plan, and hospital system goals. The PRIME to QIP transition will engage both Designated Public Hospitals and 34 District and Municipal Public Hospitals to continue quality improvement work for select priority metrics in QIP As such, this proposal will help achieve the following goals of CalAIM:

- Enhance coverage expansion to address health disparities among vulnerable populations;
- Drive delivery transformation across Designated Public Hospitals and District and Municipal Public Hospitals toward value-based care and away from volume-based care, and
- Reduce variation and complexity across hospital systems through alignment of quality measures with those required of health plans.

5.1.4 Proposed Timeline

January 1, 2021: Complete transition from PRIME to QIP for Designated Public Hospitals and District and Municipal Public Hospitals using new CMS Adult and Child Core Set measures, HEDIS measures, and other nationally-vetted and endorsed measures

5.2 Global Payment Program Extension

5.2.1 Background

The Global Payment Program is a five-year pilot program included in California's Medi-Cal 2020 Section 1115 demonstration waiver. The Global Payment Program establishes a statewide pool of funding by combining a portion of California's federal Disproportionate Share Hospital (DSH) allotment with available uncompensated care funding. These funds support public health care system efforts to provide health care for California's uninsured population and promotes the delivery of more cost-effective and higher-value care to the uninsured.

Global budgets are allocated to public health care systems based on available funding and service point thresholds to be achieved. Public health care systems can achieve their hospital specific global budget by meeting a service point threshold that incentivizes movement from high cost, avoidable services to providing higher value and preventive services in the most appropriate setting.

The Global Payment Program's requirements are established in the Special Terms and Conditions for California's Medi-Cal 2020 Section 1115 demonstration and the program

funding is authorized December 31, 2021 under the one year Medi-Cal 2020 extension proposal, submitted to CMS on September 16, 2020.

5.2.2 Proposal

DHCS proposes to extend the Global Payment Program under CalAIM through a renewal of the Medi-Cal Section 1115 waiver demonstration. The Global Payment Program will operate under the following assumptions:

- The start date of Program Year 7 will begin on January 1, 2022, and end on December 31, 2022. The Global Payment Program was originally approved through June 30, 2020. On August 3, 2020, the Centers for Medicare and Medicaid Services (CMS) approved a waiver amendment extending the program and authorizing Program Year 6A for the period of July 1, 2020 through December 31, 2020. The Medi-Cal 2020 one-year extension proposal extended the program through December 31, 2021.
- The Global Payment Program under CalAIM will be funded solely by a portion of the State's Designated Public Hospital Disproportionate Share Hospital allotment allocation and will no longer incorporate uncompensated care funding;
- The percentage of Designated Public Hospital Disproportionate Share Hospital allotment funds to be split amongst University of California hospitals and Global Payment Program public health care systems will remain constant for the entirety of the waiver with 78.104% allocated to the Global Payment Program and 21.896% allocated to University of California hospitals;
- The Global Payment Program will include an evaluation to continue to assess whether the program is achieving its stated goals;
- The Global Payment Program will continue the shifting of point values for specific services to incentivize the provision of care in the most appropriate and cost-effective settings;
- DHCS may recalibrate the initial point thresholds for each hospital. Some public health care systems consistently exceed their thresholds, while others do not. Recalibration of the initial point thresholds will serve to minimize payment adjustments; and
- All other facets of the Global Payment Program in the CalAIM period will operate per the Medi-Cal 2020 waiver Special Terms and Conditions.

5.2.3 Rationale

The Global Payment Program was established to accomplish the following goals:

- To improve health of the remaining uninsured through coordination of care and to move away from the cost-based payment methodology restricted to mostly hospital settings to a more risk-based and/or bundled payment structure;
- To encourage public healthcare systems to provide greater primary and preventive services, as well as alternative modalities such as phone visits, group visits, telemedicine, and other electronic consultations; and
- To emphasize the value of coordinated care and alternative modalities by recognizing the higher value of primary care, ambulatory care, and care management as compared to the higher cost, avoidable emergency room visits and acute care hospital stay.

DHCS collaborated with the RAND Corporation to conduct an evaluation of the Global Payment Program from the onset of the program through March 2019. The evaluation assessed whether and to what extent, changing the payment methodology resulted in a more patient-centered system of care. Results show that there has been an increase in outpatient services, an increase in access to care for the uninsured, an improvement in the coordination of care, advancements in data collection and tracking, and an appropriate allocation of resources to effectively tailor care to more appropriate settings.

These findings provide strong support for the argument that the Global Payment Program is a powerful catalyst in helping the public health care systems deliver more cost-effective and higher-value care to the State's remaining uninsured individuals and will continue to move in this direction over the next five years.

5.2.4 Proposed Timeline

DHCS proposes to extend the Global Payment Program for the next five years according to the schedule in **Attachment G.**

6. Appendices

Appendix A: 2021 and Beyond: CalAIM Implementation Timeline[3]

Date	Implementation Activity
July 1, 2020	**PRIME transitions to Quality Incentive Program**
January 1, 2021	12-month extension of Medi-Cal 2020 demonstration
April 2021	**Submission of Section 1915(b) and 1115 waiver requests** **Pharmacy Carve-Out Effective**
June 2021	**County Oversight[4]:** DHCS will engage with counties by forming a working group that will focus on developing new county performance standards monitoring and reporting mechanism. The reinstatement of County Performance Standards will include incorporation of MEDS alert monitoring statewide **County oversight (CCS, CHDP):** Development of auditing tools. **Foster Care Model of Care Workgroup** completed
October 2021	**County oversight (CCS, CHDP):** Shift to automated Plan and Fiscal Guideline submission process, develop training documents, evaluate and analyze findings and trends, and identify gaps and vulnerabilities.
November-2021	**County Inmate Pre-Release Application Process:** Stakeholder process
December 2021	**County Oversight**: DHCS will publish an updated process for the monitoring and reporting of County Performance Standards, incorporating an outline of the tiered Corrective Action steps which will include disciplinary action ranging from CPAs for counties that do not meet performance expectations, to potential fiscal penalties for unresponsive counties. **Goal approval date of Section 1915(b) and 1115 waiver requests**
2022	

[3] Implementation date TBD: IMD SMI/SED waiver, regional contracting (will vary), improving beneficiary contact and demographic information

[4] Given the Executive Order to halt all county renewal processes and negative actions through the duration of the Public Health Emergency (PHE), the implementation timeline reflected for this initiative will shift if the PHE is extended. The dates noted are based on the PHE ending and normal county business processes resuming January 2021, allowing 12 months from the end of the PHE for counties to process and clean-up the resulting backlog. Dates are subject to change once the end of the PHE is established.

Date	Implementation Activity
January 1, 2022	**Managed Care Authority:** Shifts to 1915(b) authority **Implementation of the following CalAIM proposals:** • Enhanced care management/In lieu of services (existing WPC and/ or HHP target populations) • Incentive payments • Dental benefits and pay for performance (implementation date TBD as funding for Designated State Health Programs (DSHP) is not approved in extension of the Medi-Cal 2020 demonstration) • Managed care benefit standardization continues • Mandatory managed care • Regional Rates Phase I • DMC-ODS renewal and policy improvements • Changes to behavioral health medical necessity • Multipurpose Senior Services Program carved-out of managed care • D-SNP look-alike enrollment transition in CCI counties **County Inmate Pre-Release Application Process:** Publication of guidance and begin Technical Assistance (through December 2022)
March 2022	**County Oversight**: DHCS will begin assessing County Performance Standards, in keeping with the aforementioned updated process.
June 2022	**County Oversight**: DHCS will implement the County Performance Monitoring Dashboard. The dashboard is envisioned to represent county performance in application processing, renewal processing, and MEDS alert processing, and could potentially include other measures to be mutually agreed upon in the future.
July 2022	**Behavioral Health Payment Reform** **Enhanced care management:** • Implementation of additional enhanced care management Target Populations in HHP/WPC Counties. • Managed care plans in non- WPC and/or HHP counties begin implementing enhanced care management target populations
September 2022	**County Oversight**: DHCS will begin publishing the County Performance Monitoring Dashboard on the CHHS Open Data Portal.
October 2022	**County oversight (CCS, CHDP):** Initiate Memorandum of Understanding between State and counties, continuous monitoring and oversight, and continuous updates to standards, policies, and guidelines
December 31, 2022	**Cal MediConnect:** End of program
2023	
January 2023	**Aligned Enrollment:**

Date	Implementation Activity
	• Require statewide mandatory enrollment of dual eligibles in Medi-Cal managed care[5] • All Medi-Cal health plans in CCI counties required to operate Dual Eligible Special Needs plans in all service areas they operate as an Medi-Cal managed care plan, including dual eligible LTC residents • Require statewide mandatory enrollment for eligible LTC residents for both non-dual and dual beneficiaries **County Inmate Pre-Release Application Process:** Implementation **Shared Risk/Shared Savings** (at the earliest) **Enhanced care management:** Implementation of all enhanced care management target populations, including Individuals Transitioning from Incarceration.
December 2023	**County Oversight**: DHCS will begin taking steps toward fiscal sanctions for counties who do not demonstrate sufficient improvement in meeting performance expectations or are unresponsive.
2024	
January 2024	**Regional Rates, Phase II** (at the earliest)
2025	
January 2025	**Aligned Enrollment:** • All Medi-Cal health plans in non-CCI counties required to operate Dual Eligible Special Needs plans in all service areas they operate as a Medi-Cal managed care plan.
2026	
January 2026	**NCQA:** All Medi-Cal managed care plans required to be NCQA accredited
2027	
January 2027	**Behavioral Health Administrative Integration:** submit for a single, integrated behavioral health managed care plan in each county or region responsible for providing, or arranging for the provision of, specialty mental health and substance use disorder services under the 1915(b) waiver **Long-Term Services and Supports, Long-Term Care, Dual Eligible Special Needs Plans:** Full implementation **Full Integration Plan:** Go Live (no sooner than)

[5] Mandatory Managed Care enrollment: See **Appendix F: Managed Care Enrollment Proposed Aid Code Group Coverage.**

Appendix B: Targeted Case Management

LGAs	Children Under the Age of 21	Medically Fragile Individuals	Individuals at Risk of Institutionalization	Individuals at Jeopardy of Negative Health or Psycho-Social Outcomes	Individuals with a Communicable Disease	LGAs not Participating in TCM
Alameda County	X	X	X	X		
Alpine County						X
Amador County						X
Butte County				X		
Calaveras County						X
Colusa County						X
Contra Costa County	X	X	X	X	X	
Del Norte County						X
El Dorado County						X
Fresno County						X
Glenn County						X
Humboldt County	X	X		X	X	
Imperial County						X
Inyo County						X
Kern County				X		
Kings County						X
Lake County						X
Lassen County						X
Los Angeles County	X			X		

LGAs	Children Under the Age of 21	Medically Fragile Individuals	Individuals at Risk of Institutionalization	Individuals at Jeopardy of Negative Health or Psycho-Social Outcomes	Individuals with a Communicable Disease	LGAs not Participating in TCM
Madera County				X		
Marin County						X
Mariposa County	X	X	X	X	X	
Mendocino County	X	X	X	X	X	
Merced County						X
Modoc County						X
Mono County						X
Monterey County	X	X		X		
Napa County	X	X		X		
Nevada County						X
Orange County	X	X	X	X	X	
Placer County		X	X	X		
Plumas County						X
Riverside County	X	X	X	X	X	
Sacramento County				X		
San Benito County						X
San Bernardino County						X
San Diego County	X	X	X	X	X	
San Francisco County						X
San Joaquin County						X

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LGAs	Children Under the Age of 21	Medically Fragile Individuals	Individuals at Risk of Institutionalization	Individuals at Jeopardy of Negative Health or Psycho-Social Outcomes	Individuals with a Communicable Disease	LGAs not Participating in TCM
San Luis Obispo County	X	X		X		
San Mateo County	X	X		X		
Santa Barbara County						X
Santa Clara County	X	X	X	X	X	
Santa Cruz County	X	X		X		
Shasta County		X		X		
Sierra County						X
Siskiyou County						X
Solano County	X	X		X	X	
Sonoma County	X	X	X	X	X	
Stanislaus County	X	X	X	X	X	
Sutter County	X	X	X	X	X	
Tehama County						X
Trinity County				X		
Tulare County						X
Tuolumne County	X	X	X	X		
Ventura County	X	X	X	X	X	
Yolo County						X
Yuba County						X
City of Berkeley	X	X	X	X	X	
City of Long Beach	X	X	X	X	X	
Total	**23**	**24**	**16**	**30**	**15**	**30**

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Appendix C: County Inmate Pre-Release Application Process sample contracting Models

Contracting Model	Counties Currently Using a Similar Process
County Contracts with County Sheriff's Office	Butte Kern San Bernardino San Diego San Francisco Tuolumne Ventura Yolo
County Contracts with County Jail	Glenn Santa Barbara
County Contracts with Multiple Entities (e.g. Community Based Organizations and County Sheriff's Office)	Contra Costa Imperial Placer Sacramento San Luis Obispo San Mateo Solano Sutter

Appendix D: Institutions for Mental Disease/Serious Mental Illness/Severe Emotional Disturbance Demonstration Goals & Milestones

Below is a summary of demonstration goals as outlined in CMS SMD Letter #18-011:

- Reduced utilization and lengths of stay in emergency departments among Medicaid beneficiaries with serious mental illness or serious emotional disturbance while awaiting mental health treatment in specialized settings;
- Reduced preventable readmissions to acute care hospitals and residential settings;
- Improved availability of crisis stabilization services including services made available through call centers and mobile crisis units, intensive outpatient services, as well as services provided during acute short-term stays in residential crisis stabilization programs, psychiatric hospitals, and residential treatment settings throughout the state;
- Improved access to community-based services to address the chronic mental health care needs of beneficiaries with serious mental illness or serious emotional disturbance including through increased integration of primary and behavioral health care; and
- Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.

Below is a summary of demonstration milestones as outlined in CMS SMD Letter #18-011:

- Ensuring quality of care in psychiatric hospitals and residential settings. Involves facility accreditation, unannounced visits, use of a utilization review entity, facilities meeting federal program integrity requirements, and facilities having the capacity to address co-morbid physical health conditions;
- Improving care coordination and transitions to community-based care. Involves implementation of a process to assess housing situations, requirement that facilities have protocols to contact beneficiaries within 72-hours after discharge, strategies to prevent or decrease lengths of stays in emergency departments, and strategies to develop and enhance interoperability and data sharing;
- Increasing access to continuum of care including crisis stabilization services. Involves annual assessments of availability of mental health services across the state, commitment to an approved finance plan, strategies to improve the state's

capacity to track available beds, and implementation of an evidence-based assessment tool; and

- Earlier identification and engagement in treatment including through increased integration. Involves strategies for identifying and engaging individuals in treatment sooner, increased integration of behavioral health care in non-specialty settings and establishing specialized settings and services.

Federal Application Requirements

States wishing to pursue this demonstration opportunity must first submit an application to CMS. CMS will consider a state's commitment to ongoing maintenance of effort on funding outpatient community-based mental health services as demonstrated in their application when determining whether to approve a state's proposed demonstration project to ensure that resources are not disproportionately drawn into increasing access to treatment in inpatient and residential settings at the expense of community-based services. Below is a summary of required elements for the application;

- A comprehensive description of the demonstration, including the state's strategies for addressing the goals and milestones discussed above for this demonstration initiative;
- A comprehensive plan to address the needs of beneficiaries with serious mental illness or serious emotional disturbance, including an assessment of how this demonstration will complement and not supplant state activities called for or supported by other federal authorities and funding streams;
- A description of the proposed health care delivery system, eligibility requirements, benefit coverage and cost sharing (premiums, copayments, and deductibles) required of individuals who will be impacted by the demonstration, to the extent such provisions would vary from the state's current program features and the requirements of the Social Security Act;
- A list of the waivers and expenditure authorities that the state believes to be necessary to authorize the demonstration;
- An estimate of annual aggregate expenditures by population group impacted by the demonstration, including development of baseline cost data for these populations.
- Specifically, CMS requests that states' fiscal analysis demonstrate how the proposed changes will be budget neutral, i.e., will not increase federal Medicaid spending. CMS will work closely with states to determine the feasibility of their budget neutrality models and suggest changes as necessary;

- Enrollment data including historical mental health care coverage and projected coverage over the life of the demonstration, of each category of beneficiary whose health care coverage is impacted by the demonstration;
- Written documentation of the state's compliance with the public notice requirements at 42 CFR 431.408, with a report of the issues raised by the public during the comment period and how the State considered those comments when developing the final demonstration application submitted to CMS;
- The research hypotheses that are related to the demonstration's proposed changes, goals, and objectives, and a general plan for testing the hypotheses including, if feasible, the identification of appropriate evaluation indicators; and
- An implementation plan describing the timelines and activities necessary to achieve the demonstration milestones including a financing plan. The implementation plan can be submitted with the application, or within 90 days of application approval from CMS.

Other Demonstration Requirements

In addition to the required application elements above, states must also develop the following:

- Demonstration monitoring reports including information detailing the state's progress toward meeting the milestones and timeframes outlined in the implementation plan, as well as information and data so that CMS can monitor budget neutrality.
- A Health IT plan (health information technology plan) that describes the state's ability to leverage health IT, advance health information exchange(s), and ensure health IT interoperability in support of the demonstration's goals.
- Monitoring protocols that identify expectations for quarterly and annual monitoring reports including agreed upon performance measures (see SMD #18-011 for a list of potential measures), measure concepts, and qualitative narrative summaries. The monitoring protocol will be developed and finalized after CMS approval.
- Interim and final evaluations that will draw on the data collected for the milestones and performance measures, as well as other data and information needed to support the evaluation that will describe the effectiveness and impact of the demonstration using quantitative and qualitative outcomes and a cost analysis. An evaluation design will be developed by the state, with technical assistance from CMS, to be finalized within 180 days of the demonstration approval.

States that fail to submit an acceptable and timely evaluation design as well as any monitoring, expenditure, or other evaluation reporting are subject to a $5 million deferral per deliverable.

Key Resources

- State Medicaid Director Letter #18-011: https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf
- Serious Mental Illness/Serious Emotional Disturbance Demonstration Opportunity Technical Assistance Questions & Answers: https://www.medicaid.gov/federal-policy-guidance/downloads/faq051719.pdf

Appendix E: CalAIM Benefit Changes Chart

Benefit Changes Effective April 1, 2021	
Benefits Currently Provided by Medi-Cal Managed Care Plans that will be Carved-Out to Fee-for-Service	
Pharmacy	All pharmacy benefits or services billed by a pharmacy on a pharmacy claim, which includes covered outpatient drugs (including Physician Administered Drugs), medical supplies, and enteral nutrition products. This also includes drugs currently "carved-out" of the managed care delivery system, (e.g., blood factor, HIV/AIDS, antipsychotics, and drugs used to treat substance use disorder), which are currently carved-in to some county operated health systems and AIDS Healthcare Foundation. This does not include any pharmacy benefits or services billed on medical and/or institutional claims.
Benefit Changes Effective January 1, 2022	
Benefits Currently Provided by Medi-Cal Managed Care Plans that will be Carved-Out to Fee-for-Service	
Specialty Mental Health Services	Currently full benefit in Partnership Solano (Kaiser members only) and Kaiser Sacramento
Multipurpose Senior Services Program	Currently full benefit in CCI counties (Los Angeles, Orange, San Bernardino, San Diego, San Mateo, Santa Clara, and Riverside)
Benefits to be Carved-In to Managed Care Statewide	
Major Organ Transplant	Currently full benefit in county operated health systems counties; non-county operated health systems counties currently only cover kidney transplants
Benefit Changes Effective January 1, 2023	
Benefits to be Carved-In to Managed Care Statewide	
Long Term Care	Long Term Care Umbrella • ICF-DD Disabled (excluding beneficiaries in an ICF-DD Waiver center), Disabled Habilitative, and Disabled Nursing • Pediatric Subacute Care Services • Skilled nursing facility • Specialized Rehabilitative Services in skilled nursing facility and ICF • Subacute Care Services Currently full benefit in county operated health systems and CCI counties (Los Angeles, Orange, San Bernardino, San Diego, San Mateo, Santa Clara, and Riverside); in non-county operated health systems/non-CCI counties, Medi-Cal managed care plans are responsible for the month of admission and the month following

Appendix F: Managed Care Enrollment Proposed Aid Code Group Coverage

Managed Care Enrollment Aid Code Group Coverage												
			Current			2022			2023			
Aid Code Group	**Aid Codes[6]**	**Non-Dual/ Dual[7]**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**
Adult Expansion	7U, L1, M1	Non-Dual	All Models	N/A	N/A	All Models	N/A	N/A	All Models	N/A	N/A
Non-Disabled Adults (19 & Over)	01, 02[8], 08, 30, 34, 35, 37, 39, 38, 54, 59, 81[8], 82, 83, 84, 85, 0A, 3D, 3E, 3N, 3P, 3U, 7S, G0, J1, J2, K1, K2, K6, M3	Non-Dual	All Models	N/A	N/A	All Models	N/A	N/A	All Models	N/A	N/A

[6] Members residing in a LTC facility in a non-LTC aid code subject to the LTC benefit carve-in will be transitioned into managed care based on the Non-Dual/Dual Mandatory and Voluntary timeline.
[7] Non-Dual/Dual Definitions: (1) Non-Dual – A Medi-Cal only beneficiary or a Medi-Cal only beneficiary with Medicare Part A **or** Part B only; (2) Dual – Medi-Cal only beneficiary with Medicare Part A **and** Part B or Medicare Part A, B, and D.
[8] Aid code can have a SOC or no SOC

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Managed Care Enrollment												
Aid Code Group Coverage												
			Current			2022			2023			
Aid Code Group	**Aid Codes[6]**	**Non-Dual/ Dual[7]**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**
Aged	10[9], 14, 16, 1E, 1H, 1X, 1Y	Non-Dual	All Models	N/A	N/A	All Models	N/A	N/A	All Models	N/A	N/A
Breast and Cervical Cancer Treatment Program (BCCTP)	0M, 0N, 0P, 0W	Non-Dual	All Models	N/A	N/A	All Models	N/A	N/A	All Models	N/A	N/A
Disabled	20[2], 23, 24, 26, 27, 36, 60[2], 63, 64, 66, 67, 88, 89, 2E, 2H, 6A, 6C, 6E, 6J, 6G, 6H, 6N, 6R, 6V, 6W, 6X, 6Y, 8G, 9L, K4, K8, L6	Non-Dual	All Models	N/A	N/A	All Models	N/A	N/A	All Models	N/A	N/A
Long Term Care (includes LTC SOC)	13, 23, 53, 63	Non-Dual	COHS, CCI	N/A	All Other Models	COHS, CCI	N/A	All Other Models	All Models	N/A	N/A
Foster Children	03, 04, 06, 07, 40, 42, 43, 45, 46, 49, 2P, 2R, 2S, 2T, 2U,	Non-Dual	COHS	Non-COHS	N/A	COHS	Non-COHS	N/A	COHS	Non-COHS	N/A

[9] Aid codes 10, 20, 60 are Supplemental Security Income (SSI)/State Supplemental Payment (SSP). Medi-Cal beneficiaries in these three aid codes have mandatory and voluntary enrollments based on different managed care models. These beneficiaries are mandatory in COHS, voluntary in San Benito, voluntary in GMC/Regional/Two-Plan for duals, and mandatory in GMC/Regional/Two-Plan for non-duals.

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Managed Care Enrollment Aid Code Group Coverage											
			Current			2022			2023		
Aid Code Group	**Aid Codes[6]**	**Non-Dual/ Dual[7]**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**
	4A, 4C, 4F, 4G, 4H, 4K, 4L, 4M, 4S, 4T, 4W, 5K, 5L										
Omnibus Budget Reconciliation Act (OBRA) Restricted Scope Only	58	Non-Dual	Napa, Solano, and Yolo counties	N/A	All Other Models	N/A	N/A	All Models	N/A	N/A	All Models
Share of Cost	17, 27, 37, 50, 53, 58, 67, 71, 73, 81[8], 83, 85, 87, 89, 02[8], 1Y, 4V, 5F, 5R, 6R, 6W, 6Y, 7M, 7P, 7R, 7V, 8V, C2, C4, C6, C8, D1, D3, D5, D7, D9	Non-Dual	COHS & CCI	N/A	All Other Models	N/A	N/A	All Models	N/A	N/A	All Models
Non-Disabled Adults (19 & Over)	01, 02[8], 08, 30, 34, 35, 37, 39, 38, 54, 59, 81[8], 82 ,83, 84, 85, 0A, 3D, 3E, 3N, 3P, 3U, 7S, G0, J1, J2, K1, K2, K6, M3	Dual	COHS, CCI	All Other Models	N/A	COHS, CCI	All Other Models	N/A	All Models	N/A	N/A
Non-Disabled Children (Under 19)	30, 32, 33, 34, 35, 37, 38, 39, 47, 54, 59, 72, 82, 83, 2C, 3A, 3C, 3D, 3E, 3F, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 3W, 4N, 4U, 5C, 5D, 5E, 6P,	Dual	COHS, CCI	All Other Models	N/A	COHS, CCI	All Other Models	N/A	All Models	N/A	N/A

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Managed Care Enrollment

Aid Code Group Coverage

			Current			2022			2023		
Aid Code Group	**Aid Codes[6]**	**Non-Dual/ Dual[7]**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**
	7A, 7J, 7T, 7W, 7X, 8P, 8R, 9H, E6, E7, H1, H2, H3, H4, H5, M5, P5, P7, P9, T1, T2, T3, T4, T5										
Aged	10[2], 14, 16, 1E, 1H, 1X, 1Y	Dual	COHS, CCI	All Other Models	N/A	COHS, CCI	All Other Models	N/A	All Models	N/A	N/A
Breast and Cervical Cancer Treatment Program (BCCTP)	0M, 0N, 0P, 0W	Dual	COHS, CCI	All Other Models	N/A	COHS, CCI	All Other Models	N/A	All Models	N/A	N/A
Disabled	20[2], 23, 24, 26, 27, 36, 60[2], 63, 64, 66, 67, 88, 89, 2E, 2H, 6A, 6C, 6E, 6J, 6G, 6H, 6N, 6R, 6V, 6W, 6X, 6Y, 8G, 9L, L6, K4, K8	Dual	COHS, CCI	All Other Models	N/A	COHS, CCI	All Other Models	N/A	All Models	N/A	N/A
Long Term Care (includes LTC SOC)	13, 23, 53, 63	Dual	COHS, CCI	All Other Models	N/A	COHS, CCI	All Other Models	N/A	All Models	N/A	N/A
Share of Cost	17, 27, 37, 50, 53, 58, 67, 71, 73, 81[8], 83, 85, 87, 89, 02[8], 1Y, 4V, 5F, 5R, 6R, 6W, 6Y, 7M, 7P, 7R, 7V, 8V, C2, C4, C6, C8, D1, D3, D5, D7, D9	Dual	COHS, CCI	N/A	Non-COHS & Non-CCI	N/A	N/A	All Models	N/A	N/A	All Models

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Managed Care Enrollment Aid Code Group Coverage												
			Current			2022			2023			
Aid Code Group	**Aid Codes[6]**	**Non-Dual/ Dual[7]**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**
Presumptive Eligibility (Hospital and CHDP PE)	2A, 4E, 8L, 8W, 8X, H0, H6, H7, H8, H9, P1, P2, P3	Both	N/A	N/A	All Models	N/A	N/A	All Models	N/A	N/A	All Models
Trafficking and Crime Victims Assistance Program (TCVAP)	2V, 4V, 5V, 7V, R1	Both	N/A	N/A	All Models	All Models	N/A	TCVAP SOC	All Models	N/A	TCVAP SOC
Accelerated Enrollment (AE)	8E	Both	N/A	N/A	All Models	All Models	N/A	N/A	All Models	N/A	N/A
Child Health and Disability Prevention (CHDP) Infant Deeming	8U, 8V	Both	N/A	N/A	All Models	All Models	N/A	N/A	All Models	N/A	N/A
State Medical Parole/County Compassionate Release/Incarcerated Individuals	F1, F2, F3, F4, G0, G1, G2, G3, G4, G5, G6, G7, G8, G9, J1, J2, J3, J4, J5, J6, J7, J8, K2, K3,K4, K5, K6, K7, K8, K9, N0, N5, N6, N7, N8, N9	N/A	N/A	N/A	All Models	N/A	N/A	All Models	N/A	N/A	All Models
Limited/Restricted Scope Eligible	48, 50, 53, 55, 58, 69, 71, 73, 74, 76, 77, 80, 0L, 0R, 0T, 0U, 0V, 0X, 0Y, 1U, 3T, 3V, 5J, 5R, 5T, 5W, 6U, 7C, 7F, 7G,	Both	N/A	N/A	All Models	N/A	N/A	All Models	N/A	N/A	All Models

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Managed Care Enrollment											
Aid Code Group Coverage											
			Current			2022			2023		
Aid Code Group	Aid Codes[6]	Non-Dual/ Dual[7]	Mandatory	Voluntary	Excluded from Enrollment	Mandatory	Voluntary	Excluded from Enrollment	Mandatory	Voluntary	Excluded from Enrollment
	7H, 7K, 7M, 7N, 7P, 7R, 8N, 8T, C1, C2, C3, C4, C5, C6, C7, C8, C9, D1, D2, D3, D4, D5, D6, D7, D8, D9, E1, L7, M0, M2, M4, M6, M8, P0, P4, P6, P8, T0, T6, T7, T8, T9, F1, F2, F3, F4, G1, G2, G3, G4, G5, G6, G7, G8, G9, J3, J4, J6, J8, K3, K5, K7, K9, N0, N5, N6, N7, N8, N9										

Pregnancy Related Aid Codes							
	Citizen/Lawfully Present				**Non-Citizen**		
	Aid Codes	**Current**	**Proposed (2021)**		**Aid Codes**	**Current**	**Proposed (2021)**
Title XXI (SCHIP) 213-322%	86, 87, 0E	Full Scope/MC	Full Scope/MC	Title XXI (SCHIP) 213-322%	0E	Full Scope/MC	Full Scope/MC
Title XIX (PRS/ES) 138-213%	44, M9	Limited Scope/FFS	Full Scope/MC	Title XXI (PRS – SCHIP) Title XIX (ES) 138-213%	48, M0	Limited Scope/FFS	Limited Scope/FFS
Title XIX (PRS/ES) 0-138%	M7	Full Scope/MC	Full Scope/MC	Title XXI (PRS – SCHIP) Title XIX (ES) 0-138%	D8, D9, M8	Limited Scope/FFS	Limited Scope/FFS

Population Exclusions									
Populations	**Current**			**2022**			**2023**		
	Mandatory	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**
American Indian[10]	COHS	Non-COHS	N/A	All Models[11]	N/A	N/A	All Models[11]	N/A	N/A
Beneficiaries with Other Healthcare Coverage (OHC)	COHS	N/A	Non-COHS	All Models[11]	N/A	N/A	All Models[11]	N/A	N/A
Beneficiaries in Rural Zip Codes[12]	COHS	Non-COHS	Non-COHS	All Models[11]	N/A	N/A	All Models[11]	N/A	N/A
Beneficiaries in Home and Community Based Services Waivers	COHS & CCI MLTSS = All Non-COHS & Non-CCI = Non-Duals	Non-COHS & Non-CCI = Duals	Cal MediConnect	COHS & CCI MLTSS = All Non-COHS & Non-CCI = Non-Duals	Non-COHS & Non-CCI = Duals	Cal MediConnect	All Models[11]	N/A	N/A

[10] American Indian Beneficiaries will be enrolled into a managed care plan, but they will have the option to opt out of enrollment if they choose to remain in FFS
[11] Would align with Mandatory/Voluntary/Excluded MC Enrollment by aid code, no special exclusions from enrollment solely based on zip code, OHC, American Indian or 1915c Waiver Enrollment
[12] The following zip codes are currently excluded from enrollment or are voluntary for enrollment: 93558, 90704, 92225, 92226, 92239, 92242, 92267, 92280, 92323, 92332, 92363, 92364, 92366, 93562, 9359293555, 93556, 93560, 92252, 92256, 92268, 92277, 92278, 92284, 92285, 92286, 92304,92305, 92309, 92310, 92311, 92312, 92314, 92315, 92317, 92321, 92322, 92325, 92327, 92333, 92338, 92339, 92341, 92342, 92347, 92352, 92356, 92358, 92365, 92368, 92372, 92378, 92382, 92385, 92386, 92391, 92397, 92398

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Appendix G: Global Payment Program Extension Timeline

Program Year	Calendar Year	Federal Fiscal Year	Service Period Dates
6[13]	2021	2021	January 1, 2021-December 31, 2021
7	2022	2022	January 1, 2022 – December 31, 2022
8	2023	2023	January 1, 2023 – December 31, 2023
9	2024	2024	January 1, 2024 – December 31, 2024
10	2025	2025	January 1, 2025 – December 31, 2025
11	2026	2026	January 1, 2026 – December 31, 2026

[13] *PY 6 is part of Medi-Cal 2020 demonstration extension through 12/31/21*

Appendix H: Dental in Proposition 56 vs. CalAIM

Dental Procedure Code	Description	Proposition 56 Supplemental Payment	CalAIM Performance Payment
D0120	Periodic oral evaluation – established patient	No	Yes
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No	Yes
D0150	Comprehensive oral evaluation – new or established patient	No	Yes
D0601	Caries risk assessment and documentation, with a finding of low risk (children ages 0-6)	No	Yes
D0602	Caries risk assessment and documentation, with a finding of moderate risk (children ages 0-6)	No	Yes
D0603	Caries risk assessment and documentation, with a finding of high-risk (children ages 0-6)	No	Yes
D1110	Prophylaxis – adult	Yes	No
D1120	Prophylaxis - child	No	Yes
D1206	Topical application of fluoride varnish (child)	No	Yes
	Topical application of fluoride varnish (adult)	Yes	No
D1208	Topical application of fluoride – excluding varnish (child)	No	Yes
	Topical application of fluoride – excluding varnish (adult)	Yes	No
D1310	Nutritional counseling for the control of dental disease (child)	No	Yes

Dental Procedure Code	Description	Proposition 56 Supplemental Payment	CalAIM Performance Payment
D1320	Tobacco counseling for the control and prevention of oral disease (adult)	No	Yes
D1351	Sealant – per tooth (child)	No	Yes
D1352	Preventive resin restoration in a moderate to high caries risk patient – permanent tooth (child)	No	Yes
D1354	Interim caries arresting medicament application – per tooth (children ages 0-6 and restricted adult populations)	No	Yes
D1510	Space maintainer – fixed, unilateral – per quadrant (child)	No	Yes
D1516	Space maintainer – fixed, bilateral, maxillary (child)	No	Yes
D1517	Space maintainer – fixed, bilateral, mandibular (child)	No	Yes
D1526	Space maintainer – removable, bilateral, maxillary (child)	No	Yes
D1527	Space maintainer – removable, bilateral, mandibular (child)	No	Yes
D1551	Re-cement or re-bond space maintainer – bilateral space maintainer, maxillary (child)	No	Yes
D1552	Re-cement or re-bond space maintainer – bilateral space maintainer, mandibular (child)	No	Yes
D1553	Re-cement or re-bond space maintainer – unilateral space maintainer – per quadrant (child)	No	Yes
D1556	Removal of fixed unilateral space maintainer – per quadrant (child)	No	Yes
D1557	Removal of fixed bilateral space maintainer – maxillary (child)	No	Yes
D1558	Removal of fixed bilateral space maintainer – mandibular (child)	No	Yes
D1575	Distal shoe space maintainer – fixed unilateral – per quadrant (child)	No	Yes
D1999	Unspecified preventive procedure, by report (adult)	No	Yes

Appendix I: Enhanced Care Management Target Population Descriptions

Enhanced care management is designed for populations who have the highest levels of complex health care needs as well as social factors influencing their health. To be eligible for enhanced care management, members must meet criteria below in addition to any criteria specific to the respective enhanced care management population:

1. Have complex physical or behavioral health condition with inability to successfully self-manage AND
2. Limited activity or participation in social functioning as defined by at least one of the following:
    a. Establishing and managing relationships;
    b. Major life areas, including education, employment, finances, engaging in the community

Candidates for enhanced care management have an opportunity for improved health outcomes if they receive high-touch, in-person care management and are connected to a multidisciplinary team that manages physical health, behavioral health (substance use and/or mental health), oral health, developmental disabilities, and health-related non-clinical needs as well as any needed long-term services and supports.

Enhanced care management will be implemented in phases:

- January 1, 2022: All Medi-Cal managed care plans in counties with Whole Person Care pilots and/or Health Homes Programs will begin implementation of the enhanced care management benefit, for those target populations currently receiving Health Homes Program and/or Whole Person Care services.
- July 1, 2022:
    - Medi-Cal managed care plans in counties with Whole Person Care pilots and/or Health Homes Programs will implement additional mandatory enhanced care management target populations.
    - All Medi-Cal managed care plans in counties without Whole Person Care pilots and/or Health Homes Programs must begin implementation of select enhanced care management target populations.
- January 1, 2023: All Medi-Cal managed care plans in all counties must implement enhanced care management for all target populations.

Characteristics of ECM target populations are set forth below and detailed further in this document. Risk stratification is the responsibility of the Medi-Cal managed care plans,

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which will determine member needs and apply criteria to determine eligibility and facilitate ECM services. Medi-Cal managed care plans may propose additional populations to receive ECM or propose expansions of criteria within populations. ECM target populations are subject to further refinement by DHCS.

Medi-Cal managed care plans may propose additional populations to receive enhanced care management, for example to allow the transition for members receiving services under a Whole Person Care pilot. At a minimum, Medi-Cal managed care plans must provide enhanced care management to the below list of mandatory target populations:[14]

- Children and youth with complex physical, behavioral, and/or developmental health needs (i.e. California Children Services, foster care, youth with Clinical High-Risk syndrome or first episode of psychosis).
- Individuals experiencing homelessness, chronic homelessness or who are at risk of becoming homeless.
- High utilizers with frequent hospital admissions, short-term skilled nursing facility stays, or emergency room visits.
- Individuals at risk for institutionalization, eligible for long-term care.
- Nursing facility residents who want to transition to the community.
- Individuals at risk for institutionalization with Serious Mental Illness (SMI), children and youth with Serious Emotional Disturbance (SED) or Substance Use Disorder (SUD).
- Individuals transitioning from incarceration who have significant complex physical or behavioral health needs requiring immediate transition of services to the community.

These target population descriptions are intended as guidance for Medi-Cal managed care plans. Managed care plans will determine criteria for population identification and stratification in accordance with this guidance.

Settings

For all populations, the role of enhanced care management is to coordinate all primary, acute, behavioral, developmental, oral, and long-term services and supports for the

[14] Individuals transitioning from incarceration must be included no later than 1/1/2023, except where such program already exists today through an existing WPC program, in which case this target group is mandatory as of 1/1/2022.

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member, including participating in the care planning process, regardless of setting. This benefit is intended to provide primarily face-to-face services whenever possible.

Services should be offered where the members live, seek care or prefer to access services, essentially meeting the member (and, for children and youth, their family, caretaker or circle of support) where they are within the community. This may include different settings based on the target population. For example, for individuals experiencing homelessness, enhanced care management care managers may conduct street outreach or coordinate with shelters, hotels or motels including those participating in Project Homekey, homeless services providers, recuperative care providers, community partners (e.g., homeless coordinated entry systems) and other service providers to connect with target individuals in these settings. For individuals with SMI and/or SUDs, initial contact may be in settings such as psychiatric inpatient units, Institutions for Mental Disease (IMDs) or residential settings. Children and youth may receive services in a variety of community settings, including homes and schools, where appropriate. These are examples of how enhanced care management settings will reflect individualized needs of the target populations.

Risk Stratification

Enhanced care management is the highest tier of case management and is intended for members at the highest risk level who need long-term coordination for multiple chronic conditions, social determinants of health issues, and utilization of multiple service types and delivery systems. As part of their plan submitted to DHCS, Medi-Cal managed care plans will detail the algorithms, processes, and partnerships they will use to identify those individuals who have the highest levels of complex health care needs and social factors influencing their health, and who present the best opportunity for improved health outcomes through enhanced care management services.

Algorithms and data sources may vary by population. For example, some individuals may be identified using claims data and/or other health assessment information to identify multiple complex conditions or a history of utilization of high-cost services.

However, for a variety of reasons, claims data may be insufficient to identify other good candidates for enhanced care management. For some members, access to care issues and multiple social factors may limit the utility of claims data in identifying health risks. Therefore, managed care plans must also use data sources that capture social determinants of health as well as referrals. For individuals experiencing homelessness, data systems such as the Homeless Management Information System (HMIS) may be used. For individuals transitioning from incarceration, data sharing agreements with city and county jail systems to identify those at highest risk may be considered

For many populations, referrals and partnerships will be a critical method to identify enhanced care management candidates. Entities such as health care providers, community-based organizations, social services agencies, tribal partners, and local governments are important partners in identifying individuals who are at high risk of significant health care utilization and who would benefit from enhanced care management. Medi-Cal managed care plans are encouraged to partner with these entities to ensure enhanced care management benefits are highly coordinated with other service types. Medi-Cal managed care plans should also plan to establish clear protocols to receive and consider enhanced care management referrals from external entities.

Core Components of Enhanced Care Management Services

The types of supports and services provided through enhanced care management may vary based on the needs of the target populations. In the individual target population descriptions, this document describes examples of interventions that enhanced care management may support for each unique target population. However, core components of enhanced care management that are universal for all target populations include:

- Comprehensive Assessment and Care Management Plan:
    - Engage with Members authorized to receive the enhanced care management Benefit primarily through in person contact;
        - *When in-person communication is unavailable or does not meet the needs of the Member, use alternative methods to provide culturally appropriate and accessible communication.*
    - Develop a comprehensive, individualized, person-centered care plan by working with the Member, and as appropriate their chosen family/support persons, to assess strengths, risks, needs, goals, and preferences
    - Incorporate into the Member's care plan needs in the areas including, but not limited to physical and developmental health, mental health, SUD, community-based Long-Term Services and Supports (LTSS), oral health, palliative care, trauma-informed care, necessary community-based and social services, and housing;
    - Ensure the care plan is reassessed at a frequency appropriate for the Member's individual progress or changes in need.
- Enhanced Coordination of Care:
    - Organize patient care activities as laid out in the care plan, share information with the Member's key care team, and implement the Member's care plan;

- Be continuous and integrated among all service providers and refer to primary care/physical and developmental health, mental health, SUD treatment, community-based LTSS, oral health, palliative care, trauma-informed care, necessary community-based and social services, and, housing, as needed;
- Provide support for Member treatment adherence including coordination for medication review/reconciliation, scheduling appointments, providing appointment reminders, coordinating transportation, identifying barriers to adherence, ensuring continuous enrollment in Medi-Cal, and maintaining social services benefits, and accompaniment to key appointments;
- Communicate Members' needs and preferences timely to all members of the Members' care team in a manner that ensures safe, appropriate, and effective person-centered care;
- Be in regular contact with the Member, consistent with the care plan;

- Health Promotion:
  - Work with Members to identify and build on resiliencies and potential family or community supports;
  - Provide services to encourage and support Members to make lifestyle choices based on healthy behavior, with the goal of supporting Members' ability to successfully monitor and manage their health;
  - Support the Member in strengthening skills that enable them to identify and access resources to assist them in managing their conditions and preventing other chronic conditions.
- Comprehensive Transitional Care
  - Perform engagement activities that seek to reduce avoidable Member admissions and readmissions;
  - For Members that are experiencing or are likely to experience a care transition:
    - Develop and regularly update a transition plan for the Member, and incorporate it into the Member's care plan;
    - Evaluate a Member's medical care needs and coordination of any support services to facilitate safe and appropriate transitions from and among treatment facilities, including admissions and discharges;

- Track each Member's admission or discharge to/from an emergency department, hospital inpatient facility, skilled nursing facility, residential/treatment facility, incarceration facility, or other treatment center and communicate with the appropriate care team members;
- Coordinate medication review/reconciliation; and
- Provide adherence support and referral to appropriate services.

- Member and Family Supports:
  - Document a Member's chosen caregiver or family/support person;
  - Include activities that ensure that the Member and chosen family/support persons, including as guardians and caregivers, are knowledgeable about the Member's condition(s) and care plan with the overall goal of improving the Member's care planning and follow-up, adherence to treatment, and medication management;
  - Serve as the primary point of contact for the Member and their chosen family/support persons;
  - Identify supports needed for the Member and chosen family/support persons to manage the Member's condition and direct them to access needed support services, including peer supports when applicable and available; and,
  - Provide for appropriate education of the Member, family members, guardians, and caregivers on care instructions for the Member.
- Coordination of and Referral to Community and Social Support Services:
  - Determine appropriate services to meet the needs of Members, including services that address social determinants of health needs, including housing, and services that are offered by managed care plan as an ILOS;
  - Coordinate and referring Members to available community resources and following up with Members to ensure services were rendered (i.e. "Closed loop referrals").

Target Populations

A description of each population is outlined below. Beneficiaries must be enrolled in Medi-Cal managed care to receive enhanced care management. In general, for all target populations, individuals who, after multiple outreach attempts, using different modalities, opt not to participate in enhanced care management services or whose assessment

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(completed or confirmed by the managed care plan) indicates they would not benefit from the services, would not be good candidates for enhanced care management. The number of outreach attempts and approaches will vary based on the populations and individualized needs.

Enhanced care management is designed to provide support to individuals who require high levels of intensive interventions. Individuals who are receiving or who would benefit from other existing types of interventions (e.g., end of life care, standard case management, disease management or other care coordination efforts) would not be appropriate candidates for enhanced care management unless those interventions are not successful. Medi-Cal managed care plans and/or their subcontractors or contracted providers will evaluate individuals for enhanced care management and not all individuals will be good candidates. For example, individuals with the following circumstances may not be good candidates for enhanced care management:

- Individuals who have a well-treated chronic disease and are compliant with their care plan and have unavoidable or expected admissions due to the condition.
- Individuals who refuse to engage in any telephonic or face to face case management after multiple outreach attempts using different modalities.
- Individuals receiving services that the managed care plan determines to be duplicative of enhanced care management, such as 1915(c) Home and Community Based Services (HCBS) Waiver programs.

All Medi-Cal beneficiaries currently receiving care management through the Health Homes Program and Whole Person Care shall be transitioned to enhanced care management through one of the target populations listed and will be reassessed.

The populations eligible for enhanced care management are those with the highest needs who use multiple delivery systems and services, who need ongoing coordination across medical, behavioral and social needs, and who are part of the mandatory target populations described below. Note that some enhanced care management candidates will meet criteria for multiple target populations. Medi-Cal managed care plans will assign these individuals authorized to receive enhanced care management services to an enhanced care management provider that has appropriate competencies and experience for the needs of the beneficiary. For example, individuals with SMI or SUDs may also be homeless or high utilizers. These members may be assigned to an enhanced care management provider that has the necessary skills and experience to work with individuals with SMI and SUDs.

Children and Youth

Target Population:

Children and youth (up to age 21, or foster youth to age 26) with complex physical, behavioral, and/or developmental health needs, with significant functional limitations and social factors influencing their health outcomes (e.g., California Children Services, foster care, youth with Clinical High-Risk syndrome or first episode of psychosis).

For example:

- Children/Youth with complex health needs who are medically fragile or have multiple chronic conditions. This may include children with a history of trauma and children who are engaged or have history with the child welfare system. These children often access care across multiple service delivery systems and require significant coordination to ensure their needs are being met.

- Children/Youth with significant functional limitations and multiple social factors influencing their health outcomes.

Enhanced Care Management Services:

Enhanced care management can be used to assess gaps in both health care and social support needs and develop a care plan that addresses the whole health needs of the child. While Medi-Cal managed care plans may use claims data to identify good candidates, referrals will be an important mechanism to identify children and youth who would benefit from enhanced care management. Health care providers, the child welfare system, schools, community-based organizations, California Children's Services (CCS), county behavioral health, and social services agencies are examples of other important potential referral partners for children/youth. Medi-Cal managed care plans should establish a process for providers to refer for enhanced care management based on a needs assessment, behavioral health screens, other EPSDT screening, and/or ACE score which includes consideration of the community supports available for the children and their families and caretakers, as well as social factors impacting their health.

Services should be offered where the members live, seek care or where the family, caretaker, or circle of support prefers to access services, essentially meeting the member and family/caretaker/support where they are within the community. Activities may include coordination in school-based settings if permitted by the schools. Services should be offered by culturally and linguistically aligned trauma-informed providers.

For this population, enhanced care management services include (but are not limited to):

- Helping families, caretakers, and circles of support access resources such as information, coordination, and education about the child's conditions.
- Identifying coordinating, and providing (when appropriate) services that will help families, caretakers, and circles of support with the health needs of their children, which may include referrals for services those individuals need to enable them to support their children's health (e.g., referral to behavioral health, including SUD services, for a parent, or housing-related services for households experiencing homelessness, either of which could be critical to ensure the parent can support the health needs of the child).
- Referral to housing related services for youth experiencing homelessness.
- Coordination of services across various health, behavioral health, developmental disability, housing and social services providers, including facilitating cross-provider data- and information-sharing and member advocacy to ensure the child's whole person needs are met and needed services are accessible.
- Assistance with accessing respite care as needed.
- Referral to community and social services to address food insecurity and other social factors that may impact the child's health.
- Coordination of other services as required by EPSDT.
- Referral to community and social services to address food insecurity and other social factors that may impact the child's health

Homeless

Target Population:

Individuals experiencing homelessness or chronic homelessness, or who are at risk of experiencing homelessness (as defined below), with complex health and/or behavioral health needs, for whom coordination of services would likely result in improved health outcomes and decreased utilization of high-cost services.

For example:

- Individuals with complex health care needs as a result of medical, psychiatric or SUD-related conditions, who may also experience access to care issues (resulting in unmet needs or barriers to care) and multiple social factors influencing their health outcomes.
- Individuals with repeated incidents of avoidable justice involvement, emergency department use, psychiatric emergency services or hospitalizations.

Homeless: Individuals who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution). For the purpose of enhanced care management, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, Institution for Mental Disease and State Hospitals.

Individuals who meet the definition of an individual experiencing chronic homelessness, either as defined:

A. In W&I Code section 14127(e) as “a homeless individual with a condition limiting his or her activities of daily living who has been continuously homeless for a year or more or had at least four episodes of homelessness in the past three years.” The definition also includes “an individual who is currently residing in transitional housing, as defined in Section 50675.2 of the Health and Safety Code, or who has been residing in permanent supportive housing as defined in Section 50675.14 of the Health and Safety Code for less than two years if the individual was chronically homeless prior to his or her residence.

B. By the Department of Housing and Urban Development (HUD) in 24 CFR 91.5 (including those exiting institutions but not including any limits on the number of days in the institution) as:

1. A ‘‘homeless individual with a disability,’’ as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)), who:

    i. Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and

    ii. Has been homeless and living as described in paragraph (1) (i) of this definition continuously for at least 12 months or on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least 7 consecutive nights of not living as described in paragraph (1) (i). Stays in institutional care facilities will not constitute as a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility;

2. An individual who has been residing in an institutional care facility, including a jail, substance use or mental health treatment facility, hospital, or other similar facility, and met all of the criteria in paragraph (1) of this definition, before entering that facility; or

3. A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) or (2) of this definition, including a family whose composition has fluctuated while the head of household has been homeless.

Individuals who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations as:

(1) An individual or family who:

(i) Has an annual income below 30 percent of median family income for the area, as determined by HUD;

(ii) Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place described in paragraph (1) of the “Homeless” definition in this section; and

(iii) Meets one of the following conditions:

(A) Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;

(B) Is living in the home of another because of economic hardship;

(C) Has been notified in writing that their right to occupy their current housing or living situation will be terminated within 21 days after the date of application for assistance;

(D) Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income individuals;

(E) Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;

(F) Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or

(G) Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan;

(2) A child or youth who does not qualify as “homeless” under this section, but qualifies as “homeless” under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a(3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C. 254b(h)(5)(A)), section 3(m) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(m)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or

(3) A child or youth who does not qualify as “homeless” under this section, but qualifies as “homeless” under section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), and the parent(s) or guardian(s) of that child or youth if living with her or him.

Individuals who meet the State’s No Place Like Home definition for a person with SMI and/or SED “at risk of chronic homelessness,” which includes persons exiting institutions that were homeless prior to entering the institution and Transition-age youth with

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significant barriers to housing stability, including one or more convictions and history of foster care or involvement with the juvenile justice system.

Enhanced Care Management Services:

Individuals experiencing or at risk of homelessness are among the highest-need individuals in Medi-Cal. They often lack access to necessities such as food and shelter that are critical to attaining health. Individuals often have high medical needs that are difficult to manage due to the social factors that influence the individual's health. This often results in high utilization of costly services such as emergency departments and inpatient settings.

Engagement for this population may include street outreach or coordinating with shelters, homeless services providers, recuperative care providers, community partners (e.g., homeless coordinated entry systems) and other service providers to connect with target individuals.[15] As individuals are connected to resources, the enhanced care management care coordinator will meet the member in the community or at provider locations.

Enhanced care management can be used to link individuals with a variety of services to meet their complex needs. This includes (but is not limited to):

- Utilizing housing-related in-lieu-of services (ILOS) to identify housing and prepare individuals to for securing and/or maintaining stable housing.
- Coordinating short-term post-hospitalization housing and recuperative care services as appropriate.
- Regular contact with members to ensure there are not gaps in the activities designed to address an individual's health and social service needs, and swiftly addressing those gaps to ensure progress towards regaining health and function continues.
- Coordinating and collaborating with various health and social services providers, including Regional Centers, including sharing data (as appropriate) to facilitate better-coordinated whole person care.
- Supporting member treatment adherence including scheduling appointments, appointment reminders, coordinating transportation, ensuring connection to

[15] These same entities will be important referral partners to identify potential enhanced care management candidates

public benefits, identifying barriers to adherence, and accompanying members to appointments as needed.

- Addressing barriers to housing stability by connecting member to housing, health, and social support resources.
- Utilize best practices for Member who are experiencing homelessness and who have complex health and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care

High Utilizers

Target Population:

High utilizers are Members with multiple hospital admissions, OR multiple short-term skilled nursing facility stays, OR multiple emergency room visits that could be avoided with appropriate outpatient care or improved treatment adherence.

For example:

- Individuals that have impactable conditions or opportunities for interventions that have the potential to decrease inappropriate utilization or can be performed at an alternative location.
- Individuals with repeated incidents of avoidable emergency use, hospital admissions, or nursing facility placement. Individuals with multiple chronic or poorly managed conditions requiring intensive coordination, beyond telephonic intervention.
- Significant functional limitations and/or adverse social determinant of health that impede the ability of the individual to navigate their healthcare and other services.

Enhanced Care Management Services:

Enhanced care management will provide multiple opportunities to engage individuals by stratifying risk and need and developing care plans and strategic interventions to mitigate risk and help clients achieve improved health and well-being. Medi-Cal managed care plans will identify the algorithms they will use to identify individuals who are high utilizers of medical services. DHCS expects Medi-Cal managed care plans will rely on available healthcare research related to appropriate identification of high utilizers and will leverage the managed care plan utilization data to identify members that meet the respective criteria established by the managed care plans.

For this population enhanced care management may include, but is not limited to:

- Frequent follow up visits, culturally and linguistically appropriate education and care coordination activities to ensure the member's needs are being met where they are.
- Connection to culturally and linguistically appropriate community-based organizations, programs and resources that will meet the member's needs.
- Improving member engagement to improve adherence to the member's treatment plan, including through more culturally and linguistically aligned approaches toward member and provider education and tools on how to increase adherence.

- Medication review, reconciliation, assistance obtaining medications, and culturally and linguistically appropriate reinforcement with medication adherence.

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Risk for Institutionalization – Long Term Care

Target Population:

Individuals at risk for institutionalization, eligible for long-term care services. Medi-Cal beneficiaries who, in the absence of services and supports would otherwise require care for 90 consecutive days or more in an inpatient nursing facility (NF) would qualify.

Individuals must meet NF level of care criteria AND be able continue to live safely in the community with wrap around supports. \

Examples include, but are not limited to:

- Seniors and persons with disabilities who reside in the community but are at risk of being institutionalized.
- Individuals in need of increasing assistance with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs).
- Possibly, individuals with changes to family or caregiver status.
- Possibly, individuals with medical or surgical setbacks resulting in a decrease in functional, cognitive, or psychological status.
- Possibly, individuals showing early signs of dementia with few or no natural supports.
- Possibly, individuals who are noncompliant with their prescribed medical regime.
- Possibly, individuals who are not appropriately engaged to take advantage of necessary health care services.
- Possibly, individuals who lack a family or community support system to assist in appropriate follow-up care at home.

Would not include:

- Individuals with complex needs but who are not at risk of institutionalization.

Enhanced Care Management Services:

Services include preventing skilled nursing admissions for individuals with an imminent need for nursing facility placement. For this population enhanced care management may include, but is not limited to:

- Assessment to determine natural supports available, risk factors, social determinants of health, and other factors to determine safety and feasibility of continued stay in the community. Assessments should be conducted face-to-face whenever possible.
- Connection to needed supportive services, including ILOS such as meals, environmental accessibility adaptations (home modifications), and personal care.
- Frequent follow up visits (including regular home visits), culturally and linguistically appropriate education and care coordination activities to ensure the member and family/caregiver needs are being met where they are.
- Connection to appropriate culturally and linguistically aligned community-based organizations, programs and resources that will meet the member's needs.
- Placement of wrap-around services to maintain the member in their current, community setting.
- Supporting member treatment adherence including scheduling appointments, appointment reminders, ensuring connection to public benefits, coordinating transportation, identifying barriers to adherence, and accompanying members to appointments as needed.

Nursing Facility Transition to Community

Target Population:

Individuals who are currently residing in a Nursing Facility (NF) but desire to return to living in the community. Transition from the NF to community is strictly voluntary. Individuals have the option to transition to the community when that can be done in a cost-effective manner. Individuals must be able to transition safely to the community.

Individuals must have an identified support network system and housing available to them. The support network system may consist of care providers, community-based organizations, family members, primary care physicians, home health agencies, members of the individual's medical team, licensed foster parent, or any other individual who is part of

the individual's circle of support. The individual's circle of support may consist of family members, legal representative/legally responsible adult, and any other person named by the individual.

Would not include:

- Individuals not interested in moving out of the institution.
- Individuals who are not medically appropriate to live in the community (high acuity).
- Individuals whose total projected costs outside the institution are greater than the cost of institutionalization.
- Individuals who do not have the supports to reside safely in the community.
- Individuals who would be at a high risk of re-institutionalization or experiencing homelessness.

Enhanced Care Management Services:

The care team will help individuals move safely between different care settings, such as entering or leaving a hospital or nursing facility and returning to their own home.

Services include facilitating nursing facility transition back into a homelike and community setting with the necessary wrap-around services, community supports, and natural supports when available.

Enhanced Care Manager care manager visits will occur face to face at the facility throughout the transition process. An in-person home visit will occur prior to the

individual's move to ensure the health and safety of the new residence. Post-transition individuals will then be visited in person at a determined schedule at their home or community placement.

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SMI, SED and SUD Individuals at Risk for Institutionalization

Target Population:

Individuals who are at risk for institutionalization who have co-occurring chronic health conditions and:

- Serious Mental Illness (SMI, adults);
- Serious Emotional Disturbance (SED, children, and youth); or
- Substance Use Disorder (SUD).

Potential candidates include:

- Individuals who have the highest levels of complex health care needs as a result of psychiatric or SUD-related conditions with co-occurring chronic health conditions, who may also experience access to care issues and have multiple social factors influencing their health outcomes and as a result of these factors are at risk for institutionalization.
- Individuals with repeated incidents of emergency department use, psychiatric emergency services, psychiatric inpatient hospitalizations, including stays at psychiatric health facilities, or short-term skilled nursing facility stays who could be served in community-based settings with supports.

Enhanced Care Manager Services:

For individuals with SMI or SUD, or children and youth with SED, enhanced care management will coordinate across the delivery systems through which members access care. For these individuals, Medi-Cal managed care plans may pursue contracts with county behavioral health systems to perform enhanced care management activities, but this must include coordination of all available services including medical care, behavioral health and long-term services and supports. When managed care plans do not contract with county behavioral health, enhanced care management service providers for this population should have experience and competency in working with individuals with SMI and SUDs as well as a plan to adequately coordinate enhanced care management and behavioral health services and supports across the managed care plan and county behavioral health. Initial engagement may be in treatment settings such as psychiatric inpatient units, IMDs or residential settings.

For children and youth with SED, activities may include coordination in school-based settings if permitted by the schools.

Enhanced care management can be used to link individuals with a variety of services to meet their complex needs. Medi-Cal managed care plans should closely coordinate these

enhanced care management services and supports with county behavioral health to avoid duplication and ensure adequate communication and care coordination. This includes (but is not limited to):

- Provide post-hospitalization or post-residential medical treatment care planning to connect individuals with the supports they need to avoid rehospitalization including identifying appropriate culturally and linguistically appropriate community placements. These services should be provided in close coordination with county behavioral health plans when the hospitalization or residential treatment occurs due to mental illness or substance use disorder.

- Regular culturally and linguistically appropriate contact with members to ensure there are not gaps in the activities designed to avoid institutionalization or hospitalization and swiftly addressing those gaps to ensure the individual can remain in the community placement.

- Utilizing housing related ILOS to identify housing and prepare individuals for securing and/or maintaining stable housing, if needed, and connecting to other social services to address social factors that influence the individual's health outcomes.

- Supporting the members' behavioral health recovery goals with related improvements in physical and oral health and long-term services and supports.

- Connecting families, caretakers, and circles of support to resources regarding the member's conditions to assist them with providing support for the member's health/behavioral health.

- Coordinating and collaborating with various health, behavioral health, developmental disability, and social services providers including sharing data (as appropriate).

- Supporting member treatment adherence including scheduling appointments, appointment reminders, coordinating transportation, ensuring connection to public benefits, identifying barriers to adherence, and accompanying members to appointments as needed

Individuals Transitioning from Incarceration[16]

Target Population:

Individuals transitioning from incarceration, including justice-involved juveniles who have significant complex physical or behavioral health needs requiring immediate transition of services to the community. A Medi-Cal managed care plan may stratify eligibility based on populations that have multiple incarcerations, other institutionalizations and/or high utilization. Individuals must have been released from incarceration with the last 12 months.

In addition, this population includes individuals who are involved in pre- or post-booking diversion behavioral health and criminogenic treatment programs and therefore are at risk for incarceration and who could, through care coordination and service placement, have a treatment plan designed to avoid incarceration through the use of community-based care and services.

Enhanced Care Management Services:

Some individuals transitioning from incarceration have significant health and behavioral health care needs that require ongoing treatment in the community post-release. Individuals often also experience significant social factors that impact their ability to successfully manage their health/behavioral health conditions, such as lack of safe and stable housing and unemployment. Upon transition back to the community, individuals are required to coordinate a significant number of basic life needs and as a result often experience care disruptions, which result in deterioration of their conditions and increased use of emergency departments and inpatient settings. For some individuals, unmet health care needs can increase their likelihood of returning to incarceration; diversion programs are designed to address these needs and avoid incarceration.

For this target population, enhanced care management requires coordination with the state prison system and local corrections departments, including probation, courts and the local county jail system to both to identify/refer members and also to ensure connections to care once individuals are released from incarceration. Upon release, all individuals receiving ongoing behavioral health treatment (including treatment for SUD) should be referred to county behavioral health programs and managed care plans on an as needed basis. Medi-Cal managed care plans and county behavioral health programs should coordinate closely to better serve clients that receive services from both entities. Therefore, the enhanced care management care managers will need to coordinate and

[16] This target population must be included no later than 1/1/2023, except where such program already exists today through an existing WPC program, in which case this target group is mandatory as of 1/1/2022.

collaborate closely with county behavioral health departments, and potentially also with Medi-Cal managed care plans, for those individuals.

The initial enhanced care management engagement locations will depend on the collaborations that Medi-Cal managed care plans are able to build with local justice partners. At first, enhanced care management staff will begin work with individuals expected to transition from incarceration in the setting where they are incarcerated (or just outside that setting), or in criminogenic treatment programs.[17] Post-transition, enhanced care management care managers will engage individuals in the most easily accessible setting for the member. In addition to community-based engagement such as a member's home or regular provider office, this may also include parole or probation offices if the managed care plan builds partnerships that allow for engagement in those offices.

Enhanced care management can be used to link individuals transitioning from incarceration (or in diversion programs) with a variety of services to meet their complex needs. This includes (but is not limited to):

- Coordination of an initial risk assessment to evaluate medical, psychiatric, substance use and social needs for which the individual requires assistance.
- Direct connections with community providers to ensure continuity of care for their conditions (especially for medications) and to address any health care needs not treated while they were incarcerated. This will also include peer mentorship to help provide positive social support.
- Utilizing housing related ILOS to identify housing and prepare individuals for securing and/or maintaining stable housing.
- Regular contact with members to ensure there are not gaps in the activities designed to address an individual's health and social service needs, and swiftly addressing those gaps to prevent reincarceration and ensure progress towards regaining health and function continues.
- Screening and providing referrals for various health, developmental disabilities, mental health, substance use disorder and social service needs.

[17] DHCS is looking to leverage H.R. 6 SUPPORT Act to begin providing enhanced care management for individuals exiting from incarceration with known medical and behavioral health needs 30 days prior to release. enhanced care management dollars will not be able to be used to provide services directly to justice involved members prior to release

- Coordinating and collaborating with various health, behavioral health, and social services providers as well as parole/probation including sharing data (as appropriate) to facilitate better-coordinated whole person care.
- Supporting member treatment adherence including scheduling appointments, appointment reminders, coordinating transportation, ensuring connection to public benefits, identifying barriers to adherence, and accompanying members to appointments as needed.
- Helping members set and monitor health goals to maintain or improve their health.
- Providing culturally and linguistically appropriate education to families, caretakers, and circles of support regarding the member's health care needs and available supports.
- Navigating members to other reentry support providers to address unmet needs.
- Facilitating benefits reinstatement.[18]

[18] To complement these efforts, DHCS is proposing to mandate that all counties implement a county inmate pre-release Medi-Cal application process by January 1, 2023 The enhanced care management care manager would also help facilitate accessing other benefits as needed by the member.

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Enhanced Care Management Implementation Dates by County

Counties with Whole Person Care and/or Health Homes[19] (Begin implementation on 1/1/22)		Counties without Whole Person Care or Health Homes (Begin implementation on 7/1/22*)
Alameda	HHP, WPC	Alpine
Contra Costa	WPC	Amador
Imperial	HHP	Butte
Kern	HHP, WPC	Calaveras
Kings	WPC	Colusa
Los Angeles	HHP, WPC	Del Norte
Marin	WPC	El Dorado
Mendocino	WPC	Fresno
Monterey	WPC	Glenn
Napa	WPC	Humboldt
Orange	HHP, WPC	Inyo
Placer	WPC	Lake
Riverside	HHP, WPC	Lassen
Sacramento	HHP, WPC	Madera
San Bernardino	HHP, WPC	Mariposa
San Diego	HHP, WPC	Merced
San Francisco	HHP, WPC	Modoc
San Joaquin	WPC	Mono
San Mateo	WPC	Nevada
Santa Clara	HHP, WPC	Plumas
Santa Cruz	WPC	San Luis Obispo
Shasta	WPC	Santa Barbara
Sonoma	WPC	Sierra
Tulare	HHP	Siskiyou
Ventura	WPC	Solano
		Stanislaus
		Sutter
		Tehama
		Trinity
		Tuolumne
		Yolo
		Yuba

[19] List is subject to changed based on WPC pilots decisions to continue operating through 2021.

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Appendix J: In Lieu of Services Options

Following is the proposed menu of in lieu of services that would be covered under the CalAIM initiative. ILOS are optional for both the plan to offer and the beneficiary to accept. Individuals do not have to be enrolled in Enhanced Care Management to be eligible for in lieu of services. ECM target populations/ILOS Service definitions are subject to further refinement by DHCS.

Each set of services is described in detail below:

- Housing Transition Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Short-term Post-Hospitalization Housing
- Recuperative Care (Medical Respite)
- Respite Services
- Day Habilitation Programs
- Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly (RCFE) and Adult Residential Facilities (ARF)
- Community Transition Services/Nursing Facility Transition to a Home
- Personal Care and Homemaker Services
- Environmental Accessibility Adaptations (Home Modifications)
- Meals/Medically Tailored Meals
- Sobering Centers
- Asthma Remediation

Housing Transition Navigation Services

Description/Overview

Housing transition services assist beneficiaries with obtaining housing and include:

1. Conducting a tenant screening and housing assessment that identifies the participant's preferences and barriers related to successful tenancy. The assessment may include collecting information on the participant's housing needs, potential housing transition barriers, and identification of housing retention barriers.
2. Developing an individualized housing support plan based upon the housing assessment that addresses identified barriers, includes short- and long-term measurable goals for each issue, establishes the participant's approach to meeting the goal, and identifies when other providers or services, both reimbursed and not reimbursed by Medi-Cal, may be required to meet the goal.
3. Searching for housing and presenting options.
4. Assisting in securing housing, including the completion of housing applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history).
5. Assisting with benefits advocacy, including assistance with obtaining identification and documentation for SSI eligibility and supporting the SSI application process. Such service can be subcontracted out to retain needed specialized skillset.
6. Identifying and securing available resources to assist with subsidizing rent (such as Section 8, state and local assistance programs etc.) and matching available rental subsidy resources to members.
7. If included in the housing support plan, identifying and securing resources to cover expenses, such as security deposit, moving costs, adaptive aids, environmental modifications, moving costs, and other one-time expenses. [20]
8. Assisting with requests for reasonable accommodation, if necessary.
9. Landlord education and engagement
10. Ensuring that the living environment is safe and ready for move-in.
11. Communicating and advocating on behalf of the client with landlords.

[20] Actual payment of these housing deposits and move-in expenses is a separate in-lieu service under Housing Deposits.

12. Assisting in arranging for and supporting the details of the move.
13. Establishing procedures and contacts to retain housing, including developing a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized.[21]
14. Identifying, coordinating, securing, or funding non-emergency, non-medical transportation to assist members' mobility to ensure reasonable accommodations and access to housing options prior to transition and on move in day.
15. Identifying, coordinating, environmental modifications to install necessary accommodations for accessibility.

The services provided should be based on individualized assessment of needs and documented in the individualized housing support plan. Individuals may require and access only a subset of the services listed above.

The services provided should utilize best practices for clients who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions. Examples of best practices include Housing First Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

The services may involve additional coordination with other entities to ensure the individual has access to supports needed for successful tenancy such as County Health, Public Health, Substance Use, Mental Health and Social Services Departments; County and City Housing Authorities; Continuums of Care and Coordinated Entry System; local legal service programs, community-based organizations housing providers, local housing agencies and housing development agencies. For clients who will need rental subsidy support to secure permanent housing, the services will require close coordination with local Coordinated Entry Systems, homeless services authorities, public housing authorities, and other operators of local rental subsidies. Some housing assistance (including recovery residences and emergency assistance or rental subsidies for Full Service Partnership clients) is also funded by county behavioral health agencies, and Medi-Cal managed care plans and their contracted ILOS providers should expect to coordinate access to these housing resources through county behavioral health when appropriate.

Services do not include the provision of room and board or payment of rental costs. Coordination with local entities is crucial to ensure that available options for room and board or rental payments are also coordinated with housing services and supports.

Eligibility (Population Subset)

[21] The services associated with the crisis plan are a separate in-lieu service under Housing Tenancy and Sustaining Services.

- Individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system designed to use information to identify highly vulnerable individuals with disabilities and/or one or more serious chronic conditions and/or serious mental illness, institutionalization or requiring residential services as a result of a substance use disorder and/or is exiting incarceration; or
- Individuals who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management, or who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, Institution for Mental Disease and State Hospitals; or
- Individuals who meet the definition of an individual experiencing chronic homelessness, either as defined:
    - In W&I Code section 14127(e) as “a homeless individual with a condition limiting his or her activities of daily living who has been continuously homeless for a year or more or had at least four episodes of homelessness in the past three years.” The definition also includes “an individual who is currently residing in transitional housing, as defined in Section 50675.2 of the Health and Safety Code, or who has been residing in permanent supportive housing as defined in Section 50675.14 of the Health and Safety Code for less than two years if the individual was chronically homeless prior to his or her residence.
    - By the Department of Housing and Urban Development (HUD) in 24 CFR 91.5 (including those exiting institutions but not including any limits on the number of days in the institution) as:
        - A ‘‘homeless individual with a disability,’’ as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)), who:
            a. Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and
            b. Has been homeless and living as described in paragraph (1) (i) of this definition continuously for at least 12 months

or on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least 7 consecutive nights of not living as described in paragraph (1) (i). Stays in institutional care facilities will not constitute as a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility; or

- An individual who has been residing in an institutional care facility, including a jail, substance use or mental health treatment facility, hospital, or other similar facility, and met all of the criteria in paragraph (1) of this definition, before entering that facility; or
- A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) or (2) of this definition, including a family whose composition has fluctuated while the head of household has been homeless; or

- Individuals who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations as:
    - (1) An individual or family who:
        - Has an annual income below 30 percent of median family income for the area, as determined by HUD;
        - Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place described in paragraph (1) of the "Homeless" definition in this section; and
            - Meets one of the following conditions:
                - Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;
                - Is living in the home of another because of economic hardship;
                - Has been notified in writing that their right to occupy their current housing or living situation will be

terminated within 21 days after the date of application for assistance;
- Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income individuals;
- Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;
- Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or
- Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan;

  - (2) A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a(3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C. 254b(h)(5)(A)), section 3(m) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(m)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or
  - (3) A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), and the parent(s) or guardian(s) of that child or youth if living with her or him; or

- Individuals who are determined to be at risk of experiencing homelessness are eligible to receive Housing Transition Navigation services if they have significant barriers to housing stability and meet at least one of the following:
  - Have one or more serious chronic conditions;
  - Have a Serious Mental Illness;
  - Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder
  - Have a Serious Emotional Disturbance (children and adolescents);
  - Are receiving Enhanced Care Management; or
  - Are a Transition-Age Youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or who have been victims of trafficking, or

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- Individuals who meet the State's No Place Like Home definition of "at risk of chronic homelessness", which includes persons exiting institutions that were homeless prior to entering the institution and Transition-age youth with significant barriers to housing stability, including one or more convictions and history of foster care or involvement with the juvenile justice system.

Restrictions and Limitations

In lieu of services are alternative services covered under the Medi-Cal State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu of services can only be covered if: 1) the State determines they are medically-appropriate and cost-effective substitutes or settings for the State Plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services are authorized and identified in the managed care plan contracts.

Housing Transition/Navigation services must be identified as reasonable and necessary in the individual's individualized housing support plan.

Individuals may not be receiving duplicative support from other State, local tax or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services in a culturally and linguistically appropriate manner. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

Providers must have demonstrated experience with providing housing-related services and supports and may include providers such as:

- Vocational services agencies;
- Providers of services for individuals experiencing homelessness;
- Life skills training and education providers;
- County agencies;
- Public hospital systems;
- Mental health or substance use disorder treatment providers, including county behavioral health agencies;
- Social services agencies;

- Affordable housing providers;
- Supportive housing providers; and
- Federally qualified health centers and rural health clinics.

Medi-Cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program (See Credentialing/Recredentialing and Screening/Enrollment APL 19-004) if an enrollment pathway exists, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, Medi-Cal managed care plans must credential the providers as required by DHCS.

Clients who meet the eligibility requirements for Housing Transition/Navigation services should also be assessed for enhanced care management and Housing and Tenancy Support Services (if provided in their county). When enrolled in enhanced care management, in lieu of services should be managed in coordination with enhanced care management providers. When clients receive more than one of these services, the managed care plan should ensure it is coordinated by an enhanced care management provider whenever possible to minimize the number of care/case management transitions experienced by clients and to improve overall care coordination and management.[22]

If the Medi-Cal managed care plan case manager, care coordinator or housing navigator is providing the service, that individual must have demonstrated experience working with individuals experiencing homelessness or with the provision of housing-related services and supports to vulnerable populations.

State Plan Service(s) To Be Avoided

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient Hospital services, emergency department services, emergency transport services, and skilled nursing facility services.

[22] One exception to this is for benefits advocacy, which may require providers with a specialized skill set.

Housing Deposits

Description/Overview

Housing Deposits assist with identifying, coordinating, securing, or funding one-time services and modifications necessary to enable a person to establish a basic household that do not constitute room and board, such as:

1. Security deposits required to obtain a lease on an apartment or home.
2. Set-up fees/deposits for utilities or service access and utility arrearages.
3. First month coverage of utilities, including but not limited to telephone, gas, electricity, heating, and water.
4. First month's and last month's rent as required by landlord for occupancy.
5. Services necessary for the individual's health and safety, such as pest eradication and one-time cleaning prior to occupancy.
6. Goods such as an air conditioner or heater, and other medically-necessary adaptive aids and services, designed to preserve an individuals' health and safety in the home such as hospital beds, Hoyer lifts, air filters, specialized cleaning or pest control supplies etc., that are necessary to ensure access and safety for the individual upon move-in to the home.

The services provided should be based on individualized assessment of needs and documented in the individualized housing support plan. Individuals may require, and access only a subset of the services listed above.

The services provided should utilize best practices for clients who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

Services do not include the provision of room and board or payment of ongoing rental costs beyond the first and last month's coverage as noted above.

Eligibility (Population Subset)

- Any individual who received Housing Transition/Navigation Services ILOS in counties that offer Housing Transition/Navigation Services.
- Individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system designed to use information to identify highly vulnerable individuals with

disabilities and/or one or more serious chronic conditions and/or serious mental illness, institutionalization or requiring residential services as a result of a substance use disorder and/or is exiting incarceration; or

- Individuals who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management, or who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, Institution for Mental Disease and State Hospitals; or

- Individuals who meet the definition of an individual experiencing chronic homelessness, either as defined:
    - In W&I Code section 14127(e) as “a homeless individual with a condition limiting his or her activities of daily living who has been continuously homeless for a year or more or had at least four episodes of homelessness in the past three years.” The definition also includes “an individual who is currently residing in transitional housing, as defined in Section 50675.2 of the Health and Safety Code, or who has been residing in permanent supportive housing as defined in Section 50675.14 of the Health and Safety Code for less than two years if the individual was chronically homeless prior to his or her residence.
    - By the Department of Housing and Urban Development (HUD) in 24 CFR 91.5 (including those exiting institutions but not including any limits on the number of days in the institution) as:
        - A ‘‘homeless individual with a disability,’’ as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)), who:
            c. Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and
            d. Has been homeless and living as described in paragraph (1) (i) of this definition continuously for at least 12 months or on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions

included at least 7 consecutive nights of not living as described in paragraph (1) (i). Stays in institutional care facilities will not constitute as a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility; or

- An individual who has been residing in an institutional care facility, including a jail, substance use or mental health treatment facility, hospital, or other similar facility, and met all of the criteria in paragraph (1) of this definition, before entering that facility; or
- A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) or (2) of this definition, including a family whose composition has fluctuated while the head of household has been homeless; or

- Individuals who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations as:
    - (1) An individual or family who:
        - Has an annual income below 30 percent of median family income for the area, as determined by HUD;
        - Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place described in paragraph (1) of the “Homeless” definition in this section; and
            - Meets one of the following conditions:
                - Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;
                - Is living in the home of another because of economic hardship;
                - Has been notified in writing that their right to occupy their current housing or living situation will be terminated within 21 days after the date of application for assistance;

        - Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income individuals;
        - Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;
        - Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or
        - Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan;
    - (2) A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a(3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C. 254b(h)(5)(A)), section 3(m) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(m)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or
    - (3) A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), and the parent(s) or guardian(s) of that child or youth if living with her or him; or
- Individuals who are determined to be at risk of experiencing homelessness are eligible to receive Housing Transition Navigation services if they have significant barriers to housing stability and meet at least one of the following:
    - Have one or more serious chronic conditions;
    - Have a Serious Mental Illness;
    - Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder
    - Have a Serious Emotional Disturbance (children and adolescents);
    - Are receiving Enhanced Care Management; or
    - Are a Transition-Age Youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or who have been victims of trafficking, or

- Individuals who meet the State's No Place Like Home definition of "at risk of chronic homelessness", which includes persons exiting institutions that were homeless prior to entering the institution and Transition-age youth with significant barriers to housing stability, including one or more convictions and history of foster care or involvement with the juvenile justice system.

Restrictions and Limitations

In lieu of services are alternative services covered under the State plan but are delivered by a different provider or in a different setting than is described in the State plan. In lieu of service can only be covered if: 1) the State determines they are medically-appropriate and a cost-effective substitutes or settings for the State plan service, 2) beneficiaries are not required to use the in lieu of service and 3) the in lieu of service is authorized and identified in the Medi-Cal managed care plan contracts.

Housing Deposits are available once in an individual's lifetime. Housing Deposits can only be approved one additional time with documentation as to what conditions have changed to demonstrate why providing Housing Deposits would be more successful on the second attempt. Plans are expected to make a good faith effort to review information available to them to determine if individual has previously received services.

These services must be identified as reasonable and necessary in the individual's individualized housing support plan and are available only when the enrollee is unable to meet such expense.

Individuals must also receive Housing Transition/Navigation services (at a minimum, the associated tenant screening, housing assessment and individualized housing support plan) in conjunction with this service.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing and Allowable Providers

Providers must have experience and expertise with providing these unique services in a culturally and linguistically appropriate manner. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

The entity that is coordinating an individual's Housing Transition Navigation Services, or the Medi-Cal managed care plan case manager, care coordinator or housing navigator may coordinate these services and pay for them directly (e.g., to the landlord, utility company, pest control company, etc.) or subcontract the services.

Providers must have demonstrated or verifiable experience and expertise with providing these unique services.

Medi-cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established enrollment process, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plans must credential the providers as required by DHCS.

State Plan Service(s) To Be Avoided

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient hospital services, emergency department services, emergency transport services, skilled nursing facility services.

Housing Tenancy and Sustaining Services

Description/Overview

This service provides tenancy and sustaining services, with a goal of maintaining safe and stable tenancy once housing is secured.

Services include:

1. Providing early identification and intervention for behaviors that may jeopardize housing, such as late rental payment, hoarding, substance use, and other lease violations.
2. Education and training on the role, rights and responsibilities of the tenant and landlord.
3. Coaching on developing and maintaining key relationships with landlords/property managers with a goal of fostering successful tenancy.
4. Coordination with the landlord and case management provider to address identified issues that could impact housing stability.
5. Assistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action including developing a repayment plan or identifying funding in situations in which the client owes back rent or payment for damage to the unit.
6. Advocacy and linkage with community resources to prevent eviction when housing is or may potentially become jeopardized.
7. Assisting with benefits advocacy, including assistance with obtaining identification and documentation for SSI eligibility and supporting the SSI application process. Such service can be subcontracted out to retain needed specialized skillset.
8. Assistance with the annual housing recertification process.
9. Coordinating with the tenant to review, update and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers.
10. Continuing assistance with lease compliance, including ongoing support with activities related to household management.
11. Health and safety visits, including unit habitability inspections.
12. Other prevention and early intervention services identified in the crisis plan that are activated when housing is jeopardized (e.g., assisting with reasonable accommodation requests that were not initially required upon move-in).

13. Providing independent living and life skills including assistance with and training on budgeting, including financial literacy and connection to community resources.

The services provided should be based on individualized assessment of needs and documented in the individualized housing support plan. Individuals may require and access only a subset of the services listed above.

The services provided should utilize best practices for clients who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

The services may involve coordination with other entities to ensure the individual has access to supports needed to maintain successful tenancy.

Services do not include the provision of room and board or payment of rental costs. Please see housing deposits ILOS.

Eligibility (Population Subset)

- Any individual who received Housing Transition/Navigation Services ILOS in counties that offer Housing Transition/Navigation Services.
- Individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system designed to use information to identify highly vulnerable individuals with disabilities and/or one or more serious chronic conditions and/or serious mental illness, institutionalization or requiring residential services as a result of a substance use disorder and/or is exiting incarceration; or
- Individuals who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management, or who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, Institution for Mental Disease and State Hospitals; or
- Individuals who meet the definition of an individual experiencing chronic homelessness, either as defined:

- In W&I Code section 14127(e) as "a homeless individual with a condition limiting his or her activities of daily living who has been continuously homeless for a year or more or had at least four episodes of homelessness in the past three years." The definition also includes "an individual who is currently residing in transitional housing, as defined in Section 50675.2 of the Health and Safety Code, or who has been residing in permanent supportive housing as defined in Section 50675.14 of the Health and Safety Code for less than two years if the individual was chronically homeless prior to his or her residence.
- By the Department of Housing and Urban Development (HUD) in 24 CFR 91.5 (including those exiting institutions but not including any limits on the number of days in the institution) as:
    - A ''homeless individual with a disability,'' as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)), who:
        e. Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and
        f. Has been homeless and living as described in paragraph (1) (i) of this definition continuously for at least 12 months or on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least 7 consecutive nights of not living as described in paragraph (1) (i). Stays in institutional care facilities will not constitute as a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility; or
    - An individual who has been residing in an institutional care facility, including a jail, substance use or mental health treatment facility, hospital, or other similar facility, and met all of the criteria in paragraph (1) of this definition, before entering that facility; or
    - A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) or (2) of this definition, including a family whose

composition has fluctuated while the head of household has been homeless; or

- Individuals who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations as:
    - (1) An individual or family who:
        - Has an annual income below 30 percent of median family income for the area, as determined by HUD;
        - Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place described in paragraph (1) of the "Homeless" definition in this section; and
            - Meets one of the following conditions:
                - Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;
                - Is living in the home of another because of economic hardship;
                - Has been notified in writing that their right to occupy their current housing or living situation will be terminated within 21 days after the date of application for assistance;
        - Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income individuals;
        - Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;
        - Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or
        - Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan;
    - (2) A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a(3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C.

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254b(h)(5)(A)), section 3(m) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(m)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or

- (3) A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), and the parent(s) or guardian(s) of that child or youth if living with her or him; or

- Individuals who are determined to be at risk of experiencing homelessness are eligible to receive Housing Transition Navigation services if they have significant barriers to housing stability and meet at least one of the following:
  - Have one or more serious chronic conditions;
  - Have a Serious Mental Illness;
  - Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder
  - Have a Serious Emotional Disturbance (children and adolescents);
  - Are receiving Enhanced Care Management; or
  - Are a Transition-Age Youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or who have been victims of trafficking, or

- Individuals who meet the State's No Place Like Home definition of "at risk of chronic homelessness", which includes persons exiting institutions that were homeless prior to entering the institution and Transition-age youth with significant barriers to housing stability, including one or more convictions and history of foster care or involvement with the juvenile justice system.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu of services can only be covered if: 1) the State determines they are medically appropriate and cost-effective substitutes or settings for the State Plan service 2) beneficiaries are not required to use the in lieu of services, and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

These services are available from the initiation of services through the time when the individual's housing support plan determines they are no longer needed. They are only available for a single duration in the individual's lifetime. Housing Tenancy and Sustaining Services can only be approved one additional time with documentation as to what

conditions have changed to demonstrate why providing Housing Tenancy and Sustaining Services would be more successful on the second attempt. Plans are expected to make a good faith effort to review information available to them to determine if individual has previously received services.

These services must be identified as reasonable and necessary in the individual's individualized housing support plan and are available only when the enrollee is unable to successfully maintain longer-term housing without such assistance.

Many individuals will have also received Housing Transition/Navigation services (at a minimum, the associated tenant screening, housing assessment and individualized housing support plan) in conjunction with this service but it is not a requirement.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services in a culturally and linguistically appropriate manner. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

Providers must have demonstrated or verifiable experience or expertise with providing housing-related services and supports and may include providers such as:

- Vocational services agencies
- Providers of services for individuals experiencing homelessness
- Life skills training and education providers
- County agencies
- Public hospital systems
- Mental health or substance use disorder treatment providers, including county behavioral health agencies
- Supportive housing providers
- Federally qualified health centers and rural health clinics

Medi-cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established

enrollment process, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plans must credential the providers as required by DHCS.

If the Medi-Cal managed care plan case manager, care coordinator or housing navigator is providing the service, that individual must have demonstrated experiencing working with individuals experiencing homelessness or with the provision of housing-related services and supports to vulnerable populations. Medi-Cal managed care plans should coordinate with county homelessness entities to provide these services.

Clients who meet the eligibility requirements for Housing and Tenancy Support Services should also be assessed for enhanced care management and may have received Housing Transition/Navigation services (if provided in their county). When enrolled in enhanced care management, in lieu of services should be managed in coordination with enhanced care management providers. When clients receive more than one of these services, the managed care plan should ensure it is coordinated by an enhanced care management provider whenever possible to minimize the number of care/case management transitions experienced by clients and to improve overall care coordination and management.

State Plan Service(s) To Be Avoided

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient hospital services, emergency department services, emergency transport services, skilled nursing facility services.

Short-term Post-Hospitalization Housing

Description/Overview

Short-Term Post-Hospitalization housing provides beneficiaries who do not have a residence and who have high medical or behavioral health needs with the opportunity to continue their medical/psychiatric/substance use disorder recovery immediately after exiting an inpatient hospital (either acute or psychiatric or Chemical Dependency and Recovery hospital), residential substance use disorder treatment or recovery facility, residential mental health treatment facility, correctional facility, nursing facility, or recuperative care.[23]

This setting provides individuals with ongoing supports necessary for recuperation and recovery such as gaining (or regaining) the ability to perform activities of daily living, receiving necessary medical/psychiatric/substance use disorder care, case management and beginning to access other housing supports such as Housing Transition Navigation.[24]

This setting may include an individual or shared interim housing setting, where residents receive the services described above.

Beneficiaries must be offered Housing Transition Navigation supports during the period of Short-Term Post-Hospitalization housing to prepare them for transition from this setting. These services should include a housing assessment and the development of individualized housing support plan to identify preferences and barriers related to successful housing tenancy after Short-Term Post-Hospitalization housing.[25]

The services provided should utilize best practices for clients who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

Eligibility (Population Subset)

- Individuals exiting recuperative care.
- Individuals exiting an inpatient hospital stay (either acute or psychiatric or Chemical Dependency and Recovery hospital), residential substance use disorder

[23] Up to 90 days of recuperative care is available under specified circumstances as a separate in-lieu service.
[24] Housing Transition/Navigation is a separate in-lieu service.
[25] The development of a housing assessment and individualized support plan are covered as a separate in-lieu service under Housing Transition/Navigation Services.

treatment or recovery facility, residential mental health treatment facility, correctional facility, or nursing facility and who meet any of the following criteria:

- Individuals who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management, or who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, Institution for Mental Disease and State Hospitals; or

- Individuals who meet the definition of an individual experiencing chronic homelessness, either as defined:
    - In W&I Code section 14127(e) as "a homeless individual with a condition limiting his or her activities of daily living who has been continuously homeless for a year or more or had at least four episodes of homelessness in the past three years." The definition also includes "an individual who is currently residing in transitional housing, as defined in Section 50675.2 of the Health and Safety Code, or who has been residing in permanent supportive housing as defined in Section 50675.14 of the Health and Safety Code for less than two years if the individual was chronically homeless prior to his or her residence.
    - By the Department of Housing and Urban Development (HUD) in 24 CFR 91.5 (including those exiting institutions but not including any limits on the number of days in the institution) as:
        - A ''homeless individual with a disability,'' as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)), who:
            g. Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and

            h. Has been homeless and living as described in paragraph (1) (i) of this definition continuously for at least 12 months or on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least 7 consecutive nights of not living as

described in paragraph (1) (i). Stays in institutional care facilities will not constitute as a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility; or

- An individual who has been residing in an institutional care facility, including a jail, substance use or mental health treatment facility, hospital, or other similar facility, and met all of the criteria in paragraph (1) of this definition, before entering that facility; or
- A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) or (2) of this definition, including a family whose composition has fluctuated while the head of household has been homeless; or

- Individuals who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations as:
    - (1) An individual or family who:
        - Has an annual income below 30 percent of median family income for the area, as determined by HUD;
        - Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place described in paragraph (1) of the “Homeless” definition in this section; and
            - Meets one of the following conditions:
                - Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;
                - Is living in the home of another because of economic hardship;
                - Has been notified in writing that their right to occupy their current housing or living situation will be terminated within 21 days after the date of application for assistance;
        - Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income individuals;

        - Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;
        - Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or
        - Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan;
    - (2) A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a(3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C. 254b(h)(5)(A)), section 3(m) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(m)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or
    - (3) A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), and the parent(s) or guardian(s) of that child or youth if living with her or him; or
- Individuals who are determined to be at risk of experiencing homelessness are eligible to receive Housing Transition Navigation services if they have significant barriers to housing stability and meet at least one of the following:
    - Have one or more serious chronic conditions;
    - Have a Serious Mental Illness;
    - Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder
    - Have a Serious Emotional Disturbance (children and adolescents);
    - Are receiving Enhanced Care Management; or
    - Are a Transition-Age Youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or who have been victims of trafficking, or
- Individuals who meet the State's No Place Like Home definition of "at risk of chronic homelessness", which includes persons exiting institutions that were homeless prior to entering the institution and Transition-age youth with significant

barriers to housing stability, including one or more convictions and history of foster care or involvement with the juvenile justice system.

In addition to meeting one of these criteria at a minimum, individuals must have medical/behavioral health needs such that experiencing homelessness upon discharge from the hospital, substance use or mental health treatment facility, correctional facility, nursing facility, or recuperative care would likely result in hospitalization, re-hospitalization, or institutional readmission.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu of services can only be covered if: 1) the State determines they are medically-appropriate and cost-effective substitutes or settings for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

Short-Term Post-Hospitalization services are available once in an individual's lifetime and are limited and are not to exceed a duration of six (6) months per episode (but may be authorized for a shorter period based on individual needs). Plans are expected to make a good faith effort to review information available to them to determine if individual has previously received services.

The service is only available if enrollee is unable to meet such an expense.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services. The below list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with but is not an exhaustive list of providers who may offer the services.

- Interim housing facilities with additional on-site support
- Shelter beds with additional on-site support
- Converted homes with additional on-site support
- County directly operated or contracted recuperative care facilities
- Supportive Housing providers
- County agencies
- Public Hospital Systems

- Social service agencies
- Providers of services for individuals experiencing homelessness

Facilities may be unlicensed. Medi-Cal managed care plans must apply minimum standards to ensure adequate experience and acceptable quality of care standards are maintained. Managed care plans can adopt or adapt local or national standards for short-term post-hospitalization housing. Medi-Cal managed care plans shall monitor the provision of all the services included above.

Managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established enrollment process, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plans must credential the providers as required by DHCS.

State Plan Service(s) To Be Avoided

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient hospital services, emergency department services, emergency transport services, skilled nursing facility services.

Recuperative Care (Medical Respite)

Description/Overview

Recuperative care, also referred to as medical respite care, is short-term residential care for individuals who no longer require hospitalization, but still need to heal from an injury or illness (including behavioral health conditions) and whose condition would be exacerbated by an unstable living environment. It allows individuals to continue their recovery and receive post-discharge treatment while obtaining access to primary care, behavioral health services, case management and other supportive social services, such as transportation, food, and housing.

At a minimum, the service will include interim housing with a bed and meals and ongoing monitoring of the individual's ongoing medical or behavioral health condition (e.g., monitoring of vital signs, assessments, wound care, medication monitoring). Based on individual needs, the service may also include:

1. Limited or short-term assistance with Instrumental Activities of Daily Living &/or ADLs
2. Coordination of transportation to post-discharge appointments
3. Connection to any other on-going services an individual may require including mental health and substance use disorder services
4. Support in accessing benefits and housing
5. Gaining stability with case management relationships and programs

Recuperative care is primarily used for those individuals who are experiencing homelessness or those with unstable living situations who are too ill or frail to recover from an illness (physical or behavioral health) or injury in their usual living environment; but are not otherwise ill enough to be in a hospital.

The services provided to an individual while in recuperative care should not replace or be duplicative of the services provided to members utilizing the enhanced care management program. Recuperative Care may be utilized in conjunction with other housing in lieu of services. Whenever possible, other housing in lieu of services should be provided to members onsite in the recuperative care facility. When enrolled in enhanced care management, in lieu of services should be managed in coordination with enhanced care management providers.

The services provided should utilize best practices for clients who are experiencing homelessness and who have complex health, disability, and/or behavioral health

conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

Eligibility (Population Subset)

- Individuals who are at risk of hospitalization or are post-hospitalization, and
- Individuals who live alone with no formal supports; or
- Individuals who face housing insecurity or have housing that would jeopardize their health and safety without modification. [26]

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu of services can only be covered if: 1) the State determines they are medically-appropriate and a cost-effective substitutes or setting for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

Recuperative care/medical respite is an allowable in lieu of services service if it is 1) necessary to achieve or maintain medical stability and prevent hospital admission or re-admission, which may require behavioral health interventions, 2) not more than 90 days in continuous duration, and 3) does not include funding for building modification or building rehabilitation.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- Interim housing facilities with additional on-site support
- Shelter beds with additional on-site support
- Converted homes with additional on-site support

[26] For this population, the service could be coordinated with home modifications (which are covered as a separate in lieu service) and serve as a temporary placement until the individual can safely return home

- County directly operated or contracted recuperative care facilities

Facilities are unlicensed. Medi-Cal managed care plans must apply minimum standards to ensure adequate experience and acceptable quality of care standards are maintained. Managed care plans can adopt or adapt local or national standards for recuperative care or interim housing. Managed care plans shall monitor the provision of all the services included above.

Managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established enrollment process, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plan must credential the providers as required by DHCS.

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient hospital services, skilled nursing facility, and emergency department services.

Respite Services

Description/Overview

Respite services are provided to caregivers of participants who require intermittent temporary supervision. The services are provided on a short-term basis because of the absence or need for relief of those persons who normally care for and/or supervise them and are non-medical in nature. This service is distinct from medical respite/recuperative care and is rest for the caregiver only.

Respite services can include any of the following:

1. Services provided by the hour on an episodic basis because of the absence of or need for relief for those persons normally providing the care to individuals.
2. Services provided by the day/overnight on a short-term basis because of the absence of or need for relief for those persons normally providing the care to individuals.
3. Services that attend to the participant's basic self-help needs and other activities of daily living, including interaction, socialization and continuation of usual daily routines that would ordinarily be performed by those persons who normally care for and/or supervise them.

The Home Respite services are provided to the participant in his or her own home or another location being used as the home.

The Facility Respite services are provided in an approved out-of-home location.

Respite should be made available when it is useful and necessary to maintain a person in their own home and to preempt caregiver burnout to avoid institutional services for which the Medi-Cal managed care plan is responsible.

Eligibility (Population Subset)

Individuals who live in the community and are compromised in their Activities of Daily Living (ADLs) and are therefore dependent upon a qualified caregiver who provides most of their support, and who require caregiver relief to avoid institutional placement.

Other subsets may include children who previously were covered for Respite Services under the Pediatrics Palliative Care Waiver, foster care program beneficiaries, beneficiaries enrolled in California Children's Services, and Genetically Handicapped Persons Program (GHPP), and Clients with Complex Care Needs.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu of service can only be covered if: 1) the State determines they are medically-appropriate and a cost-effective substitutes or settings for the State plan service, 2) beneficiaries are not required to use the in lieu of service and 3) the in lieu of service is authorized and identified in the Medi-Cal managed care plan contracts.

In the home setting, these services, in combination with any direct care services the member is receiving, may not exceed 24 hours per day of care.

Service limit is up to 336 hours per calendar year. The service is inclusive of all in-home and in-facility services. Exceptions to the 336 hour per calendar year limit can be made, with Medi-Cal managed care plan authorization, when the caregiver experiences an episode, including medical treatment and hospitalization that leaves a Medicaid member without their caregiver. Respite support provided during these episodes can be excluded from the 336-hour annual limit.

This service is only to avoid placements for which the Medi-Cal managed care plan would be responsible.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- Home health or respite agencies to provide services in:
  - Private residence
  - Residential facility approved by the State, such as, Congregate Living Health Facilities (CLHFs)
  - Providers contracted by county behavioral health

Other community settings that are not a private residence, such as:

- Adult Family Home/Family Teaching Home
- Certified Family Homes for Children

- Residential Care Facility for the Elderly (RCFE)
- Child Day Care Facility; Child Day Care Center; Family Child Care Home
- Respite Facility; Residential Facility: Small Family Homes (Children Only)
- Respite Facility; Residential Facility: Foster Family Agency (FFA)-Certified Family Homes (Children Only)
- Respite Facility; Residential Facility: Adult Residential Facilities (ARF)
- Respite Facility; Residential Facility: Group Homes (Children Only)
- Respite Facility; Residential Facility: Family Home Agency (FHA): Adult Family Home (AFH)/Family Teaching Home (FTH)
- Respite Facility; Residential Facility: Adult Residential Facility for Persons with Special Health Care Needs
- Respite Facility; Residential Facility: Foster Family Homes (FFHs) (Children Only)

Medi-cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established enrollment process, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plans must credential the providers as required by DHCS.

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient hospital services, emergency department services, and skilled nursing or other institutional care.

Day Habilitation Programs

Description/Overview

Day Habilitation Programs are provided in a participant's home or an out-of-home, non-facility setting. The programs are designed to assist the participant in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to reside successfully in the person's natural environment. The services are often considered as peer mentoring when provided by an unlicensed caregiver with the necessary training and supervision. For individuals experiencing homelessness who are receiving enhanced care management or other in lieu of services, the day habilitation program can provide a physical location for participants to meet with and engage with these providers. When possible, these services should be provided by the same entity to minimize the number of care/case management transitions experienced by clients and to improve overall care coordination and management.

Day habilitation program services include, but are not limited to, training on:

1. The use of public transportation;
2. Personal skills development in conflict resolution;
3. Community participation;
4. Developing and maintaining interpersonal relationships;
5. Daily living skills (cooking, cleaning, shopping, money management); and,
6. Community resource awareness such as police, fire, or local services to support independence in the community.

Programs may include assistance with, but not limited to:

1. Selecting and moving into a home; [27]
2. Locating and choosing suitable housemates;
3. Locating household furnishings;
4. Settling disputes with landlords; [28]
5. Managing personal financial affairs;

[27] Refer to the Housing Transition/Navigation Services In Lieu of Services
[28] Refer to the Housing- Tenancy and Sustaining Services In Lieu of Services

6. Recruiting, screening, hiring, training, supervising, and dismissing personal attendants;
7. Dealing with and responding appropriately to governmental agencies and personnel;
8. Asserting civil and statutory rights through self-advocacy;
9. Building and maintaining interpersonal relationships, including a circle of support;
10. Coordination with Medi-Cal managed care plan to link participant to any in lieu of services and/or enhanced care management services for which the client may be eligible;
11. Referral to non-in lieu of services housing resources if participant does not meet Housing Transition/Navigation Services in lieu of services eligibility criteria;
12. Assistance with income and benefits advocacy including General Assistance/General Relief and SSI if client is not receiving these services through in lieu of services or enhanced care management; and
13. Coordination with Medi-Cal managed care plan to link participant to health care, mental health services, and substance use disorder services based on the individual needs of the participant for participants who are not receiving this linkage through in lieu of services or enhanced care management.

The services provided should utilize best practices for clients who are experiencing homelessness or formerly experienced homelessness including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

Eligibility (Population Subset)

Individuals who are experiencing homelessness, individuals who exited homelessness and entered housing in the last 24 months, and individuals at risk of homelessness or institutionalization whose housing stability could be improved through participation in a day habilitation program.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu of services can only be covered if: 1) the State determines they are medically-appropriate and a cost-effective substitutes or settings for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- Mental health or substance use disorder treatment providers, including county behavioral health agencies
- Licensed Psychologists
- Licensed Certified Social Workers
- Registered Nurses
- Home Health Agencies
- Professional Fiduciary
- Vocational Skills Agencies

Medi-Cal managed care network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established enrollment process, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plans must credential the providers as required by DHCS.

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to: Inpatient and outpatient hospital services, skilled nursing facility, emergency department services.

Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly and Adult Residential Facilities

DESCRIPTION/OVERVIEW

Nursing Facility Transition/Diversion services assist individuals to live in the community and/or avoid institutionalization when possible.

The goal is to both facilitate nursing facility transition back into a home-like, community setting and/or prevent skilled nursing admissions for beneficiaries with an imminent need for nursing facility level of care (LOC). Individuals have a choice of residing in an assisted living setting as an alternative to long-term placement in a nursing facility when they meet eligibility requirements.

The assisted living provider is responsible for meeting the needs of the participant, including Activities of Daily Living (ADLs), Instrumental ADLs (IADLs), meals, transportation, and medication administration, as needed.

For individuals who are transitioning from a licensed health care facility to a living arrangement in a Residential Care Facilities for Elderly (RCFE) and Adult Residential Facilities (ARF); includes non-room and board costs (medical, assistance w/ ADLs.). Allowable expenses are those necessary to enable a person to establish a community facility residence that does not include room and board and includes:

1. Assessing the participant's housing needs and presenting options.[29]
2. Assessing the service needs of the participant to determine if the participant needs enhanced onsite services at the RCFE/ARF so the client can be safely and stably housed in an RCFE/ARF.
3. Assisting in securing a facility residence, including the completion of facility applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history).
4. Communicating with facility administration and coordinating the move.
5. Establishing procedures and contacts to retain facility housing.
6. Coordinating with the Medi-Cal managed care plan to ensure that the needs of participants who need enhanced services to be safely and stably housed in RCFE/ARF settings have in lieu of services and/or enhanced care management services that provide the necessary enhanced services or fund RCFE/ARF operator directly to provide enhanced services.

[29] Refer to Housing Transition/Navigation Services In Lieu of Services for additional details.

Eligibility (Population Subset)

A. For Nursing Facility Transition:
   1. Has resided 60+ days in a nursing facility;
   2. Willing to live in an assisted living setting as an alternative to a Nursing Facility; and
   3. Able to reside safely in an assisted living facility with appropriate and cost-effective supports.

B. For Nursing Facility Diversion:
   1. Interested in remaining in the community;
   2. Willing and able to reside safely in an assisted living facility with appropriate and cost-effective supports and services; and
   3. Must be currently receiving medically necessary nursing facility LOC or meet the minimum criteria to receive NF LOC services and in lieu of going into a facility, is choosing to remain in the community and continue to receive medically necessary nursing facility LOC services at an Assisted Living Facility.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu of services can only be covered if: 1) the State determines they are medically-appropriate and a cost-effective substitutes or settings for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

Individuals are directly responsible for paying their own living expenses.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services in a culturally and linguistically appropriate manner. The below list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with but is not an exhaustive list of providers who may offer the services.

- Case management agencies

- Home Health agencies
- Medi-Cal managed care plans
- ARF/RCFE Operators

Medi-cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established enrollment process, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plans must credential the providers as required by DHCS.

The RCFE/ARFs are licensed and regulated by the California Department of Social Services, Community Care Licensing (CCL) Division.

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to skilled nursing facility services.

Community Transition Services/Nursing Facility Transition to a Home

Description/Overview

Community Transition Services/Nursing Facility Transition to a Home helps individuals to live in the community and avoid further institutionalization.

Community Transition Services/Nursing Facility Transition to a Home are non-recurring set-up expenses for individuals who are transitioning from a licensed facility to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and include:

1. Assessing the participant's housing needs and presenting options.[30]
2. Assisting in searching for and securing housing, including the completion of housing applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history).
3. Communicating with landlord, if applicable and coordinating the move.
4. Establishing procedures and contacts to retain housing.
5. Identifying, coordinating, securing, or funding non-emergency, non-medical transportation to assist members' mobility to ensure reasonable accommodations and access to housing options prior to transition and on move-in day.
6. Identifying the need for and coordinating funding for environmental modifications to install necessary accommodations for accessibility.[31]
7. Identifying the need for and coordinating funding for services and modifications necessary to enable a person to establish a basic household that does not constitute room and board, such as: security deposits required to obtain a lease on an apartment or home; set-up fees for utilities or service access; first month coverage of utilities, including telephone, electricity, heating and water; services necessary for the individual's health and safety, such as pest eradication and one-time cleaning prior to occupancy; home modifications, such as an air conditioner or heater; and other medically-necessary services, such as hospital beds, Hoyer lifts, etc. to ensure access and reasonable accommodations. [32]

Eligibility (Population Subset)

[30] Refer to Housing Transition/Navigation Services In Lieu of Services for additional details.
[31] Refer to Home Modification In Lieu of Services for additional details.
[32] Refer to Housing Deposits In Lieu of Services for additional details.

1. Currently receiving medically necessary nursing facility LOC services and in lieu of remaining in, the nursing facility setting, is choosing to transition home and continue to receive medically necessary nursing facility LOC services;
2. Has lived 60+ days in a nursing home;
3. Interested in moving back to the community; and
4. Able to reside safely in the community with appropriate and cost-effective supports and services.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu of services can only be covered if: 1) the State determines they are medically-appropriate and a cost-effective substitutes or settings for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

- Community Transition Services do not include monthly rental or mortgage expense, food, regular utility charges, and/or household appliances or items that are intended for purely diversionary/recreational purposes.
- Community Transition Services are payable up to a total lifetime maximum amount of $5,000.00. The only exception to the $5,000.00 total maximum is if the participant is compelled to move from a provider-operated living arrangement to a living arrangement in a private residence through circumstances beyond his or her control.
- Community Transition Services must be necessary to ensure the health, welfare, and safety of the participant, and without which the participant would be unable to move to the private residence and would then require continued or re-institutionalization.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services. The list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- Case management agencies
- Home Health agencies
- Medi-Cal managed care plans
- County mental health providers
- 1915c HCBA/ALW providers
- CCT/Money Follows the Person providers

Medi-cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established enrollment process, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plans must credential the providers as required by DHCS.

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to skilled nursing facility services.

Personal Care and Homemaker Services

Description/Overview

Personal Care Services and Homemaker Services provided for individuals who need assistance with Activities of Daily Living (ADL) such as bathing, dressing, toileting, ambulation or feeding. Personal Care Services can also include assistance with Instrumental Activities of Daily Living (IADL) such as meal preparation, grocery shopping and money management.

Services provided through the In-Home Support Services (In-Home Supportive Services) program include housecleaning, meal preparation, laundry, grocery shopping, personal care services (such as bowel and bladder care, bathing, grooming and paramedical services), accompaniment to medical appointments and protective supervision for the mentally impaired.

Homemaker/Chore services include help with tasks such as cleaning and shopping, laundry, and grocery shopping. Personal Care, Homemaker and Chore programs aids individuals who otherwise could not remain in their homes.

In lieu of services can be utilized:

- Above and beyond any approved county In-Home Supportive Services hours, when additional hours are required and if In-Home Supportive Services benefits are exhausted; and
- As authorized during any In-Home Supportive Services waiting period (member must be already referred to In-Home Supportive Services); this approval time period includes services prior to and up through the In-Home Supportive Services application date.
- For members not eligible to receive In-Home Supportive Services, to help avoid a short-term stay in a skilled nursing facility (not to exceed 60 days).

Similar services available through In-Home Supportive Services should always be utilized first. These Personal Care and Homemaker in lieu of services should only be utilized if appropriate and if additional hours/supports are not authorized by In-Home Supportive Services.

Eligibility (Population Subset)

- Individuals at risk for hospitalization, or institutionalization in a nursing facility; or
- Individuals with functional deficits and no other adequate support system; or

- Individuals approved for In-Home Supportive Services. Eligibility criteria can be found at: http://www.cdss.ca.gov/In-Home-Supportive-Services.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu of services can only be covered if: 1) the State determines medically-appropriate and a cost-effective substitutes or settings for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

This service cannot be utilized in lieu of referring to the In-Home Supportive Services program. Member must be referred to the In-Home Supportive Services program when they meet referral criteria.

If a member receiving Personal Care and Homemaker services has any change in their current condition, they must be referred to In-Home Supportive Services for reassessment and determination of additional hours. Members may continue to receive Personal Care and Homemaker in lieu of services during this reassessment waiting period.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- Home health agencies
- County agencies
- Personal care agencies
- AAA (Area Agency on Aging)

Medi-cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established enrollment process, through the recognized enrollment process developed by another

managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plans must credential the providers as required by DHCS.

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient hospital services, emergency department services, skilled nursing facility.

Environmental Accessibility Adaptations (Home Modifications)

Description/Overview

Environmental Accessibility Adaptations (EAAs also known as Home Modifications) are physical adaptations to a home that are necessary to ensure the health, welfare and safety of the individual, or enable the individual to function with greater independence in the home: without which the participant would require institutionalization.

Examples of environmental accessibility adaptions include:

- Ramps and grab-bars to assist beneficiaries in accessing the home;
- Doorway widening for beneficiaries who require a wheelchair;
- Stair lifts;
- Making a bathroom and shower wheelchair accessible (e.g., constructing a roll-in shower).
- Installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies of the beneficiary; and
- Installation and testing of a Personal Emergency Response System (PERS) for persons who are alone for significant parts of the day without a caregiver and who otherwise require routine supervision (including monthly service costs, as needed).

The services are available in a home that is owned, rented, leased, or occupied by the individual. For a home that is not owned by the individual, the individual must provide written consent from the owner for physical adaptations to the home or for equipment that is physically installed in the home (e.g., grab bars, chair lifts, etc.).

When authorizing environmental accessibility adaptations as an in lieu of service, the managed care plan must receive and document an order from the participant's current primary care physician or other health professional specifying the requested equipment or service as well as documentation from the provider of the equipment or service describing how the equipment or service meets the medical needs of the participant, including any supporting documentation describing the efficacy of the equipment where appropriate. Brochures will suffice in showing the purpose and efficacy of the equipment; however, a brief written evaluation specific to the participant describing how and why the equipment or service meets the needs of the individual will still be necessary.

For environmental accessibility adaptations, the managed care plan must also receive and document:

1. A physical or occupational therapy evaluation and report to evaluate the medical necessity of the requested equipment or service unless the managed care plan determines it is appropriate to approve without an evaluation. This should typically come from an entity with no connection to the provider of the requested equipment or service. The physical or occupational therapy evaluation and report should contain at least the following:

   A. An evaluation of the participant and the current equipment needs specific to the participant, describing how/why the current equipment does not meet the needs of the participant;

   B. An evaluation of the requested equipment or service that includes a description of how/why it is necessary for the participant *and reduces the risk of institutionalization*. This should also include information on the ability of the participant and/or the primary caregiver to learn about and appropriately use any requested item, and

   C. A description of similar equipment used either currently or in the past that has demonstrated to be inadequate for the participant and a description of the inadequacy.

3. If possible, a minimum of two bids from appropriate providers of the requested service, which itemize the services, cost, labor, and applicable warranties; and

4. That a home visit has been conducted to determine the suitability of any requested equipment or service.

The assessment and authorization for EAAs must take place within a 90-day time frame beginning with the request for the EAA, unless more time is required to receive documentation of homeowner consent, or the individual receiving the service requests a longer time frame.

Eligibility (Population Subset)

Individuals at risk for institutionalization in a nursing facility.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu of services can only be covered if: 1) the State determines they are medically-appropriate and a cost-effective substitutes or settings for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

- If another State Plan service such as Durable Medical Equipment, is available and would accomplish the same goals of independence and avoiding institutional placement, that service should be used.
- EAAs must be conducted in accordance with applicable State and local building codes.
- EAAs are payable up to a total lifetime maximum of $5,000. The only exceptions to the $5,000 total maximum are if the beneficiary's place of residence changes or if the beneficiary's condition has changed so significantly that additional modifications are necessary to ensure the health, welfare and safety of the beneficiary, or are necessary to enable the beneficiary to function with greater independence in the home and avoid institutionalization or hospitalization.
- EAAs may include finishing (e.g., drywall and painting) to return the home to a habitable condition, but do not include aesthetic embellishments.
- Modifications are limited to those that are of direct medical or remedial benefit to the beneficiary and exclude adaptations or improvements that are of general utility to the household. Adaptations that add to the total square footage of the home are excluded except when necessary to complete an adaptation (e.g., to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).
- Before commencement of a physical adaptation to the home or equipment that is physically installed in the home (e.g., grab bars, chair lifts, etc.), the managed care plan must provide the owner and beneficiary with written documentation that the modifications are permanent, and that the State is not responsible for maintenance or repair of any modification nor for removal of any modification if the participant ceases to reside at the residence.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

The Medi-Cal managed care plan may manage these services directly or may coordinate with a provider to manage the service.

Medi-cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established enrollment process, through the recognized enrollment process developed by another

managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plans must credential the providers as required by DHCS.

Providers must have experience and expertise with providing these unique services. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- Area Agencies on Aging (AAA)
- Local health departments
- Community-based providers and organizations

All EAAs that are physical adaptations to a residence must be performed by an individual holding a California Contractor's License with the exception of a PERS installation, which may be performed in accordance with the system's installation requirements.

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to nursing facility services, inpatient and outpatient hospital services, emergency department services and emergency transport services.

Meals/Medically Tailored Meals

Description/Overview

Malnutrition and poor nutrition can lead to devastating health outcomes, higher utilization, and increased costs, particularly among members with chronic conditions. Meals help individuals achieve their nutrition goals at critical times to help them regain and maintain their health. Results include improved member health outcomes, lower hospital readmission rates, a well-maintained nutritional health status and increased member satisfaction.

1. Meals delivered to the home immediately following discharge from a hospital or nursing home when members are most vulnerable to readmission.
2. Medically-Tailored Meals: meals provided to the member at home that meet the unique dietary needs of those with chronic diseases.
3. Medically-Tailored meals are tailored to the medical needs of the member by a Registered Dietitian (RD) or other certified nutrition professional, reflecting appropriate dietary therapies based on evidence-based nutritional practice guidelines to address medical diagnoses, symptoms, allergies, medication management, and side effects to ensure the best possible nutrition-related health outcomes.

4. Medically-supportive food and nutrition services, including medically tailored groceries and healthy food vouchers.

Eligibility (Population Subset)

1. Individuals with chronic conditions, such as but not limited to diabetes, cardiovascular disorders, congestive heart failure, stroke, chronic lung disorders, human immunodeficiency virus (HIV), cancer, gestational diabetes, or other high risk perinatal conditions, and chronic or disabling mental/behavioral health disorders.
2. Individuals being discharged from the hospital or a skilled nursing facility or at high risk of hospitalization or nursing facility placement; or
3. Individuals with extensive care coordination needs.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu of services can only be covered if: 1) the State determines they are medically-appropriate

and a cost-effective substitutes or settings for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

- Up to three medically-tailored meals per day and/or medically-supportive food and nutrition services for up to 12 weeks, or longer if medically necessary.
- Meals that are eligible for or reimbursed by alternate programs are not eligible.
- Meals are not covered to respond solely to food insecurities.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- Home delivered meal providers
- Area Agencies on Aging
- Nutritional Education Services to help sustain healthy cooking and eating habits
- Meals on Wheels providers

Medi-cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established enrollment process, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plans must credential the providers as required by DHCS.

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient hospital services, emergency department services.

Sobering Centers

Description/Overview

Sobering centers are alternative destinations for individuals who are found to be publicly intoxicated (due to alcohol and/or other drugs) and would otherwise be transported to the emergency department or jail. Sobering centers provide these individuals, primarily those who are homeless or those with unstable living situations, with a safe, supportive environment to become sober.

Sobering centers provide services such as medical triage, lab testing, a temporary bed, rehydration and food service, treatment for nausea, wound and dressing changes, shower and laundry facilities, substance use education and counseling, navigation and warm hand-offs for additional substance use services or other necessary health care services, and homeless care support services.

- When utilizing this service, direct coordination with the county behavioral health agency is required and warm hand-offs for additional behavioral health services are strongly encouraged.
- The service also includes screening and linkage to ongoing supportive services such as follow-up mental health and substance use disorder treatment and housing options, as appropriate.
- This service requires partnership with law enforcement, emergency personnel, and outreach teams to identify and divert individuals to Sobering Centers. Sobering centers must be prepared to identify clients with emergent physical health conditions and arrange transport to a hospital or appropriate source of medical care.
- The services provided should utilize best practices for clients who are homeless and who have complex health and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

Eligibility (Population Subset)

Individuals age 18 and older who are intoxicated but conscious, cooperative, able to walk, nonviolent, free from any medical distress (including life threatening withdrawal symptoms or apparent underlying symptoms) and who would otherwise be transported to the emergency department or a jail or who presented at an emergency department and are appropriate to be diverted to a Sobering Center.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu

of services can only be covered if: 1) the State determines they are medically-appropriate and a cost-effective substitutes or settings for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

This service is covered for a duration of less than 24 hours.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- Sobering Centers, or other appropriate and allowable substance use disorder facilities. Medi-Cal managed care plans should consult with county behavioral health agencies to ensure these facilities can offer an appropriate standard of care and properly coordinate follow up access to substance use disorder services and other behavioral health services.
- These facilities are unlicensed. Medi-Cal managed care plans must apply minimum standards, subject to review and approval by DHCS, to ensure adequate experience and acceptable quality of care standards are maintained. Medi-Cal managed care plans shall monitor the provision of all the services included above.
- All allowable providers must be approved by the managed care organization to ensure adequate experience and appropriate quality of care standards are maintained.

Medi-cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established enrollment process, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plans must credential the providers as required by DHCS.

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient hospital services, emergency department services, emergency transportation services.

Asthma Remediation[33]

Description/Overview

Environmental Asthma Trigger Remediations are physical modifications to a home environment that are necessary to ensure the health, welfare, and safety of the individual, or enable the individual to function in the home and without which acute asthma episodes could result in the need for emergency services and hospitalization.

Examples of environmental asthma trigger remediations include:

- Allergen-impermeable mattress and pillow dustcovers;
- High-efficiency particulate air (HEPA) filtered vacuums;
- Integrated Pest Management (IPM) services;
- De-humidifiers;
- Air filters;
- Other moisture-controlling interventions;
- Minor mold removal and remediation services;
- Ventilation improvements;
- Asthma-friendly cleaning products and supplies;
- Other interventions identified to be medically appropriate and cost effective.

The services are available in a home that is owned, rented, leased, or occupied by the individual or their caregiver.

When authorizing asthma remediation as an in lieu of service, the managed care plan must receive and document:

1. The participant's current licensed health care provider's order specifying the requested remediation(s);
2. Depending on the type of remediation(s) requested, documentation from the provider describing how the remediation(s) meets the medical needs of the participant. A brief written evaluation specific to the participant describing how and why the remediation(s) meets the needs of the individual will still be necessary;
3. That a home visit has been conducted to determine the suitability of any requested remediation(s).

[33] Asthma Remediation should not interfere with EPSDT benefits. All appropriate EPSDT services should be provided and ILOS should be complementary. See https://www.hud.gov/sites/dfiles/HH/documents/HUD%20Asthma%20Guide%20Document_Final_7_18.pdf; Appendix B)

Asthma remediation includes providing information to individuals about actions to take around the home to mitigate environmental exposures that could trigger asthma symptoms and remediations designed to avoid asthma-related hospitalizations such as:

1. Identification of environmental triggers commonly found in and around the home, including allergens and irritants.
2. Using dust-proof mattress and pillow covers, high-efficiency particulate air vacuums, asthma-friendly cleaning products, dehumidifiers, and air filters.
3. Health-related minor home repairs such as pest management or patching holes and cracks through which pests can enter.

Eligibility (Population Subset)

Individuals with poorly controlled asthma (as determined by an emergency department visit or hospitalization or two sick or urgent care visits in the past 12 months or a score of 19 or lower on the Asthma Control Test) for whom a licensed health care provider has documented that the service will likely avoid asthma-related hospitalizations, emergency department visits, or other high-cost services.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu of services can only be covered if: 1) the State determines they are medically-appropriate and a cost-effective substitutes or settings for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

- If another State Plan service such as Durable Medical Equipment, is available and would accomplish the same goals of preventing asthma emergencies or hospitalizations.
- Asthma remediations must be conducted in accordance with applicable State and local building codes.
- Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.
- Asthma remediations are payable up to a total lifetime maximum of $5,000. The only exception to the $5,000 total maximum is if the beneficiary's condition has changed so significantly that additional modifications are necessary to ensure the health, welfare, and safety of the beneficiary, or are necessary to enable the

beneficiary to function with greater independence in the home and avoid institutionalization or hospitalization.

- Asthma remediation modifications are limited to those that are of direct medical or remedial benefit to the beneficiary and exclude adaptations or improvements that are of general utility to the household. Remediations may include finishing (e.g., drywall and painting) to return the home to a habitable condition, but do not include aesthetic embellishments.

- Before commencement of a physical adaptation to the home or installation of equipment in the home, the managed care plan must provide the owner and beneficiary with written documentation that the modifications are permanent, and that the State is not responsible for maintenance or repair of any modification nor for removal of any modification if the participant ceases to reside at the residence.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

The Medi-Cal managed care plan may: manage these services directly; coordinate with an existing Medi-Cal provider to manage the services; and/or contract with a county agency, community-based organization or other organization, as needed. The services should be provided in conjunction with culturally appropriate asthma self-management education.

Providers must have experience and expertise with providing these unique services. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- American Lung Association
- Allergy and Asthma Network
- National Environmental Education Foundation
- Local health departments
- Community-based providers and organizations

Asthma Remediation that is a physical adaptation to a residence must be performed by an individual holding a California Contractor's License.

- Medi-Cal managed care plans must apply minimum standards to ensure adequate experience and acceptable quality of care standards are maintained. Medi-Cal managed care plans shall monitor the provision of all the services included above.
- All allowable providers must be approved by the managed care organization to ensure adequate experience and appropriate quality of care standards are maintained.

Medi-cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established enrollment process, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plans must credential the providers as required by DHCS.

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient hospital services and emergency department services.

Glossary

Medicaid Section 1115 Demonstration Waivers: Section 1115 wavers permit States to use federal Medicaid funds in ways that are not otherwise allowed under federal rules, as long as the U.S. Secretary of Health and Human Services determines that the initiative is an "experimental, pilot, or demonstration project" that is "likely to assist in promoting the objectives of the program." Section 1115 waivers are generally approved for a five-year period.

Section 1915(b) "Freedom of Choice" waivers: States generally use section 1915(b) waivers to require enrollment in managed care delivery systems for certain populations. Many States originally used Section 1115 waiver authority to move enrollees into managed care, but the new federal regulations acknowledge that managed care is now the predominant delivery system in Medicaid and CMS has indicated that Section 1115 waivers may not be the most appropriate authority vehicle for managed care.

Section 1915(c) "Home and Community Based Services" waivers: States generally use 1915(c) waivers to develop programs that meet the needs of people who prefer to get long-term care services and supports in their home or community, rather than in an institutional setting.

Behavioral Health: Mental health and substance use disorder services.

Behavioral Health Managed Care Plan: The county prepaid inpatient health plan (PIHP) that would provide specialty mental health services and SUD treatment services under a single contract with DHCS, after full implementation of the behavioral health integration proposal.

CalAIM: California Advancing and Innovating Medi-Cal: DHCS' multi-year initiative to implement overarching policy changes across all Medi-Cal delivery systems with the following objectives:

- Identify and manage member risk and need through Whole Person Care Approaches and addressing Social Determinants of Health;
- Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility; and
- Improve quality outcomes, reduce health disparities, and drive delivery system transformation and innovation through value-based initiatives, modernization of systems, and payment reform.

Coordinated Care Initiative (CCI): CCI was implemented in 2014 in seven California counties with the goal of coordinating the delivery of medical, behavioral, and long-term services and supports to Medi-Cal beneficiaries also eligible for Medicare ("dual eligibles"). The CCI is composed of Cal MediConnect and Managed Medi-Cal Long-Term

Services and Supports (MLTSS). The Cal MediConnect portion of CCI is currently authorized through December 31, 2022.

County Inmate Pre-Release Application Process: A CalAIM proposal that all counties must implement an inmate pre-release Medi-Cal application process to ensure that county inmates/juveniles who are eligible for Medi-Cal and are in need of ongoing physical or behavioral health treatment receive timely access to services upon release from incarceration. The proposed process would require all county jails and juvenile facilities to implement a process for facilitated referral and linkage from county jail release to specialty mental health, Drug Medi-Cal, DMC-ODS and Medi-Cal managed care providers, in cases where the inmate was receiving behavioral health services while incarcerated, to allow for continuation of behavioral health treatment in the community.

County Organized Health System (COHS): A local agency created by a county board of supervisors to contract with the Medi-Cal program. Nearly all Medi-Cal beneficiaries in a COHS county receive their care from the COHS health plan.

Cal MediConnect: A program that coordinates medical, behavioral, and long-term services and supports (i.e. both Medicare and Medi-Cal benefits) for dual eligibles in seven California CCI counties.

Dental Transformation Initiative (DTI): The DTI is a component of the Medi-Cal 2020 demonstration that aims to increase the use of preventive dental services for children, prevent and treat more early childhood caries, and increase continuity of care for children.

Designated Public Hospitals: A California hospital operated by a county, a city and a county, or the University of California.

Designated State Health Programs: Designated State Health Programs (DSHPs) are existing State-funded health programs that have not previously qualified for federal funding, including Medicaid. CMS released a State Medicaid Director Letter informing States that they would phase-out federal funding for DSHPs beginning in 2017, meaning that California's DSHPs will not receive federal funding past December 31, 2020 when the Medi-Cal 2020 demonstration expires.

Drug Medi-Cal: Drug Medi-Cal pays for the SUD treatment services a Medi-Cal beneficiary receives through a Drug Medi-Cal certified program.

Drug Medi-Cal Organized Delivery System (DMC-ODS): DMC-ODS is a continuum of care modeled after the American Society of Addiction Medicine Criteria for substance use disorder treatment services. The program enables more local control and accountability, provides greater administrative oversight, creates utilization controls to improve care and efficient use of resources, implements evidenced based practices in substance abuse treatment, and coordinates with other systems of care. These systems are currently operating in 30 California counties. This program was initially authorized in during the

2010 Bridge to Reform demonstration and was reauthorized in the current Medi-Cal 2020 demonstration.

Enhanced Care Management: A collaborative and interdisciplinary benefit to provide intensive and comprehensive ('whole-person') care management services to high-need Medi-Cal beneficiaries.

Full Integration Plan: A CalAIM proposal to consolidate multiple Medi-Cal delivery systems (Medi-Cal managed care, mental health managed care, DMC-ODS, and dental) under one contract with DHCS. This proposal would only be implemented in select areas with managed care plans and corresponding counties who have mutually volunteered to participate.

Global Payment Program (GPP): Established a statewide pool of funding for the remaining uninsured by combining federal disproportional share hospital and uncompensated care funding, where select Designated Public Hospital systems can achieve their "global budget" by meeting a service threshold that incentivizes movement from high cost, avoidable services to providing higher value, preventive services. GPP is currently set to expire on December 31, 2020 and with approval pending under the Medi-Cal 2020 Demonstration extension to continue for calendar year 2021.

Health Homes Program: Enables participating health plans to provide a range of supports to Med-Cal beneficiaries with complex medical needs and chronic conditions. The HHP includes coordination of the full range of physical health, behavioral health, and community-based long-term services and supports.

Indian Health Care Providers: Means a health care program operated by the Indian Health Service or by an Indian Tribe, Tribal Organization, or Urban Indian Organization per 42 CFR §438.14(a).

In lieu of services: Services offered by a Medi-Cal health plan that are not included in the State Plan, but are medically appropriate, cost-effective substitutes for State Plan services included within the contract. Applicable in lieu of services must be specifically included in a managed care plan's contract. Services are offered at the plan's option and an enrollee cannot be required to use them.

Institution for Mental Diseases (IMD): A hospital, nursing facility, or other institution with more than sixteen beds that is primarily engaged in providing diagnosis, treatment, or care to persons with mental diseases (42 U.S.C. §1396d(i)).

Long Term Care: Included skilled nursing facilities, subacute facilities, pediatric subacute facilities, and intermediate care facilities.

Long Term Service and Supports: Services that include medical and non-medical care for people with a chronic illness or disability. Long-term care services are those provided

to an individual who requires a level of care equivalent to that received in a nursing facility. Most long-term care services assist people with Activities of Daily Living, such as dressing, bathing, and using the bathroom. Long-term care can be provided at home, in the community, or in a facility.

Managed Long Term Services and Supports (MLTSS) Program: The delivery of long-term services and supports through capitated Medi-Cal managed care programs.

Medi-Cal 2020: California's current Section 1115 waiver that expires on December 31, 2020. Medi-Cal 2020 authorized the Whole Person Care program, Global Payment Program, the Public Hospital Redesign and Incentives in Medi-Cal (PRIME) Program, Dental Transformation Initiative, and extended several other California waiver programs including the Drug Medi-Cal Organized Delivery System.

Medi-Cal Managed Care Plan: A health plan that has a contract with DHCS to deliver most physical health care and mild-to-moderate mental health care services to Medicaid beneficiaries through a network of providers at a capitated rate. Managed care plans emphasize primary and preventive care.

Mental Health Managed Care Plan: A health plan that has a contract with DHCS to provide specialty mental health services to Medi-Cal beneficiaries. Mental health managed care plans in California are administered by the counties.

National Committee for Quality Assurance (NCQA): A health care accreditation organization with a focus on improving health care quality.

Population Health Management Program: A cohesive plan of action for addressing member needs across the continuum of care, based on data-driven risk stratification, predictive analytics, and standardized assessment processes. Each Medi-Cal managed care plan will provide DHCS with a strategy for how it will:

- Keep all members healthy by focusing on preventive and wellness services;
- Identify and assess member risks and needs on an ongoing basis;
- Manage member safety and outcomes during transitions, across delivery systems or settings, through effective care coordination; and
- Identify and mitigate the social determinants of health and reduce health disparities or inequities.

Public Hospital Redesign and Incentives in Medi-Cal (PRIME): An incentive program for Designated Public Hospitals and District and Municipal Public Hospitals designed to improve their delivery systems through a focus on providing high quality, value-based care. PRIME is the successor program to the first-in-the-nation DSRIP (Delivery System Reform Incentive Payment) program that was authorized in the Bridge to Reform demonstration in 2010. PRIME funding is authorized under the Medi-Cal 2020 demonstration and expired on June 30, 2020.

Quality Incentive Program (QIP): The QIP ties Medi-Cal managed care payments to performance on designated performance metrics in four strategic categories: primary care, specialty care, inpatient care, and resource utilization. The payments are linked to delivery of services under Medi-Cal managed care contracts and increase the amount of funding tied to quality outcomes. California's Designated Public Hospitals receive incentive payments based on achievement of specified improvement targets. Under CalAIM, the District and Municipal Public Hospitals started to participate in the QIP once PRIME expired.

Regional Rates: A CalAIM proposal to develop regional managed care capitation rates, rather than plan- and county-based rates, in order to simplify the rate-setting process for the Medi-Cal program and allow for more capacity to implement outcomes and value based payment structures.

Safety Net Care Pools (SNCPs): Federal Medicaid funding for safety net providers' uncompensated care costs associated with Medicaid eligible and uninsured individuals. California had SNCPs in the Section 1115 demonstrations that began in 2005 and in 2010. This funding transitioned to be a component of the Global Payment Program in the Medi-Cal 2020 demonstration.

Serious Mental Illness/Seriously Emotional Disturbance Demonstration Opportunity: A federal opportunity for States to receive federal Medicaid funding for short-term residential treatment services in settings otherwise subject to the institution for mental disease (IMD) exclusion. (See SMD #18-011)

Social Determinants of Health: Conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks (Healthy People 2020).

Targeted Case Management: Targeted Case Management (TCM) is a Medi-Cal program that provides specialized case management services to certain Medi-Cal eligible individuals to gain access to needed medical, social, educational, and other services. The TCM Program is an optional Medi-Cal Program operated with federal and local funds. Eligible populations include:

- Children under age 21;
- Medically fragile individuals;
- Individuals at risk of institutionalization;
- Individuals in jeopardy of negative health or psycho-social outcomes; and
- Individuals with a communicable disease.

Whole Person Care: A pilot program that provides approved counties with funding to coordinate health, behavioral health, and social services for Medi-Cal beneficiaries. The program is authorized under the Medi-Cal 2020 demonstration and expires on December 31, 2020, with approval pending to extend through calendar year 2021.

State of California—Health and Human Services Agency

Department of Health Care Services

CalAIM Enhanced Care Management (ECM) and
In Lieu of Services (ILOS)
Contract Template Provisions

WILL LIGHTBOURNE
DIRECTOR

GAVIN NEWSOM
GOVERNOR

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Enhanced Care Management (ECM) Definitions

1. **Enhanced Care Management (ECM):** a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high-cost Members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered. ECM is a Medi-Cal benefit.
2. **ECM Provider:** a Provider of ECM. ECM Providers are community-based entities with experience and expertise providing intensive, in-person care management services to individuals in one or more of the Populations of Focus for ECM, as described in ECM Section 3: ECM Providers.
3. **Lead Care Manager:** a Member's designated care manager for ECM, who works for the ECM Provider organization (except in circumstances under which the Lead Care Manager could be on staff with Contractor, as described in ECM Section 4: ECM Provider Capacity). The Lead Care Manager operates as part of the Member's multi-disciplinary care team and is responsible for coordinating all aspects of ECM and any In Lieu of Services (ILOS). To the extent a Member has other care managers, the Lead Care Manager will be responsible for coordinating with those individuals and/or entities to ensure a seamless experience for the Member and non-duplication of services.
4. **Model of Care:** the ECM and ILOS Model of Care (MOC) is Contractor's framework for providing ECM and ILOS, including its Policies and Procedures for partnering with ECM and ILOS Providers. The ECM and ILOS Model of Care Template (MOC Template) is the document that details the MOC. Contractor must submit its MOC Template to DHCS for review and approval prior to ECM and ILOS implementation. ECM and ILOS Provider contracts must incorporate the MOC requirements as described in ECM Section 5: Model of Care.

ECM Scope of Services

1. Contractor's Responsibility for Administration of ECM

a. Contractor shall take a whole-person approach to offering Enhanced Care Management (ECM), ensuring that ECM addresses the clinical and non-clinical needs of high-need and/or high-cost Members in distinct Populations of Focus, as defined in ECM Section 2: Populations of Focus for ECM, through systematic coordination of services and comprehensive care management. Contractor shall ensure ECM is community-based, interdisciplinary, high-touch, and person-centered.
b. Contractor shall ensure ECM is available throughout its service area.
c. Contractor shall ensure ECM is offered primarily through in-person interaction where Members and/or their family member(s), guardian, Authorized Representative(s) (AR), caregiver, and/or authorized support person(s) live, seek care, or prefer to access services in their local community. Contractor shall ensure its ECM Providers focus on building relationships with Members, and in-person visits may be supplemented with secure teleconferencing and telehealth, when appropriate and with the Member's consent.
    i. As described in ECM Section 3: ECM Providers, Contractor must contract with ECM Providers for the provision of ECM.
        a. Under limited circumstances defined in ECM Section 4: ECM Provider Capacity, Contractor may perform ECM functions using its own staff, with prior written approval from DHCS.

b. In situations where Contractor is performing ECM functions using Contractor's own staff, Contractor shall follow the same requirements as a contracted ECM Provider.

ii. Contractor shall use ECM Provider Standard Terms and Conditions provided by DHCS to develop its contracts with ECM Providers, as described in Section 14: Oversight of ECM Providers.

iii. Contractor shall ensure it has a sufficient number of contracts in place to ensure its ECM Provider capacity meets the anticipated needs of all ECM Populations of Focus in a setting consistent with all the requirements in this Contract, as described in ECM Section 4: ECM Provider Capacity.

iv. In counties with operating Health Homes Program (HHP) and Whole Person Care (WPC) pilots, Contractor shall contract with WPC Lead Entities and HHP Community-Based Care Management Entities (CB-CMEs) for the provision of ECM, as described in ECM Section 6: Transition of Whole Person Care and Health Homes Program to ECM.

d. Contractor shall follow the appropriate processes to ensure Members who may benefit from ECM receive ECM as defined in this Contract amendment.

i. Contractor shall inform Members about ECM and how to access it. Contractor shall manage and respond promptly to any requests for ECM directly from Members and on behalf of Members from ECM Providers, other Providers, and community entities, and the Member's guardian or AR, where applicable, as described in ECM Section 7: Identifying Members for ECM.

ii. Contractor shall identify Members within the ECM Populations of Focus who may benefit from ECM, as defined in ECM Section 2: Populations of Focus for ECM.

iii. Contractor shall be responsible for authorizing ECM for Members, whether they are identified by Contractor or the Member or a family member, guardian, AR, caregiver, authorized support person, or external entity requests that the Member receive ECM, as described in ECM Section 8: Authorizing Members for ECM.

iv. Contractor shall be responsible for assigning all Members authorized to receive ECM to an appropriate ECM Provider, as described in ECM Section 9: Assignment to an ECM Provider.

v. Contractor shall ensure the Member is able to decline or end ECM at any time, as described in ECM Section 10: Initiating Delivery of ECM and ECM Section 11: Discontinuation of ECM.

e. Contractor shall ensure ECM provided to each Member encompasses the ECM Core Service Components described in ECM Section 12: Core Service Components of ECM.

i. Contractor shall ensure each Member authorized to receive ECM has a Lead Care Manager who interacts directly with the Member and/or their family member(s), guardian, AR, caregiver, and/or authorized support person(s), as appropriate, and coordinates all covered physical, behavioral, developmental, oral health, long-term services and supports (LTSS), Specialty Mental Health Services, Drug Medi-Cal/Drug Medi-Cal Organized Delivery System services, any In Lieu

of Services (ILOS), and other services that address social determinants of health needs, regardless of setting.

f. Contractor shall ensure a Member receiving ECM is not receiving duplicative services both through ECM and outside of ECM, including by working with Local Governmental Agencies to ensure ECM services do not duplicate county-specified Targeted Case Management services for a Member.
g. Contractor shall complete an MOC Template and submit for DHCS to review and approve as described in ECM Section 5: Model of Care.
h. Contractor shall comply with all data system and data sharing requirements to support ECM, as described in ECM Section 13: Data System Requirements and Data Sharing to Support ECM.
i. Contractor shall be responsible for overseeing the delivery of ECM to authorized Members through its contracted ECM Providers, as described in ECM Section 14: Oversight of ECM Providers.
j. Contractor shall ensure all Subcontractors participating in any aspect of ECM administration uphold all applicable requirements as described in ECM Section 15: Delegation of ECM to Subcontractor(s) and in accordance with Exhibit A, Attachment 6, Provision 14, Subcontracts.
k. Contractor shall pay contracted ECM Providers for the provision of ECM in accordance with contracts established between Contractor and ECM Provider, including for outreach to assigned Members, as described in ECM Section 16: Payment of ECM Providers.
l. Contractor shall report ECM encounters, performance metrics, and supplemental information as specified by DHCS to allow DHCS appropriate oversight of ECM, as described in ECM Section 17: DHCS Oversight of ECM.
m. Contractor shall coordinate with the Medicare Advantage Plan in the provision of ECM for Members who are dually eligible for Medicare and Medi-Cal, when the Member is enrolled in a Medicare Advantage Plan, including a Dual-Eligible Special Needs Plan.
n. Contractor shall develop, submit for DHCS approval, and disseminate Member-facing written material about ECM for use across its ECM Provider Network. This material must:
    i. Explain ECM and how to request it;
    ii. Explain that ECM participation is voluntary and can be discontinued at any time;
    iii. Explain that the Member must authorize ECM-related data sharing;
    iv. Describe the process by which the Member may choose a different Lead Care Manager or ECM Provider; and
    v. Meet standards for culturally and linguistically appropriate communication outlined in Exhibit A, Attachment 9, Provision 13, Cultural and Linguistic Program and in Exhibit A, Attachment 13, Provision 3, Written Member Information.

2. Populations of Focus for ECM

a. Subject to the phase-in and Member transition requirements described in ECM Section 6: Transition of Whole Person Care and Health Homes

Program to ECM, Contractor shall provide ECM to the following Populations of Focus:

i. Adult Populations of Focus
    a. Experiencing Homelessness;
    b. High Utilizers;
    c. Serious Mental Illness (SMI) or Substance Use Disorder (SUD);
    d. Transitioning from Incarceration;
    e. Individuals At Risk for Institutionalization who are Eligible for Long-Term Care Services;
    f. Nursing Facility Residents Transitioning to the Community.
ii. Children/Youth (up to Age 21) Populations of Focus
    a. Experiencing Homelessness;
    b. High Utilizers;
    c. Serious Emotional Disturbance (SED) or Identified to be At Clinical High Risk (CHR) for Psychosis or Experiencing a First Episode of Psychosis;
    d. Enrolled in California Children's Services (CCS)/CCS Whole Child Model (WCM) with Additional Needs Beyond the CCS Qualifying Condition;
    e. Involved in, or with a History of Involvement in, Child Welfare (Including Foster Care up to Age 26);
    f. Transitioning from Incarceration.

b. Contractor may, but is not required to, offer ECM to Members who do not meet Population of Focus criteria in full, but may benefit from ECM.
c. Contractor shall follow all DHCS guidance that further defines the approach to ECM for each Population of Focus, including the criteria for each Population of Focus and the phase-in timeline for Populations of Focus.
d. To avoid duplication between existing care management and coordination approaches, Members are excluded from ECM while enrolled in the following programs:
    i. 1915(c) waivers:
        a. Multipurpose Senior Services Program (MSSP);
        b. Assisted Living Waiver;
        c. Home and Community-Based Alternatives (HCBA) Waiver;
        d. HIV/AIDS Waiver;
        e. HCBS Waiver for Individuals with Developmental Disabilities (DD); and
        f. Self-Determination Program for Individuals with I/DD.
    ii. Fully integrated programs for Members dually eligible for Medicare and Medicaid:
        a. Cal MediConnect;
        b. Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs); and
        c. Program for All-Inclusive Care for the Elderly (PACE).
    iii. Family Mosaic Project
    iv. California Community Transitions (CCT) Money Follows the Person (MFTP)
    v. Basic or Complex Case Management

3. ECM Providers

a. Contractor shall ensure ECM is provided primarily through in-person interaction in settings that are most appropriate for the Member (i.e., where the Member lives, seeks care, or prefers to access services in their local community).
b. ECM Providers may include, but are not limited to, the following entities:
    i. Counties;
    ii. County behavioral health Providers;
    iii. Primary Care Physician or Specialist or Physician groups;
    iv. Federally Qualified Health Centers;
    v. Community Health Centers;
    vi. Community-based organizations;
    vii. Hospitals or hospital-based Physician groups or clinics (including public hospitals and district and/or municipal public hospitals);
    viii. Rural Health Clinics and/or Indian Health Service Programs;
    ix. Local health departments;
    x. Behavioral health entities;
    xi. Community mental health centers;
    xii. SUD treatment Providers;
    xiii. Organizations serving individuals experiencing homelessness;
    xiv. Organizations serving justice-involved individuals;
    xv. CCS Providers; and
    xvi. Other qualified Providers or entities that are not listed above, as approved by DHCS.
c. For the adult Population of Focus with SMI or SUD and children/youth Population of Focus with SED, Contractor shall prioritize county behavioral health staff or behavioral health Providers to serve in the ECM Provider role, provided they agree and are able to coordinate all services needed by those Populations of Focus, not just their behavioral health services.
d. Contractor shall attempt to contract with each Indian Health Service Facility as set forth in Title 22 CCR Sections 55110-55180 to provide ECM, when applicable, as described in Exhibit A, Attachment 8, Provision 7(C).
e. To provide Members with ongoing care coordination previously provided in HHP and WPC Pilot Counties, Contractor shall contract with each WPC Lead Entity or HHP CB-CME as an ECM Provider unless there is an applicable exception *[See ECM Section 6: Transition of Whole Person Care and Health Homes Program to ECM].*
f. Contractor shall ensure ECM Providers:
    i. Are experienced in serving the ECM Population(s) of Focus they will serve;
    ii. Have experience and expertise with the services they will provide;
    iii. Comply with all applicable state and federal laws and regulations and all ECM program requirements in this Contract and associated guidance;
    iv. Have the capacity to provide culturally appropriate and timely in-person care management activities in accordance with Exhibit A, Attachment 6, Provision 13, Ethnic and Cultural Composition, including accompanying Members to critical appointments when necessary;

v. Are able to communicate in culturally and linguistically appropriate and accessible ways, in accordance with Exhibit A, Attachment 9, Provision 14, Cultural and Linguistic Program;
vi. Have formal agreements and processes in place to engage and cooperate with area hospitals (when not serving as the ECM Provider), primary care practices, behavioral health Providers, Specialists, and other entities, including ILOS Providers, to coordinate care as appropriate to each Member; and
vii. Use a care management documentation system or process that supports the documentation and integration of physical, behavioral, social service, and administrative data and information from other entities to support the management and maintenance of a Member care plan that can be shared with other Providers and organizations involved in each Member's care. Care management documentation systems may include Certified Electronic Health Record Technology, or other documentation tools that can: document Member goals and goal attainment status; develop and assign care team tasks; define and support Member care coordination and care management needs; gather information from other sources to identify Member needs and support care team coordination and communication; and support notifications regarding Member health status and transitions in care (e.g., discharges from a hospital, long-term care facility, housing status) *[See ECM Section 13: Data System Requirements and Data Sharing to Support ECM for more detailed requirements on data exchange].*

g. Contractor shall ensure all ECM Providers for whom a state-level enrollment pathway exists enroll in Medicaid, pursuant to relevant DHCS All Plan Letters (APLs), including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004.
    i. If APL 19-004 does not apply to an ECM Provider, Contractor shall have a process for vetting qualifications and experience of ECM Providers, which may extend to individuals employed by or delivering services on behalf of the ECM Provider, to ensure it can meet the capabilities and standards required to be an ECM Provider.
h. Contractor shall not require eligible ECM Providers to be National Committee for Quality Assurance (NCQA) certified or accredited as a condition of contracting as an ECM Provider.

4. ECM Provider Capacity

a. Contractor shall develop and manage a Network of ECM Providers.
b. Contractor shall ensure sufficient ECM Provider capacity to meet the needs of all ECM Populations of Focus *[See ECM Section 2: Populations of Focus for ECM]*.
c. DHCS will evaluate ECM Provider capacity separately from general Network Adequacy; ECM Provider capacity does not alter the general Network Adequacy provisions in Exhibit A, Attachment 6, Provider Network.
d. Contractor shall report on its ECM Provider capacity to DHCS initially in its MOC Template *[See ECM Section 5: Model of Care],* and on an ongoing basis pursuant to DHCS reporting requirements.

e. Contractor shall report 60 days in advance or as soon as possible on its ECM Provider capacity whenever there are significant changes, pursuant to DHCS reporting requirements.
f. If Contractor is unable to provide sufficient capacity to meet the needs of all ECM Populations of Focus in a community-based manner through contracts with ECM Providers, Contractor may request written approval for an exception to the ECM Provider contracting requirement from DHCS that authorizes Contractor to use Contractor's own staff for ECM. Any such request must be submitted in accordance with DHCS guidelines and must evidence one or more of the following:
    i. There are insufficient ECM Providers, or a lack of ECM Providers with experience and expertise to provide ECM for one or more of the Populations of Focus in one or more counties;
    ii. There is a justified quality of care concern with one or more of the otherwise qualified ECM Providers;
    iii. Contractor and the ECM Provider(s) are unable to agree on contracted rates;
    iv. ECM Provider(s) is/are unwilling to contract;
    v. ECM Provider(s) is/are unresponsive to multiple attempts to contract;
    vi. For ECM Providers who have a state-level pathway to Medi-Cal enrollment: Provider(s) is/are unable to comply with the Medi-Cal enrollment process or vetting by the Contractor; and/or
    vii. For ECM Providers without a state-level pathway to Medi-Cal enrollment: Provider(s) is/are unable to comply with Contractor's processes for vetting ECM Providers.
g. During any exception period approved by DHCS, Contractor shall take steps to continually develop and increase the capacity of its ECM Provider Network. The initial exception period will be in effect no longer than one year. After the initial one-year period, Contractor must submit a new exception request to DHCS for DHCS review and approval on a case-by-case basis.
h. Unless Contractor has DHCS approval, based on one of the exceptions defined above, failure of Contractor to provide ECM Provider capacity to meet the needs of all ECM Populations of Focus in a community-based manner shall result in imposition of corrective action proceedings, which may lead to sanctions as set forth in Exhibit E, Attachment 2, Provision 16, Sanctions.

5. Model of Care

a. Contractor shall develop and submit to DHCS for review and approval an MOC, which must detail Contractor's framework for providing ECM, including a listing of its ECM Providers and Policies and Procedures for partnering with ECM Providers.
b. Contractor shall detail its MOC using the DHCS-approved MOC Template for DHCS review.
c. In developing and executing contracts with ECM Providers, Contractor must incorporate all requirements and Policies and Procedures described in its MOC, in addition to the ECM Provider Standard Terms and Conditions.

d. Contractor is encouraged to collaborate on development of its MOC with other Medi-Cal Managed Care Health Plans within the same county, if applicable.
e. Contractor shall submit to DHCS any significant updates to its MOC for review and approval 60 days in advance of any changes or updates, consistent with DHCS guidance.

6. Transition of Whole Person Care and Health Homes Program to ECM

a. Contractor shall promote continuity from WPC Pilots and the HHP to ECM.
b. Contractor shall authorize ECM for Members in HHP and WPC Pilot Counties, following DHCS' implementation schedule.
c. To ensure continuity between HHP and ECM, Contractor shall:
    i. Automatically authorize ECM for all Members of ECM Populations of Focus who are enrolled in or are in the process of being enrolled in HHP; and
    ii. Ensure that each Member automatically authorized for ECM under this provision is assessed within six months, or other timeframes provided by DHCS in guidance for specific transitioning subpopulations, to determine the most appropriate level of services for the Member, to confirm whether ECM or a lower level of care coordination best meets the Member's needs.
d. To ensure continuity between WPC Pilots and ECM, Contractor shall:
    i. Automatically authorize all Members enrolled in a WPC Pilot who are identified by the WPC Lead Entity as belonging to an ECM Population of Focus; and
    ii. Ensure each Member automatically authorized under this provision is assessed within six months, or other timeframes provided by DHCS in guidance for specific transitioning subpopulations, to determine the most appropriate level of services for the Member, to confirm whether ECM or a lower level of care coordination best meets the Member's needs.
e. Contractor shall contract with each WPC Lead Entity and/or HHP CB-CME as an ECM Provider to provide Members with ongoing care coordination previously provided in HHP and WPC Pilot Counties, except under the permissible exceptions set forth in f. below.
f. Contractor shall submit to DHCS for prior approval any requests for exceptions to the contracting requirement with a WPC Lead Entity or HHP CB-CME as an ECM Provider. Permissible exceptions to contracting are:
    i. There is a justified quality of care concern with the ECM Provider(s);
    ii. Contractor and ECM Provider(s) are unable to agree on contracted rates;
    iii. ECM Provider(s) is/are unwilling to contract;
    iv. ECM Provider(s) is/are unresponsive to multiple attempts to contract;
    v. ECM Provider(s) is/are unable to comply with the Medi-Cal enrollment process or vetting by the Contractor; and/or
    vi. For ECM Provider(s) without a state-level pathway to Medi-Cal enrollment, ECM Provider(s) is/are unable to comply with Contractor processes for vetting qualifications and experience.

7. Identifying Members for ECM

a. Contractor shall proactively identify Members who may benefit from ECM and who meet the criteria for the ECM Populations of Focus described in ECM Section 2: Populations of Focus for ECM.
b. To identify such Members, Contractor must consider Members' health care utilization; needs across physical, behavioral, developmental, and oral health; health risks and needs due to social determinants of health; and LTSS needs.
c. Contractor shall identify Members for ECM through the following pathways:
    i. Analysis of Contractor's own enrollment, claims, and other relevant data and available information. Contractor shall use data analytics to identify Members who may benefit from ECM and who meet the criteria for the ECM Populations of Focus. Contractor shall consider data sources, including but not limited to:
        a. Enrollment data;
        b. Encounter data;
        c. Utilization/claims data;
        d. Pharmacy data;
        e. Laboratory data;
        f. Screening or assessment data;
        g. Clinical information on physical and/or behavioral health;
        h. SMI/SUD data, as available;
        i. Risk stratification information for children in County Organized Health System (COHS) counties with Whole Child Model (WCM) programs;
        j. Information about social determinants of health, including standardized assessment tools (e.g., PRAPARE) and/or ICD-10 codes;
        k. Results from any available Adverse Childhood Experience (ACE) screening; and
        l. Other cross-sector data and information, including housing, social services, foster care, criminal justice history, and other information relevant to the ECM Populations of Focus (e.g., Homeless Management Information System (HMIS), available data from the education system).
    ii. Receipt of requests from ECM Providers and other Providers or community-based entities.
        a. Contractor shall accept requests for ECM on behalf of Members from:
            i. ECM Providers;
            ii. Other Providers;
            iii. Community-based entities, including those contracted to provide ILOS, as described in ILOS Section 3: ILOS Providers.
        b. Contractor shall directly engage with Network Providers and county agencies to inform these entities of ECM, the ECM Populations of Focus, and how to request ECM for Members.
        c. Contractor shall encourage ECM Providers to identify Members who meet the criteria for the ECM Populations of

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Focus, and shall develop a process for receiving and responding to requests from ECM Providers.

iii. Receipt of requests from Members.
    a. Contractor shall have a process for allowing Members and/or their family member(s), guardian, AR, caregiver, and/or authorized support person(s) to request ECM on a Member's behalf, and shall provide information to Members regarding the Member and/or family ECM request and approval process.

8. Authorizing Members for ECM

a. Contractor shall be responsible for authorizing ECM for each Member identified through any of the pathways described in ECM Section 7: Identifying Members for ECM.
b. Contractor shall develop Policies and Procedures that explain how it will authorize ECM for eligible Members in an equitable and non-discriminatory manner.
c. For requests from Providers and other external entities, and for Member or family requests:
    i. Contractor shall ensure that authorization or a decision not to authorize ECM occurs as soon as possible and in accordance with Exhibit A, Attachment 5, Provision 3, Timeframes for Medical Authorization and APL 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments (i.e., within five working days for routine authorizations and within 72 hours for expedited requests);
    ii. If Contractor does not authorize ECM, Contractor shall ensure the Member and the requesting individual or entity (as applicable) who requested ECM on a Member's behalf are informed of the Member's right to appeal and the appeals process by way of the Notice of Action (NOA) process as described in Exhibit A, Attachment 13, Provision 8, Denial, Deferral, or Modification of Prior Authorization Requests, and Attachment 14, Member Grievance and Appeal System and APL 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments; and
    iii. Contractor shall follow its standard Grievances and Appeals process outlined in Exhibit A, Attachment 14, Member Grievance and Appeal System and APL 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments for Members who were not authorized to receive ECM.
d. Contractor shall follow requirements for transitioning Members previously served by WPC Pilots or HHP contained in ECM Section 6: Transition of Whole Person Care and Health Homes Program to ECM.
e. Contractor is encouraged to work with ECM Providers to define a process and appropriate circumstances for presumptive authorization or preauthorization of ECM, whereby select ECM Providers would be able to directly authorize ECM and be paid for ECM services for a fixed period of time until Contractor validates or denies ECM based on a complete assessment of Member eligibility for ECM consistent with Population of Focus criteria.

f. To inform Members that ECM has been authorized, Contractor shall follow its standard notice process outlined in Exhibit A, Attachment 13, Provision 8, Denial, Deferral, or Modification of Prior Authorization Requests and APL 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments.

9. Assignment to an ECM Provider

a. Contractor shall assign every Member authorized for ECM to an ECM Provider. Contractor may assign Members to Contractor itself only with a DHCS-approved exception to the ECM Provider contracting requirement *[See ECM Section 4: ECM Provider Network Capacity].*
b. Contractor shall develop a process to disseminate information of assigned Members to ECM Provider(s) on a regular cycle.
c. Contractor shall ensure communication of Member assignment to the designated ECM Provider occurs within ten business days of authorization.
d. If the Member's preferences for a specific ECM Provider are known to Contractor, Contractor shall follow those preferences, to the extent practicable.
e. If the Member's assigned Primary Care Provider (PCP) is a contracted ECM Provider, Contractor shall assign the Member to the PCP as the ECM Provider, unless the Member has expressed a different preference or Contractor identifies a more appropriate ECM Provider given the Member's individual needs and health conditions.
f. If a Member receives services from a Specialty Mental Health Plan for SED, SUD, and/or SMI and the Member's behavioral health Provider is a contracted ECM Provider, Contractor shall assign that Member to that behavioral health Provider as the ECM Provider, unless the Member has expressed a different preference or Contractor identifies a more appropriate ECM Provider given the Member's individual needs and health conditions.
g. For children enrolled in CCS and when the Member's CCS Case Manager is affiliated with a contracted ECM Provider, Contractor shall assign that Member to the CCS Case Manager as the ECM Provider, unless the Member or family has expressed a different preference or Contractor identifies a more appropriate ECM Provider given the Member's individual needs and health conditions.
h. Contractor shall notify the Member's PCP, if different from the ECM Provider, of the assignment to the ECM Provider, within ten (10) business days of the date of assignment.
i. Contractor shall document the Member's ECM Lead Care Manager in its system of record.
j. Contractor shall permit Members to change ECM Providers at any time. Contractor shall implement any requested ECM Provider change within thirty days.

10. Initiating Delivery of ECM

a. Contractor shall not require Member authorization for ECM-related data sharing (whether in writing or otherwise) as a condition of initiating delivery of ECM, unless such authorization is required by federal law.

b. Contractor shall develop Policies and Procedures for its Network of ECM Providers to:
    i. Where required by federal law, ensure that Members authorize information sharing with the Contractor and all others involved in the ECM Member's care as needed to support the Member and maximize the benefits of ECM.
    ii. Communicate Member-level record of any authorization required by federal law, to allow data sharing (once obtained) back to Contractor.
c. Contractor shall ensure that upon the initiation of ECM, each Member receiving ECM has a Lead Care Manager with responsibility for interacting directly with the Member and/or family, AR, caretakers, and/or other authorized support person(s) as appropriate.
    i. The assigned Lead Care Manager shall be responsible for engaging with a multi-disciplinary care team to identify gaps in Member's care and ensure appropriate input is obtained to effectively coordinate all primary, behavioral, developmental, oral health, LTSS, ILOS, and other services that address social determinants of health, regardless of setting, at a minimum.
d. Contractor shall ensure accurate and up-to-date Member-level records related to the provision of ECM services are maintained for Members authorized for ECM.

11. Discontinuation of ECM

a. Contractor shall ensure Members are able to decline or end ECM upon initial outreach and engagement, or at any other time.
b. Contractor shall require the ECM Provider to notify Contractor to discontinue ECM for Members when any of the following circumstances are met:
    i. The Member has met all care plan goals;
    ii. The Member is ready to transition to a lower level of care;
    iii. The Member no longer wishes to receive ECM or is unresponsive or unwilling to engage; and/or
    iv. The ECM Provider has not been able to connect with the Member after multiple attempts.
c. Contractor shall develop processes to determine if the Member is no longer authorized to receive ECM and notify ECM Provider to initiate discontinuation of services in accordance with the NOA process as described in Exhibit A, Attachment 13, Provision 8, Denial, Deferral, or Modification of Prior Authorization Requests, and Attachment 14, Member Grievance and Appeals and APL 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments.
d. Contractor shall develop processes for transitioning Members from ECM to lower levels of care management to provide coordination of ongoing needs.
e. Contractor shall notify the ECM Provider when ECM has been discontinued.
f. Contractor shall notify the Member of the discontinuation of the ECM benefit and ensure the Member is informed of their right to appeal and the appeals process by way of the NOA process as described in Exhibit A, Attachment 13, Provision 8, Denial, Deferral, or Modification of Prior

Authorization Requests, and Attachment 14, Member Grievance and Appeals and APL 17-006: Grievance and Appeal Requirements and Revised Notice Templates and “Your Rights” Attachments.

12. Core Service Components of ECM

a. Contractor shall ensure all Members receive all ECM core service components described below:
    i. Outreach and Engagement
        a. Contractor shall develop Policies and Procedures for its ECM Providers with respect to outreach to and engagement of ECM-authorized Members.
    ii. Comprehensive Assessment and Care Management Plan, which must include, but is not limited to:
        a. Engaging with each Member authorized to receive ECM primarily through in-person contact;
            i. When in-person communication is unavailable or does not meet the needs of the Member, the ECM Provider shall use alternative methods (including use of telehealth) to provide culturally appropriate and accessible communication in accordance with Member choice.
        b. Identifying necessary clinical and non-clinical resources that may be needed to appropriately assess Member health status and gaps in care, and may be needed to inform the development of an individualized Care Management Plan;
        c. Developing a comprehensive, individualized, person-centered Care Management Plan with input from the Member and/or their family member(s), guardian, AR, caregiver, and/or other authorized support person(s) as appropriate to assess strengths, risks, needs, goals and preferences and make recommendations for service needs;
        d. Incorporating into the Member’s Care Management Plan identified needs and strategies to address those needs, including, but not limited to, physical and developmental health, mental health, dementia, SUD, LTSS, oral health, palliative care, necessary community-based and social services, and housing;
        e. Ensuring the Member is reassessed at a frequency appropriate for the Member’s individual progress or changes in needs and/or as identified in the Care Management Plan; and
        f. Ensuring the Care Management Plan is reviewed, maintained and updated under appropriate clinical oversight.
    iii. Enhanced Coordination of Care, which shall include, but is not limited to:
        a. Organizing patient care activities, as laid out in the Care Management Plan, sharing information with those involved as part of the Member’s multi-disciplinary care team, and

implementing activities identified in the Member's Care Management Plan;

b. Maintaining regular contact with all Providers that are identified as being a part of the Member's multi-disciplinary care team, whose input is necessary for successful implementation of Member goals and needs;
c. Ensuring care is continuous and integrated among all service Providers and referring to and following up with primary care, physical and developmental health, mental health, SUD treatment, LTSS, oral health, palliative care, and necessary community-based and social services, including housing, as needed;
d. Providing support to engage the Member in their treatment, including coordination for medication review and/or reconciliation, scheduling appointments, providing appointment reminders, coordinating transportation, accompaniment to critical appointments, and identifying and helping to address other barriers to Member engagement in treatment;
e. Communicating the Member's needs and preferences timely to the Member's multi-disciplinary care team in a manner that ensures safe, appropriate, and effective person-centered care; and
f. Ensuring regular contact with the Member and their family member(s), guardian, AR, caregiver, and/or authorized support person(s), when appropriate, consistent with the care plan.

iv. Health Promotion, which shall include, but is not limited to:
    a. Working with Members to identify and build on successes and potential family and/or support networks;
    b. Providing services to encourage and support Members to make lifestyle choices based on healthy behavior, with the goal of supporting Members' ability to successfully monitor and manage their health; and
    c. Supporting Members in strengthening skills that enable them to identify and access resources to assist them in managing their conditions and preventing other chronic conditions.
v. Comprehensive Transitional Care, which shall include, but is not limited to:
    a. Developing strategies to reduce avoidable Member admissions and readmissions across all Members receiving ECM;
    b. For Members who are experiencing or are likely to experience a care transition:
        i. Developing and regularly updating a transition plan for the Member;
        ii. Evaluating a Member's medical care needs and coordinating any support services to facilitate safe and appropriate transitions from

and among treatment facilities, including admissions and discharges;

iii. Tracking each Member's admission and/or discharge to or from an emergency department, hospital inpatient facility, skilled nursing facility, residential or treatment facility, incarceration facility, or other treatment center and communicating with the appropriate care team members;

iv. Coordinating medication review/reconciliation; and

v. Providing adherence support and referral to appropriate services.

c. Member and Family Supports, which shall include, but are not limited to:

i. Documenting a Member's authorized family member(s), guardian, AR, caregiver, and/or other authorized support person(s) and ensuring all required authorizations are in place to ensure effective communication between the ECM Providers; the Member and/or their family member(s), AR, guardian, caregiver, and/or authorized support person(s); and Contractor, as applicable;

ii. Activities to ensure the Member and/or their family member(s), guardian, AR, caregiver, and/or authorized support person(s) are knowledgeable about the Member's condition(s), with the overall goal of improving the Member's care planning and follow-up, adherence to treatment, and medication management, in accordance with federal, tate, and local privacy and confidentiality laws;

iii. Ensuring the Member's ECM Lead Care Manager serves as the primary point of contact for the Member and/or family member(s), guardian, AR, caregiver, and/or other authorized support person(s);

iv. Identifying supports needed for the Member and/or their family member(s), AR, guardian, caregiver, and/or authorized support person(s) to manage the Member's condition and assist them in accessing needed support services;

v. Providing for appropriate education of the Member and/or their family member(s), guardian, AR, caregiver, and/or authorized support person(s) about care instructions for the Member; and

vi. Ensuring that the Member has a copy of his/her care plan and information about how to request updates.

d. Coordination of and Referral to Community and Social Support Services, which shall include, but are not limited to:
   i. Determining appropriate services to meet the needs of Members, including services that address social determinants of health needs, including housing, and services offered by Contractor as ILOS; and
   ii. Coordinating and referring Members to available community resources and following up with Members to ensure services were rendered (i.e., "closed loop referrals").

13. Data System Requirements and Data Sharing to Support ECM

a. Contractor shall have an IT infrastructure and data analytic capabilities to support ECM, including the capabilities to:
   i. Consume and use claims and encounter data, as well as other data types listed in ECM Section 7: Identifying Members for ECM, to identify Populations of Focus;
   ii. Assign Members to ECM Providers;
   iii. Keep records of Members receiving ECM and authorizations necessary for sharing Personally Identifiable Information between Contractor and ECM and other Providers, among ECM Providers and family member(s) and/or support person(s), whether obtained by ECM Provider or by Contractor;
   iv. Securely share data with ECM Providers and other Providers in support of ECM;
   v. Receive, process, and send encounters from ECM Providers to DHCS;
   vi. Receive and process supplemental reports from ECM Providers;
   vii. Send ECM supplemental reports to DHCS; and
   viii. Open, track, and manage referrals to ILOS Providers.

b. In order to support ECM, Contractor shall follow DHCS guidance on data sharing and provide the following information to all ECM Providers, at a minimum:
   i. Member assignment files, defined as a list of Medi-Cal Members authorized for ECM and assigned to the ECM Provider;
   ii. Encounter and/or claims data;
   iii. Physical, behavioral, administrative, and social determinants of health data (e.g., HMIS data) for all Members assigned to the ECM Provider; and
   iv. Reports of performance on quality measures and/or metrics, as requested.

c. Contractor shall use defined federal and State standards, specifications, code sets, and terminologies when sharing physical, behavioral, social, and administrative data with ECM Providers and with DHCS, to the extent practicable.

14. Oversight of ECM Providers

a. Contractor shall perform oversight of ECM Providers, holding them accountable to all ECM requirements contained in this Contract amendment and associated guidance and Contractor's MOC.
b. Contractor shall use ECM Provider Standard Terms and Conditions to develop its ECM contracts with ECM Providers and shall incorporate all of its ECM Provider requirements, reviewed and approved by DHCS as part of its MOC, including all monitoring and reporting expectations and criteria.
c. To streamline ECM implementation:
    i. Contractor shall hold ECM Providers responsible for the same reporting requirements as those the Contractor has with DHCS.
    ii. Contractor shall not impose mandatory reporting requirements that differ from or are additional to those required for encounter and supplemental reporting; and
    iii. Contractor is encouraged to collaborate with other Medi-Cal Managed Care Health Plans within the same county on oversight of ECM Providers.
d. Contractor shall not utilize tools developed or promulgated by NCQA to perform oversight of ECM Providers, unless by mutual consent with the ECM Provider.
e. Contractor shall provide ECM training and technical assistance to ECM Providers, including in-person sessions, webinars, and/or calls, as necessary, in addition to Network Provider training requirements described in Exhibit A, Attachment 7, Provision 5, Network Provider Training.

15. Delegation of ECM to Subcontractor(s)

a. Contractor may subcontract with other entities to administer ECM in accordance with the following:
    i. Contractor shall maintain and be responsible for oversight of compliance with all Contract provisions and Covered Services, regardless of the number of layers of subcontracting, as described in Exhibit A, Attachment 6, Provision 14, Subcontracts;
    ii. Contractor shall be responsible for developing and maintaining DHCS-approved Policies and Procedures to ensure Subcontractors meet required responsibilities and functions as described in Exhibit A, Attachment 6, Provision 14, Subcontracts;
    iii. Contractor shall be responsible for evaluating the prospective Subcontractor's ability to perform services as described in Exhibit A, Attachment 6, Provision 14, Subcontracts;
    iv. Contractor shall remain responsible for ensuring the Subcontractor's ECM Provider capacity is sufficient to serve all Populations of Focus;
    v. Contractor shall report to DHCS the names of all Subcontractors by Subcontractor type and service(s) provided, and identify the county or counties in which Members are served as described in Exhibit A, Attachment 6, Provision 12, Plan Subcontractors; and
    vi. Contractor shall make all Subcontractor agreements available to DHCS upon request. Such agreements must contain minimum required information specified by DHCS, including method and amount of compensation as described in Exhibit A, Attachment 6, Provision 14, Subcontracts.

b. Contractor shall ensure the agreement between Contractor and Subcontractor mirrors the requirements set forth in this Contract and the ECM Provider Standard Terms and Conditions, as applicable to Subcontractor.
c. Contractor is encouraged to collaborate with its Subcontractors on the approach to ECM to minimize divergence in how ECM will be implemented between Contractor and its Subcontractor(s) and/or across multiple Subcontractors and ensure a streamlined, seamless experience for ECM Providers and Members.

16. Payment of ECM Providers

a. Contractor shall pay contracted ECM Providers for the provision of ECM in accordance with contracts established between Contractor and each ECM Provider.
b. Contractor shall ensure that ECM Providers are eligible to receive payment when ECM is initiated for any given Member, as defined in ECM Section 10: Initiating Delivery of ECM.
c. Contractor is encouraged to tie ECM Provider payments to value, including payment strategies and arrangements that focus on achieving outcomes related to high-quality care and improved health status.
d. Contractor shall utilize the claims timeline as dictated in Exhibit A, Attachment 8, Provision 5, Claims Processing.

17. DHCS Oversight of ECM

a. Contractor shall submit the following data and reports to DHCS to support DHCS' oversight of ECM:
    i. Encounter data.
        a. Contractor must submit all ECM encounters to DHCS using national standard specifications and code sets to be defined by DHCS.
        b. Contractor shall be responsible for submitting to DHCS all encounter data for ECM services to its Members, regardless of the number of levels of delegation and/or sub-delegation between Contractor and the ECM Provider.
        c. In the event the ECM Provider is unable to submit ECM encounters to Contractor using the national standard specifications and code sets to be defined by DHCS, Contractor shall be responsible for converting the ECM Provider's encounter information into the national standard specifications and code sets, for submission to DHCS.
    ii. Supplemental reporting. Contractor shall submit ECM supplemental reports, on a schedule and in a format to be defined by DHCS.
b. Contractor shall track and report to DHCS, in a format to be defined by DHCS, information about outreach efforts related to potential Members to be enrolled in ECM.
c. In the event of underperformance by Contractor in relation to its administration of ECM, DHCS may impose sanctions as described in Exhibit E, Attachment 2, Provision 16, Sanctions.

18. ECM Quality and Performance Incentive Program

a. Contractor shall meet all quality management and quality improvement requirements in Exhibit A, Attachment 4, Quality Improvement System and any additional quality requirements set forth in associated guidance from DHCS for ECM.
b. Contractor may participate in a performance incentive program related to building Provider capacity for ECM, related health care quality and outcomes, and/or other performance milestones and measures, to be defined in forthcoming DHCS guidance.

In Lieu of Services

In Lieu of Services Definitions

1. **In Lieu of Services (ILOS):** Pursuant to 42 CFR 438.3(e)(2), ILOS are services or settings that are offered in place of services or settings covered under the California Medicaid State Plan and are medically appropriate, cost-effective alternatives to services or settings under the State Plan. ILOS are optional for both Contractor and the Member and must be approved by DHCS. DHCS already has authorized the list of ILOS included in Section 2: DHCS-Approved ILOS ("pre-approved ILOS") services *[See ILOS Section 2: DHCS Pre-Approved ILOS].*
2. **ILOS Provider:** a contracted Provider of DHCS-approved ILOS. ILOS Providers are entities with experience and expertise providing one or more of the ILOS approved by DHCS.

In Lieu of Services

1. Contractor's Responsibility for Administration of ILOS

a. Contractor is authorized and encouraged to provide DHCS pre-approved ILOS *[See ILOS Section 2: DHCS-Pre-Approved ILOS].*
    i. The remainder of this section refers only to ILOS that the Contractor elects to offer unless otherwise specified.
b. To offer ILOS in accordance with 42 CFR 438.3(e)(2), Contractor may select from the list of ILOS "pre-approved" by DHCS as medically appropriate and cost-effective substitutes for covered services or settings under the State Plan *[See ILOS Section 2: DHCS Pre-Approved ILOS].*
    i. Contractor shall ensure the underlying State Plan services are made available to the Member if medically necessary for the Member, or if the Member declines the ILOS.
    ii. Contractor may submit a request to DHCS to offer ILOS in addition to the pre-approved ILOS *[See ILOS Section 2: DHCS Pre-Approved ILOS].*
c. With respect to pre-approved ILOS, Contractor shall adhere to DHCS guidance on eligible populations, code sets, potential ILOS Providers, and parameters for each ILOS that Contractor chooses to provide.
d. Contractor need not offer elected ILOS in each county it serves. Contractor shall report to DHCS the counties in which it intends to offer the ILOS. *[For requirements regarding the extent to which ILOS must be provided throughout a county selected by Contractor, see Section 4: ILOS Provider Network Capacity].*
e. Contractor shall identify individuals who may benefit from ILOS and for whom ILOS will be a medically appropriate and cost-effective substitute for State Plan Covered Services, and accept requests for ILOS from Members and on behalf of Members from Providers and organizations that serve them, including community-based organizations *[See ILOS Section 7: Identifying Members for ILOS].*
f. Contractor shall authorize ILOS for Members deemed eligible *[See ILOS Section 8: Authorizing Members for ILOS and Communication of Authorization Status].*

g. Electing to offer one or more ILOS shall not preclude Contractor from offering value-added services (VAS).
h. Any discontinuation of an ILOS is considered a change in the availability of services and therefore requires Contractor to adhere to the requirements of Exhibit A, Attachment 9, Provision 10, Changes in Availability or Location of Covered Services and Exhibit A, Attachment 13, Provision 5, Notification of Changes in Access to Covered Services.
i. Contractor shall coordinate with the Medicare Advantage Plan in the provision of ILOS for Members dually eligible for Medicare and Medi-Cal, when the Member is enrolled in a Medicare Advantage Plan, including a Dual-Eligible Special Needs Plan.
j. Contractor shall not require Members to use ILOS.

2. DHCS Pre-Approved ILOS

a. Contractor can choose to offer Members one or more of the following pre-approved ILOS, and any later DHCS-approved ILOS additions, in each county:
    i. Housing Transition Navigation Services;
    ii. Housing Deposits;
    iii. Housing Tenancy and Sustaining Services;
    iv. Short-Term Post-Hospitalization Housing;
    v. Recuperative Care (Medical Respite);
    vi. Respite Services;
    vii. Day Habilitation Programs;
    viii. Nursing Facility Transition/Diversion to Assisted Living Facilities;
    ix. Community Transition Services/Nursing Facility Transition to a Home;
    x. Personal Care and Homemaker Services;
    xi. Environmental Accessibility Adaptations;
    xii. Meals/Medically Tailored Meals;
    xiii. Sobering Centers; and/or
    xiv. Asthma Remediation.
b. Contractor shall indicate in Contractor's MOC Template and through MOC amendments which ILOS it will offer.
c. Contractor shall ensure ILOS are provided to Members in as timely a manner as possible, and shall develop Policies and Procedures outlining its approach to managing Provider shortages or other barriers to timely provision of ILOS.
d. Contractor is permitted to begin offering new pre-approved ILOS every six months upon notice and submission of an updated MOC to DHCS.
e. Contractor is permitted to discontinue offering ILOS annually with notice to DHCS.
    i. Contractor shall ensure ILOS that were authorized for a Member prior to the discontinuation of that specific ILOS are not disrupted by a change in ILOS offerings, either by completing the authorized service or by seamlessly transitioning the Member into other Medically Necessary services or programs that meet their needs.
f. Contractor shall notify Members affected by a decision to discontinue an ILOS of 1) the change and timing of discontinuation, and 2) the procedures

that will be used to ensure completion of the authorized ILOS or a transition into other Medically Necessary services.

g. Contractor is not restricted from providing voluntary services that are neither State-approved ILOS nor Covered Services when medically appropriate in accordance with 42 CFR 438.3(e)(1). Such voluntary services are not subject to the terms of this Provision and are subject to the limitations of 42 CFR 438.3(e)(1).

3. ILOS Providers

a. Contractor shall contract with ILOS Providers for the delivery of elected ILOS.

b. ILOS Providers are entities that Contractor has determined can provide the ILOS to eligible Members in an effective manner consistent with culturally and linguistically appropriate care.

c. Contractor shall ensure all ILOS Providers with which it contracts have sufficient experience and/or training in the provision of the ILOS being offered.
    i. ILOS Providers can include but are not limited to those listed in the In Lieu of Services – Service Description section of the ILOS Program Guide under “Licensing/Allowable Providers.” Other entities that have training and/or experience providing ILOS in a culturally and linguistically competent manner may also serve as contracted ILOS Providers.

d. Contractor shall ensure ILOS Providers for whom a state-level enrollment pathway exists enroll in Medi-Cal, pursuant to relevant DHCS APLs including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004.
    i. If APL 19-004 does not apply to an ILOS Provider, Contractor shall have a process for vetting the ILOS Provider, which may extend to individuals employed by or delivering services on behalf of the ILOS Provider, to ensure it can meet the capabilities and standards required to be an ILOS Provider.

e. Contractor shall support ILOS Provider access to systems and processes allowing them to obtain and document Member information including eligibility, ILOS authorization status, Member authorization for data sharing (to the extent required by federal law), and other relevant demographic and administrative information, and to support notification to Contractor and ECM Provider and PCP, as applicable, when a referral has been fulfilled *[See ILOS Section 10: Data System Requirements and Data Sharing to Support ILOS].*

f. To the extent Contractor elects to offer ILOS, Contractor is encouraged to coordinate its approach with other Medi-Cal Managed Care Health Plans offering ILOS in the same county.

4. ILOS Provider Capacity

a. Contractor shall make best efforts to develop a robust network of ILOS Providers to deliver all elected ILOS.

b. If Contractor is unable to offer its elected ILOS to all eligible Members for whom it is medically appropriate and cost-effective, it shall do the following:

i. Develop Policies and Procedures describing how Contractor will prioritize the delivery of ILOS when capacity is limited to avoid wait lists, including how it will ensure those Policies and Procedures are non-discriminatory in their application(s);
ii. Submit a three-year plan to DHCS detailing how it will build Network capacity over time, and update the plan annually; and
iii. Participate in regular meetings with DHCS to review progress towards expanding ILOS network capacity.

c. Contractor shall ensure its contracted ILOS Providers have sufficient capacity to receive referrals for ILOS and provide the agreed-upon volume of ILOS to Members who are authorized for such services on an ongoing basis.

5. Model of Care

a. Contractor shall develop and submit to DHCS for review and approval an MOC that shall be Contractor's framework for providing ILOS, which details:
   i. Which ILOS Contractor plans to offer;
   ii. Contractor's network of ILOS Providers; and,
   iii. All Policies and Procedures for the delivery of elected ILOS.
b. Contractor shall detail its MOC using the DHCS-developed MOC Template for DHCS review.
c. In developing and executing ILOS contracts with ILOS Providers, Contractor must incorporate requirements and Policies and Procedures described in its MOC, in addition to the ILOS Provider Standard Terms and Conditions.
d. Contractor is encouraged to collaborate on its MOC with other Medi-Cal Managed Care Health Plans within the same county, if applicable.
e. Contractor shall submit to DHCS any significant updates to its MOC for review and approval 60 days in advance of any changes or updates, consistent with DHCS guidance.

6. Transition of Whole Person Care and Health Homes Program to ILOS

a. In HHP and WPC Pilot Counties, Contractor is strongly encouraged to offer ILOS to HHP and WPC participants who are being provided similar services through WPC or HHP to provide continuity of the services being delivered as part of those programs.
b. In HHP and WPC Pilot Counties, Contractor shall contract with all WPC Lead Entities and HHP CB-CMEs as ILOS Providers unless Contractor receives prior written approval from DHCS, through the MOC review process, based on one or more of the following exceptions.
   i. ILOS Provider(s) does not provide the ILOS that Contractor has elected to offer;
   ii. There is a justified quality of care concern with the ILOS Provider(s);
   iii. Contractor and the ILOS Provider(s) are unable to agree on contracted rates;
   iv. ILOS Provider(s) is/are unwilling to contract;
   v. ILOS Provider(s) is/are unresponsive to multiple attempts to contract;
   vi. ILOS Provider(s) is/are unable to comply with the Medi-Cal enrollment process or vetting by the Contractor; and/or

vii. For ILOS Provider(s) without a state-level pathway to Medi-Cal enrollment, ILOS Provider(s) is/are unable to comply with Contractor processes for vetting qualifications and experience.

c. The requirement to contract with WPC Lead Entities and HHP CB-CMEs except as allowed under requirements b.i – vii of this section applies regardless of whether a Contractor offers an ILOS on a county-wide basis or not.

7. Identifying Members for ILOS

a. Contractor shall utilize a variety of methods to identify Members who may benefit from ILOS, including:
   i. Working with ECM Providers to identify Members receiving ECM who could benefit from ILOS;
   ii. Proactively identifying Members who may benefit from the DHCS-authorized ILOS that Contractor is offering;
   iii. Accepting requests from Providers and other community-based entities; and
   iv. Accepting Member and/or their family member(s), guardian, AR, caregiver, and/or authorized support person(s) requests.
b. Contractor shall develop Policies and Procedures for how Contractor will identify Members, and how it will accept requests for ILOS from Providers, other community-based entities, and Member and/or their family.
c. Contractor shall submit its Policies and Procedures to DHCS for review and approval.
d. Contractor shall develop Policies and Procedures to inform Members of ILOS for which they may be eligible and shall submit those Policies and Procedures and all Member notices to DHCS for review and approval prior to implementation.
   i. Contractor shall ensure that Member identification methods for ILOS are equitable and do not exacerbate or contribute to existing racial and ethnic disparities.

8. Authorizing Members for ILOS and Communication of Authorization Status

a. Contractor shall develop Policies and Procedures that explain how it will authorize ILOS for eligible Members in an equitable and non-discriminatory manner *[See ILOS Section 4: ILOS Provider Capacity].*
b. Contractor shall monitor and evaluate ILOS authorizations to ensure they are equitable and non-discriminatory. Contractor shall have Policies and Procedures for what immediate actions will be taken if monitoring/evaluation processes identify that service authorizations have had an inequitable effect.
c. Contractor shall validate Member eligibility for ILOS using a consistent methodology and authorize ILOS for Members for whom the ILOS is determined to be a medically appropriate and cost-effective alternative to services and settings covered under the State Plan.
   i. Contractor shall not restrict the authorization of ILOS only to Members who are transitioning from WPC and/or HHP.
d. Contractor shall submit Policies and Procedures to ensure Members do not experience undue delays pending the authorization process for ILOS.

i. If Medically Necessary, Contractor shall make available the State Plan Covered Services that the ILOS replaces, pending authorization of the requested ILOS.
ii. Contractor shall evaluate medical appropriateness and cost-effectiveness when determining whether to provide ILOS to a Member. Providing a particular ILOS to a Member in one instance does not automatically mean that providing another ILOS to the same Member, the same ILOS to another Member, or the same ILOS to the same Member in a different instance would be medically appropriate and cost-effective.

e. Contractor shall have Policies and Procedures for expediting the authorization of certain ILOS for urgent needs, as appropriate, and that identify the circumstances in which any expedited authorization processes apply.
i. Contractor is encouraged to work with ILOS Providers to define a process and appropriate circumstances for presumptive authorization of ILOS whereby select ILOS Providers would be able to directly authorize an ILOS, potentially only for a limited period of time, under specified circumstances when a delay would be harmful to the Member or inconsistent with efficiency and cost-effectiveness.

f. Contractor shall permit Members who sought one or more ILOS offered by Contractor but were not authorized to receive the ILOS to submit a Grievance and/or Appeal to Contractor.

g. When a Member has requested an ILOS, directly or through a Provider, community-based organization, or other entity *[See ILOS Section 7: Identifying Members for ILOS]*, Contractor shall notify the requesting entity of Contractor's decision regarding ILOS authorization. If the Member is enrolled in ECM, Contractor shall ensure the ECM Provider is informed of the ILOS authorization decision.

9. Referring Members to ILOS Providers for ILOS

a. Contractor shall develop Policies and Procedures to define how ILOS Provider referrals will occur.
i. For Members enrolled in ECM, Policies and Procedures must address how Contractor will work with the ECM Provider to coordinate the ILOS referral and communicate the outcome of the referral back to the ECM Provider (i.e., using closed loop referrals).
ii. Policies and Procedures must include expectations and procedures to ensure referrals occur in a timely manner after service authorization.

b. If the Member's preferences for an ILOS Provider are known, Contractor shall follow those preferences, to the extent practicable.

c. Contractor shall track referrals to ILOS Provider(s) to verify if the authorized service has been delivered to the Member.
i. If the Member receiving the ILOS is also receiving ECM, Contractor shall monitor to ensure that the ECM Provider tracks whether the Member receives the authorized service from the ILOS Provider.

d. Contractor shall not require Member authorization for ILOS-related data sharing (whether in writing or otherwise) as a condition of initiating delivery of ILOS, unless such authorization is required by federal law.

e. Contractor shall develop Policies and Procedures for its Network of ILOS Providers to:
    i. Ensure the Member agrees to the receipt of ILOS;
    ii. Where required by federal law, ensure that Members authorize information sharing with the Contractor and all others involved in the Member's care as needed to support the Member and maximize the benefits of ILOS; and
    iii. Communicate Member-level record of any authorization required by federal law, to allow data sharing (once obtained) back to Contractor.

10. Data System Requirements and Data Sharing to Support ILOS

a. Contractor shall use systems and processes capable of tracking ILOS referrals, access to ILOS, and grievances and appeals to Contractor.
    i. Contractor will support ILOS Provider access to systems and processes allowing them to track and manage referrals for ILOS and Member information.
b. As part of the referral process to ILOS Providers and consistent with federal, state and, if applicable, local privacy and confidentiality laws, Contractor shall ensure ILOS Providers have access to:
    i. Demographic and administrative information confirming the referred Member's eligibility and authorization for the requested service;
    ii. Appropriate administrative, clinical, and social service information the ILOS Providers might need to effectively provide the requested service; and
    iii. Billing information necessary to support the ILOS Providers' ability to submit claims or invoices to Contractor.
c. Contractor shall use defined federal and State standards, specifications, code sets, and terminologies when sharing physical, behavioral, social, and administrative data with ILOS Providers and with DHCS, to the extent practicable.

11. Oversight of ILOS Providers

a. Contractor shall perform oversight of ILOS Providers, holding them accountable to all ILOS requirements contained in this Contract amendment and associated guidance and Contractor's MOC.
b. Contractor shall use ILOS Provider Standard Terms and Conditions to develop its ILOS contracts with ILOS Providers and shall incorporate all of its ILOS Provider requirements, reviewed and approved by DHCS as part of its MOC, including all monitoring and reporting expectations and criteria.
c. To streamline ILOS implementation:
    i. Contractor shall hold ILOS Providers responsible for the same reporting requirements as those that Contractor must report to DHCS.
    ii. Contractor shall not impose mandatory reporting requirements that are alternative or additional to those required for encounter and supplemental reporting.
    iii. Contractor is encouraged to collaborate with other Medi-Cal Managed Care Health Plans within the same county on reporting requirements and oversight.

d. Contractor shall not utilize tools developed or promulgated by NCQA to perform oversight of ILOS Providers, unless by mutual consent with the ILOS Provider.
e. Contractor shall provide ILOS training and technical assistance to ILOS Providers, including in-person sessions, webinars, and/or calls, as necessary, in addition to Network Provider training requirements described in Exhibit A, Attachment 7, Provision 5, Network Provider Training.

12. Delegation of ILOS to Subcontractor(s)

a. Contractor may contract with other entities to administer ILOS in accordance with the following:
    i. Contractor shall maintain and be responsible for oversight of compliance with all Contract provisions and Covered Services, regardless of the number of layers of subcontracting, as described in Exhibit A, Attachment 6, Provision 14, Subcontracts;
    ii. Contractor shall be responsible for developing and maintaining DHCS-approved Policies and Procedures to ensure Subcontractors meet required responsibilities and functions as described in Exhibit A, Attachment 6, Provision 14, Subcontracts;
    iii. Contractor shall be responsible for evaluating the prospective Subcontractor's ability to perform services as described in Exhibit A, Attachment 6, Provision 14, Subcontracts;
    iv. Contractor shall report to DHCS the names of all Subcontractors by Subcontractor type and service(s) provided, and identify the county or counties in which Members are served as described in Exhibit A, Attachment 6, Provision 12, Plan Subcontractors; and
    v. Contractor shall make all Subcontractor agreements available to DHCS upon request. Such agreements must contain minimum required information specified by DHCS, including method and amount of compensation as described in Exhibit A, Attachment 6, Provision 14, Subcontracts.
b. Contractor shall ensure the agreement between Contractor and Subcontractor mirrors the requirements set forth in this Contract and the standard ILOS Provider Terms and Conditions, as applicable to the Subcontractor.
c. Contractor is encouraged to collaborate with its Subcontractors on the approach to ILOS to minimize divergence in how the ILOS will be implemented between Contractor and its Subcontractor(s) and/or across multiple Subcontractors and ensure a streamlined, seamless experience for ILOS Providers and Members.

13. Payment of ILOS Providers

a. Contractor shall pay contracted ILOS Providers for the provision of authorized ILOS to Members in accordance with established contracts between Contractor and each ILOS Provider.
b. Contractor shall utilize the claims timeline and process as described in Exhibit A, Attachment 8, Provider Compensation Arrangements, 5. Claims Processing, B.

c. Contractor shall identify any circumstances under which payment for an ILOS must be expedited to facilitate timely delivery of the ILOS to the Member (e.g., recuperative care for an individual who is homeless and being discharged from the hospital) *[See ILOS Section 8: Authorizing Members for ILOS and Communication of Authorization Status].*
    i. For such circumstances, Contractor shall develop Policies and Procedures to ensure payment to the ILOS Provider is expedited, and share such Policies and Procedures with DHCS for prior approval.
d. Contractor shall ensure ILOS Providers submit a claim for ILOS rendered, to the greatest extent possible.
    i. If an ILOS Provider is unable to submit a claim for ILOS rendered, Contractor shall ensure the ILOS Provider documents services rendered using an invoice.
    ii. Upon receipt of such an invoice, Contractor shall be responsible for documenting the encounter for the ILOS rendered.

14. DHCS Oversight of ILOS

a. Contractor shall include details on the ILOS Contractor plans to offer in its MOC, including in which counties ILOS will be offered and its Network of ILOS Providers *[See Section 5: ILOS Model of Care].*
b. After implementation of ILOS, Contractor shall submit the following data and reports to DHCS to support DHCS' oversight of ILOS:
    i. Encounter data.
        a. Contractor must submit all ILOS encounters to DHCS using national standard specifications and code sets to be defined by DHCS. DHCS will provide guidance on invoicing standards for Contractor to use with ILOS Providers.
        b. Contractor shall be responsible for submitting to DHCS all ILOS encounter data, including encounter data for ILOS generated under subcontracting arrangements.
        c. In the event the ILOS Provider is unable to submit ILOS encounters to Contractor using the national standard specifications and code sets to be defined by DHCS, Contractor shall be responsible for converting ILOS Providers' invoice data into the national standard specifications and code sets, for submission to DHCS.
    ii. Supplemental reporting**.** Contractor shall submit supplemental reports, on a schedule and in a format to be defined by DHCS.
c. In the event of underperformance by Contractor in relation to its administration of ILOS, DHCS may administer sanctions as set out in Exhibit E, Attachment 2, Provision 16, Sanctions.

15. ILOS Quality and Performance Incentive Program

a. Contractor shall meet all quality management and quality improvement requirements described in Exhibit A, Attachment 4, Quality Improvement System and any additional quality requirements set forth in associated guidance from DHCS for ILOS offered.

b. Contractor may participate in a performance incentive program related to adoption of ILOS, building infrastructure and Provider capacity for ILOS, related health care quality and outcomes, and/or other performance milestones and measures, to be defined in forthcoming DHCS guidance.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 5, 2021
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

6. Consider Authorizing Execution of Amendment(s) to CalOptima's Primary Agreement with the California Department of Health Care Services (DHCS) Related to the Health Insurance Portability and Accountability Act (HIPAA)

Contacts

Richard Sanchez, Chief Executive Officer, (657) 900-1481
Carmen Dobry, Executive Director, Compliance, (657) 235-6997

Recommended Action

Authorize and direct the Chairman of the Board of Directors to execute an Amendment(s) to the Primary Agreement between DHCS and CalOptima related to the updated Exhibit G: Health Insurance Portability and Accountability Act (HIPAA)

Background

As a County Organized Health System (COHS), CalOptima contracts with DHCS to provide health care services to Medi-Cal beneficiaries in Orange County. In January 2009, CalOptima entered into a new five (5) year agreement with the DHCS. Amendments to this agreement are summarized in the attached appendix, including Amendment 49, which extends the agreement through December 31, 2021. The agreement contains, among other terms and conditions, the payment rates CalOptima receives from DHCS to provide health care services. As a health plan, CalOptima is a covered entity under HIPAA, but it is also a business associate of DHCS, and Exhibit G to the Primary Agreement is CalOptima's business associate agreement with DHCS.

Discussion

In June 2021, DHCS notified CalOptima that an updated Exhibit G: Health Insurance Portability and Accountability Act (HIPAA) will be incorporated into CalOptima's Primary Agreement with the DHCS along with the bridge period contract amendments covering the July 1, 2019 – December 31, 2020 period. Staff expects to receive the final version of the new Exhibit G in August 2021.

These language changes were expected by Staff, based on DHCS's previous notification that the updated Exhibit G would be incorporated into CalOptima's Primary Agreement with the DHCS, as it was previously incorporated into Agreement 16 – 93274, in order to ensure consistent application of the requirements across all of CalOptima's lines of business.

Authority to incorporate the updated Exhibit G into CalOptima's Care Coordination Agreement (Agreement 16 – 93274) was granted to Chairman of the CalOptima Board of Directors during August 2020 Board meeting. Authority is now being sought to incorporate similar language into the Primary Agreement. The changes in the updated Exhibit G included the following:

1. The title was changed from Exhibit G, Health Insurance Portability and Accountability Act (HIPAA) to Exhibit G, Business Associate Addendum (BAA);
2. Revisions were made to the Information Security controls; and

3. The 72 – hour reporting requirement for privacy and security incidents was removed.

CalOptima staff plans to be meeting the referenced new information security control requirements ahead of the new Exhibit G language taking effect. If, upon receipt the amendment is not consistent with staff's understanding as presented in this document, or if it includes significant unexpected language changes, staff will return to the Board of Directors to request a revised and updated authority through ratification.

Fiscal Impact
The recommended action to execute an amendment related to the updated Exhibit G: HIPAA is projected to be budget neutral.

Rationale for Recommendation
The addition of the updated Exhibit G to CalOptima's Primary Agreement with the DHCS will ensure consistent application of the requirements across all of CalOptima's lines of business.

Concurrence
Gary Crockett, Chief Counsel

Attachments
Attachment 1_Appendix summary of amendments to Primary Agreements with DHCS

/s/ Richard Sanchez — *07/28/2021*
Authorized Signature — **Date**

APPENDIX TO AGENDA ITEM 6

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

Amendments to Primary Agreement	Board Approval
A-01 provided language changes related to Indian Health Services, home and community-based services, and addition of aid codes effective January 1, 2009.	October 26, 2009
A-02 provided rate changes that reflected implementation of the gross premiums tax authorized by AB 1422 (2009) for the period January 1, 2009, through June 30, 2009.	October 26, 2009
A-03 provided revised capitation rates for the period July 1, 2009, through June 30, 2010; and rate increases to reflect the gross premiums tax authorized by AB 1422 (2009) for the period July 1, 2009, through June 30, 2010.	January 7, 2010
A-04 included the necessary contract language to conform to AB X3 (2009), to eliminate nine (9) Medi-Cal optional benefits.	July 8, 2010
A-05 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, including rate increases to reflect the gross premium tax authorized by AB 1422 (2009), the hospital quality assurance fee (QAF) authorized by AB 1653 (2010), and adjustments for maximum allowable cost pharmacy pricing.	November 4, 2010
A-06 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, for funding for legislatively mandated rate adjustments to Long Term Care facilities effective August 1, 2010; and rate increases to reflect the gross premiums tax on the adjusted revenues for the period July 1, 2010, through June 30, 2011.	September 1, 2011
A-07 included a rate adjustment that reflected the extension of the supplemental funding to hospitals authorized in AB 1653 (2010), as well as an Intergovernmental Transfer (IGT) program for Non-Designated Public Hospitals (NDPHs) and Designated Public Hospitals (DPHs).	November 3, 2011
A-08 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, for funding related to the Intergovernmental Transfer (IGT) Agreement between CalOptima and the University of California, Irvine.	March 3, 2011
A-09 included contract language and supplemental capitation rates related to the addition of the Community Based Adult Services (CBAS) benefit in managed care plans.	June 7, 2012

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A-10 included contract language and capitation rates related to the transition of Healthy Families Program (HFP) subscribers into CalOptima's Medi-Cal program	December 6, 2012
A-11 provided capitation rates related to the transition of HFP subscribers into CalOptima's Medi-Cal program.	April 4, 2013
A-12 provided capitation rates for the period July 1, 2011 to June 30, 2012.	April 4, 2013
A-13 provided capitation rates for the period July 1, 2012 to June 30, 2013	June 6, 2013
A-14 extended the Primary Agreement until December 31, 2014	June 6, 2013
A-15 included contract language related to the mandatory enrollment of seniors and persons with disabilities, requirements related to the Balanced Budget Amendment of 1997 (BBA) and Health Insurance Portability and Accountability Act (HIPAA) Omnibus Rule	October 3, 2013
A-16 provided revised capitation rates for the period July 1, 2012, through June 30, 2013 and revised capitation rates for the period January 1, 2013, through June 30, 2014 for Phases 1, 2 and 3 transition of Healthy Families Program (HFP) children to the Medi-Cal program	November 7, 2013
A-17 included contract language related to implementation of the Affordable Care Act, expansion of Medi-Cal, the integration of the managed care mental health and substance use benefits and revised capitation rates for the period July 1, 2013 through June 30, 2014.	December 5, 2013
A-18 provided revised capitation rates for the period July 1, 2013, through June 30, 2014.	June 5, 2014
A-19 extended the Primary Agreement until December 31, 2015 and included language that incorporates provisions related to **Medicare Improvements for Patients and Providers Act** (MIPPA)-compliant contracts and eligibility criteria for Dual Eligible Special Needs Plans (D-SNPs)	August 7, 2014
A-20 provided revised capitation rates for the period July 1, 2012, through June 30, 2013, for funding related to the Intergovernmental Transfer (IGT) Agreement between CalOptima and the University of California, Irvine and Optional Targeted Low-Income Child Members	September 4, 2014
A-21 provided revised 2013-2014 capitation rates.	November 7, 2013
A-22 revised capitation rates for Fiscal Year (FY) 2013-14 and added an aid code to implement Express Lane/CalFresh Eligibility	November 6, 2014
A-23 revised ACA 1202 rates for January – June 2014, established base capitation rates for FY 2014-2015, added an aid code related to the OTLIC and AIM programs, and contained language revisions related to supplemental payments for coverage of Hepatitis C medications.	December 4, 2014
A-24 revises capitation rates to include SB 239 Hospital Quality Assurance Fees for the period January 1, 2014 to June 30, 2014.	May 7, 2015
A-25 extends the contract term to December 31, 2016. DHCS is obtaining a continuation of the services identified in the original agreement.	May 7, 2015

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A-26 adjusts the 2013-2014 Intergovernmental Transfer (IGT) rates.	May 7, 2015
A-27 adjusts 2013-2014 capitation rates for Optional Expansion and SB 239.	May 7, 2015
A-28 incorporates language requirements and supplemental payments for BHT into primary agreement.	October 2, 2014
A-29 added optional expansion rates for January- June 2015; also added updates to MLR language.	April 2, 2015
A-30 incorporates language regarding Provider Preventable Conditions (PPC), determination of rates, and adjustments to 2014-2015 capitation rates with respect to Intergovernmental Transfer (IGT) Rate Range and Hospital Quality Assurance Fee (QAF).	December 1, 2016
A-31 extends the Primary Agreement with DHCS to December 31, 2020.	December 1, 2016
A-32 incorporates base rates for July 2015 to June 2016 with Behavioral Health Treatment (BHT) and Hepatitis–C supplemental payments, and Partial Dual/Medi-Cal only rates, and added aid codes 4U, and 2P–2U as covered aid codes.	February 2, 2017
A-33 incorporates base rates for July 2016 to June 2017.	February 2, 2017
A-34 incorporates revised Adult Optional Expansion rates for January 2015 to June 2015. These rates were revised to include the impact of the Hospital Quality Assurance Fee (HQAF) required by Senate Bill (SB) 239.	June 1, 2017
A–35 incorporates Managed Long–Term Services and Supports (MLTSS) into CalOptima's Primary Agreement with the DHCS.	March 6, 2014 February 2, 2017
A–36 incorporates revised base rates for July 2015 to June 2016.	December 7, 2017
A–37 incorporates revised base rates for July 2016 to June 2017.	February 7, 2019
A–38 incorporates full dual rates for Calendar Year (CY) 2015	August 1, 2019
A–39 incorporates full dual rates for Calendar Year (CY) 2016	August 1, 2019
A-40 incorporates Final Rule contract language.	June 1, 2017 February 6, 2020
A-41 incorporates base rates for July 2017 to June 2018, Transportation, American Indian Health Program, Mental Health Parity, CCI updates and Adult Expansion Risk Corridor language for SFY 2017-18.	December 7, 2017 June 7, 2018 February 6, 2020
A-42 incorporated revised base rates for July 2017 to June 2018, directed payments language and mental health parity documentation requirements.	August 1, 2019
A–43 incorporates revises Hospital Quality Assurance Fee (HQAF) rates for January 1, 2017 to June 30, 2017.	August 1, 2019
A-44 incorporates full dual rates for Calendar Year (CY) 2017.	August 1, 2019
A–45 incorporates the new requirements of the 2018 Final Rule Amendment, Behavioral Health Treatment (BHT) and State Fiscal Year (SFY) 2018 – 19 capitation rates	June 7, 2018 August 1, 2019 August 6, 2020
A-46 incorporates full dual rates for Calendar Year (CY) 2018.	August 1, 2019
A-47 incorporates full dual rates for Calendar Year (CY) 2019.	October 1, 2020
A-49 extends the Primary Agreement with DHCS to December 31, 2021	November 5, 2020

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A-50 incorporates full dual rates for Calendar Year (CY) 2020.	February 4, 2021

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

Amendments to Secondary Agreement	Board Approval
A-01 implemented rate amendments to conform to rate amendments contained in the Primary Agreement with DHCS (08-85214).	July 8, 2010
A-02 implemented rate adjustments to reflect a decrease in the statewide average cost for Sensitive Services for the rate period July 1, 2010 through June 30, 2011.	August 4, 2011
A-03 extended the term of the Secondary Agreement to December 31, 2014.	June 6, 2013
A-04 incorporates rates for the periods July 1, 2011 through June 30, 2012, and July 1, 2012 through June 30, 2013 as well as extends the current term of the Secondary Agreement to December 31, 2015	January 5, 2012 (FY 11-12 and FY 12-13 rates) May 1, 2014 (term extension)
A-05 incorporates rates for the periods July 1, 2013 through June 30, 2014, and July 1, 2014 through June 30, 2015. For the period July 1, 2014 through June 30, 2015, Amendment A-05 also adds funding for the Medi-Cal expansion population for services provided through the Secondary Agreement.	December 4, 2014
A-06 incorporates rates for the period July 1, 2015 onward. A-06 also extends the term of the Secondary Agreement to December 31, 2016.	May 7, 2015 (term extension) Ratification of rates requested April 7, 2016
A-07 extends the Secondary Agreement with the DHCS to December 31, 2020.	December 1, 2016
A–08 incorporates Adult & Family/Optional Targeted Low–Income Child and Adult Expansion rates for July 2016 to June 2017 and July 2017 to June 2018.	December 6, 2018
A-10 extends the Secondary Agreement with DHCS to December 31, 2021	November 5, 2020

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

Amendments to Agreement 16-93274	Board Approval
A-01 extends the Agreement 16-93274 with DHCS to December 31, 2018.	August 3, 2017
A–02 extends the Agreement 16–93274 with DHCS to December 31, 2019	June 7, 2018

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A–03 extends the Agreement 16–93274 with DHCS to December 31, 2020	May 2, 2019
A–04 extends the Agreement 16–93274 with DHCS to December 31, 2021	June 4, 2020
A–05 extends the Agreement 16–93274 with DHCS to December 31, 2023.	June 3, 2021

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

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

IV. Exhibit A, Attachment 3, MANAGEMENT INFORMATION SYSTEMS (MIS), is amended to add:

1. Management Information System Capability

A. Contractor's Management and Information System (MIS) shall **be fully compliant with 42 CFR section 438.242 requirements and** 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. All data related to this Contract shall be available to DHCS and to the Centers for Medicare and Medicaid Services (CMS) upon request. Contractor shall have and maintain a MIS that provides, at a minimum:

5) Provider Network information, ~~and~~

6) Financial information as specified in Exhibit A, Attachment 1, Provision 8. Administrative Duties/Responsibilities~~.~~**, and**

7) Member and Member's authorized representative Alternative Format Selection(s) (AFS).

C. Contractor shall 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 431 431.70, and in APL 22-XXX. 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).

8. Tracking and Submitting Alternative Format Selections (AFS)

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

1) Collect and store Member AFS, as well as the AFS of a Member's authorized representative.

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

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

B. Contractor shall 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 shall submit to DHCS all new Member AFS at the time of the Member's request. Submissions shall be submitted 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 Alternate Formats database. The DHCS weekly file data elements and file path is 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 shall submit to DHCS policies and procedures for collecting and sharing AFS data in accordance with the requirements in APL 22-002.

9. Interoperability API System Requirements

A. Contractor must verify that data collected from Network Providers and Subcontractors to be made available through the API is accurate, complete, and timely, and collected in accordance with the oversight and monitoring guidance in APL 22-XXX. 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 shall be made in accordance with the guidance provided in APL 22-XXX.

V. Exhibit A, Attachment 9, ACCESS AND AVAILABILITY, is amended to read:

14. Linguistic Services

B. Contractor shall comply with 42 CFR 438.10(d)**(3) and** (4) and provide, at minimum, the following linguistic services at no cost to Medi-Cal Members or Potential Enrollees:

4) Auxiliary Aids such as Telephone Typewriters (TTY)/ Telecommunication Devices for the Deaf (TDD) and American Sign Language**, and, in accordance with written informing materials in alternative formats, selected by the Member, as specified in APL 21-004 and APL 22-002**.

a) In determining what types of Auxiliary Aids and services to provide, Contractor must give primary consideration to a Member's request for a particular Auxiliary Aid or service.

b) In addition to Members and Potential Enrollees, Contractor must provide Auxiliary Aids and services to someone in the Member's family, or a friend or associate, if required by the ADA. This includes an individual identified as the Member's authorized representative or as someone with whom it is appropriate for Contractor to communicate, such as a Member's disabled spouse.

c) If a Member selects an electronic format, such as an audio or data CD, for any Member materials as identified in Exhibit A, Attachment 13, Provision 3 of this Contract, then Contractor may provide the materials in an unencrypted format but only with the Member's informed consent. If the Member requests a password-protected electronic format, Contractor must provide the materials as requested with unencrypted instructions on how the Member can access the encrypted information.

VI. Exhibit A, Attachment 10, SCOPE OF SERVICES, is amended to add:

6. Services for Adults

B. Adult Preventive Services

Contractor shall cover and ensure the delivery of all preventive services and Medically Necessary diagnostic and treatment services for adult

Members.

3) Contractor must ensure the provision of an annual brief 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.

8. Services for All Members

E. Mental Health and Substance Use Disorder Services

1) Contractor shall cover mild to moderate ~~Outpatient~~ **Non-Specialty** Mental Health Services **(NSMHS)** that are within the scope of practice of Primary Care Providers and mental health care Providers. Contractor's policies and procedures shall define and describe ~~what~~ **the** services are to be provided by Primary Care Providers.

In addition, Contractor shall cover and ensure the provision of psychotherapeutic drugs prescribed by its Primary Care Providers or other mental health care professionals, except those specifically excluded in this Contract as stipulated below.

VII. Exhibit A, Attachment 11, CASE MANAGEMENT AND EXTERNAL COORDINATION OF CARE, is amended to read:

8. Services for Persons with Developmental Disabilities

C. Contractor shall refer Members with developmental disabilities to a Regional Center for the developmentally disabled for evaluation and for access to those non-medical services provided through the Regional Centers, such as but not limited to, respite, out-of-home placement, and supportive living. Contractor shall participate with Regional Center staff in the development of the individual developmental services plan required for all persons with developmental disabilities, which includes identification of all appropriate services, including medical care services and Medically Necessary ~~Outpatient~~ **Non-Specialty** Mental Health Services **(NSMHS)**, which need to be provided to the Member.

D. ~~Services provided under the Home and Community-Based Services (HCBS) waiver programs to persons with developmental disabilities are not covered under this Contract. Contractor shall implement and maintain systems to identify Members with developmental disabilities that may meet the requirements for participation in this waiver and refer these~~

~~Members to the HCBS Waiver program administered by the State Department of Developmental Services (DDS).~~

~~If DDS concurs with the Contractor's assessment of the Member and there is available placement in the waiver program, the Member will receive waiver services while enrolled in the plan. Contractor shall continue to provide all Medically Necessary Covered Services.~~

Contractor shall refer to Provision 18, Home and Community-Based Services Programs, of this Attachment for further coordination of care requirements related to providing Home and Community-Based Services (HCBS) through the HCBS-DD Waiver.

~~**12. Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS)**~~

~~Services provided under the HIV/AIDS Home and Community Based Services Waiver Program are not covered under this Contract. Contractor shall maintain procedures for identifying Members who may be eligible for the HIV/AIDS Home and Community Based Services Waiver Program and shall facilitate referrals of these Members to the HIV/AIDS Home and Community Based Services Waiver Program.~~

~~Medi-Cal beneficiaries enrolled in Medi-Cal Managed Care Health Plans who are subsequently diagnosed with HIV/AIDS, according to the definition most recently published in the Mortality and Morbidity Report from the Centers for Disease Control and Prevention, may participate in the HIV/AIDS Home and Community Based Services Waiver Program without having to disenroll from their Medi-Cal managed care plan. Members of Medi-Cal managed care plans must meet the eligibility requirements of the HIV/AIDS Home and Community Based Services Medi-Cal Waiver Program and enrollment is dependent on available space. Persons already enrolled in the HIV/AIDS Home and Community Based Services Medi-Cal Waiver Program may voluntarily enroll in a Medi-Cal managed care health plan.~~

~~13~~ 12. Dental

~~14~~ 13. Direct Observed Therapy (DOT) for Treatment of Tuberculosis (TB)

~~15~~ 14. Women, Infants, and Children (WIC) Supplemental Nutrition Program

~~16~~ 15. Excluded Services Requiring Member Disenrollment

~~17~~ 16. Immunization Registry Reporting

~~18~~ 17. Erectile Dysfunction (ED) Drugs and Other ED Therapies

19 18. ~~Waiver~~ 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~~) Waiver p~~**P**rograms authorized under ~~Section 1915(c) of the Social Security Act~~ **the Medicaid program**. **HCBS Programs provide long-term, community-based services and supports to Eligible Beneficiaries in the community setting of their choice instead of in an institution.**

B. Contractor shall continue to provide all services covered under this Contract to a Member when that Member is enrolled in, or applying to enroll in, receiving, or applying to receive a HCBS Program other than this Contract. Contractor shall continuously collaborate and exchange Member healthcare and medical information with all third-party entities providing the Member with Medi-Cal HCBS or administering a Medi-Cal-funded HCBS Program pursuant to the third-party entity's contractual or legal authority to administer Medi-Cal-funded HCBS Programs and/or provide HCBS to the Member. Such third-party entities include, but are not limited to:

1) DHCS;

2) State departments that operate or administer Medi-Cal programs offering HCBS pursuant to legal authority and/or Inter-Agency Agreements with DHCS, including but not limited to, the California Department of Social Services; the California Department of Developmental Services, the California Department of Public Health, the California Department of Aging;

3) Home & Community Based Alternatives Waiver Agencies;

4) Assisted Living Waiver Care Coordination Agencies;

5) Regional centers;

6) Multipurpose Senior Services Program Sites;

7) Medi-Cal AIDS Waiver Program Agencies;

8) Counties;

9) CCS County and State Programs;

10) California Community Transitions Lead Organizations; and

12) The Genetically Handicapped Persons Program (GHPP).

C. Contractor shall have procedures in place to identify Members who may benefit from the **Medi-Cal** HCBS ~~Waiver~~ programs, and refer Members to the ~~agency~~ **third-party entity** administrating the ~~waiver~~ **HCBS** p**P**rogram. ~~These waiver~~ **HCBS** p**P**rograms include, but are not limited to~~,~~**:** ~~the nursing facility/acute hospital waiver and all HCBS waivers~~ **HCBS Programs authorized under section 1915(c) of the SSA, the Community First Choice California Medicaid State Plan (State Plan) option authorized under section 1915(k) of the SSA, State Plan HCBS benefits authorized under section 1915(i) of the SSA, and other State and federally-funded Medi-Cal HCBS Programs**. If ~~the agency administering the waiver program concurs with Contractor's assessment of the Member and there is available placement in the waiver program,~~ the Member ~~will~~ **is then authorized to** receive **Medi-Cal-funded** HCBS ~~waiver~~ **Program** services**,** ~~while remaining~~ **they shall remain** enrolled with Contractor~~.~~**,and** Contractor shall continue ~~comprehensive case management and shall continue to cover all Medically Necessary Covered Services~~ **to provide all services and benefits covered under this Contract** to the Member. ~~If the Member does not meet the criteria for the HCBS Waiver Program, or if placement is not available, Contractor shall continue to case manage and provide all Medically Necessary covered Services 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, shall include, but is not limited to:

1) Maintaining sufficient staff assigned to coordinate with such third-party entities, 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 shall 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 related assistance.

3) As contracted delegates of the State, Contractor and such third-party entities are authorized to share Member information with one another, including PHI/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, the provisions within the State's Business Associate Agreements, and for sharing this information with each other as part of their contractual responsibilities, per 45 CFR sections 164.502(a)(1)(ii), 164.502(a)(3), and 164.506(c).

4) Contractor may, but is not required to, enter into Memorandums of Understanding (MOU) with such third-party entities administering HCBS Programs and/or providing HCBS Program services within their Service Area to document information sharing obligations and procedures. Contractor must not delay the sharing of information, nor care coordination based on the lack of a MOU. If Contractor has a question about whether it can share information with any particular jurisdictional entity, Contractor shall immediately contact their Medi-Cal managed care contract manager for support.

VIII. Exhibit A, Attachment 13, MEMBER SERVICES, is amended to read:

1. Members Rights and Responsibilities

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-XXX. 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 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 and Network Providers, within one (1) Working Day after receiving the data from Providers;

c) Clinical data, including diagnoses and related codes, medical records, laboratory test results, and statements of medical necessity, within one (1) Working Day after the data is received by the 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 HIPAA Security Rule, 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.

3. Written Member Information

D. Member information shall include the Member Services Guide/Evidence of Coverage (EOC), provider directory, significant mailings and notices, and any notices related to Grievances, actions, and Appeals. All Member information shall be in a format that is easily understood and in a font size no smaller than 12-point, pursuant to 42 CFR 438.10, 42 CFR 438.404 and 438.408, W&I Code Section 14029.91, and Title 22 CCR Section 53876.

2) **For Members with disabilities, including visual impairment Contractor shall provide** Member information ~~shall be provided~~ in 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, ~~or~~ audio **CD format, or data CD** format) and through Auxiliary Aids at no cost, upon request, and in a timely fashion appropriate for the format being requested and taking into consideration the special needs of Members with disabilities or LEP.

a) Contractor shall 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 shall accommodate the communication needs of qualified individuals with disabilities, such as the Member's authorized representative or someone with whom it is appropriate for Contractor to communicate, such as a Member's disabled spouse. For these qualified individuals, Contractor shall be prepared to facilitate alternative format requests as identified in this Paragraph, as well as requests for other Auxiliary Aids and services.

4) Contractor shall post a DHCS-approved nondiscrimination notice. Contractor shall 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 shall include Contractor's toll-free and the TTY/TDD telephone number for obtaining these services, and shall be posted as follows:

c) In the Member Services Guide/Evidence of Coverage, and in all Member information, informational notices, and materials critical to obtaining services targeted to Members, Potential Enrollees, applicants, and members of the public, in accordance with APL 21-004, **APL 22-002,** 42 CFR section 438.10(d)(2)-(3), and W&I Code Section 14029.91(f).

E. Provider Directory

5) Contractor must implement and maintain a publicly accessible standards-based provider directory API, as described in 42 CFR section 431.70 and APL 22-XXX, which must include the information in this Paragraph E, Provider Directory. The provider directory APIs must meet the technical standards in 45 CFR section 170.215, excluding the security protocols related to user authentication and authorization.

~~5~~**6**) Provider directories shall be compliant with 42 CFR section 438.10(h) and Health and Safety Code section 1367.27, and shall include the following information for PCPs, Specialists, hospitals,

behavioral health Providers, MLTSS Providers as appropriate, and any other Providers contracted for Medi-Cal Covered Services:

a) The Provider or site's name and any group affiliation, NPI number, **street** address**(es)**, **all** telephone number**s** **associated with the practice site**, and, if applicable, web site URL for each service location, and Provider specialty as appropriate;

c) The hours and days when each service location is open**, including the availability of evening or weekend hours**;

IX. Exhibit A, Attachment 14, MEMBER GRIEVANCE AND APPEAL SYSTEM, is amended to read:

4. Notice of Action (NOA)

D. For visually impaired Members, the NOA must be provided in the Member's selected alternative format in order to be considered adequate notice. Contractor shall not deny, delay, modify, limit, or terminate services or treatments without providing adequate notice within the timeframes stated in Paragraph A of this Provision. In accordance with APL 22-002, Contractor shall 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.

7. State Hearings and Independent Medical Reviews

A. State Hearings

1) Members, or a Provider or authorized representative acting on behalf of a Member and with the Member's written consent, may request a State Hearing:

a) After receiving a notice of Appeal resolution confirming that Contractor's action has been upheld, and the request is made within 120 calendar days from the date on the notice Appeal of resolution; ~~or~~

b) If the Member is deemed to have exhausted the Appeals process due to Contractor's failure to comply with Appeal notice and timing requirements ~~Contractor shall maintain~~

~~documentation to demonstrate to the Department, why the extension is necessary~~, as stated in this Contract**,** the Member may request a State Hearing. In **such** cases of ~~such~~ 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.

X. Exhibit A, Attachment 17, REPORTING REQUIREMENTS, is amended to add:

Attachment 3 MANAGEMENT INFORMATION SYSTEM		
2. Encounter Data Submittal C.	Encounter Data Submittal	Monthly
6. Network Data Reporting	Network Data Submittal in the 274 Provider File	Monthly
8. Tracking Member Alternative Format Selections (AFS)	**Member AFS Data**	**As Requested by Member**

Attachment 19 COMMUNITY BASED ADULT SERVICES (CBAS)		
1. Provider Network F.	Subcontracted CBAS Providers and Accessibility Standards Report	Annually
~~4. Required Reports for the CBAS Program A.~~	~~Provision of ECM Report~~	~~Quarterly~~
4. Required Reports for the CBAS Program B.	CBAS Enrollment Report	Quarterly
4. Required Reports for the CBAS Program C.	Addition to Grievance and Appeal Report	Quarterly
Attachment 20 MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS		

3. Provider Network Reports A.	Addition to the Provider Network Report	Quarterly
3. Provider Network Reports B.	~~Outpatient~~ **Non-Specialty** Mental Health Services **(NSMHS)** Providers Report	Monthly
Exhibit E - ADDITIONAL PROVISIONS		
Attachment 2 PROGRAM TERMS AND CONDITIONS		
9. Certifications **A. Data, Information, and Documentation Submitted to DHCS**	**9) Interoperability Requirements**	**Monthly**
34. Treatment of Recoveries C. Recovery of Overpayment	Recovery of Overpayment Report	Annually

XI. Exhibit A, Attachment 18, IMPLEMENTATION PLAN AND DELIVERABLES, is amended to add:

3. Management Information System (MIS)

K. Submit policies and procedures to demonstrate how Contractor will conduct routine testing and monitoring, and update their systems as appropriate to ensure the APIs are functioning properly and complying with HIPAA requirements.

13. Member Services

N. 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 (1) Working Day of receipt data or information, or one (1) Working Day after a claim is adjudicated or Encounter Data is received.

O. Submit policies and procedures to demonstrate how Contractor will update its provider directory API no later than 30 calendar days after receiving updated Provider information or being notified of a Provider change.

P. Submit website mock-ups showing how a Member, Member's authorized representative, or a third-party applicant, can easily access Contractor's patient access and provider directory APIs.

Q. Submit a policies and procedures or step-by-step guides demonstrating the Member process to access Contractor's patient access and provider directory APIs.

R. Submit a policies and procedures or step-by-step guides demonstrating the Member process to navigate Contractor's patient access and provider directory APIs.

S. Submit copies of Member materials relating to the implementation of the patient access and provider directory APIs.

18. Community Based Adult Services (CBAS)

Submit the following consistent with the requirements of Exhibit A, Attachment 19.

C. Submit all policies and procedures ~~required by the Medi-Cal 2020 Waiver Special Terms and Conditions, Section VII.A.51.b~~ **on providing CBAS Emergency Remote Services (ERS)**.

D. 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**.

G. Submit policies and procedures for community participation for Members receiving CBAS.

H. Submit policies and procedures for notifying DHCS of payments made to a CBAS Provider involved in a credible allegation of fraud.

19. Mental Health and Substance Use Disorder Benefits

Submit the following consistent with the requirements of Exhibit A, Attachment 20.

B. Submit policies and procedures for ensuring timely access to ~~Outpatient~~ **Non-Specialty** Mental Health Services **(NSMHS)**.

E. Submit policies and procedures for verifying the credentials of licensed

mental health Providers of ~~Outpatient Mental Health Services~~ **NSMHS**.

J. Submit policies and procedures for when a Member becomes eligible for Specialty Mental Health Services during the course of receiving medically necessary ~~Outpatient Mental Health Services~~ **NSMHS**.

XII. Exhibit A, Attachment 19, COMMUNITY BASED ADULT SERVICES (CBAS), is amended to add:

1. Provider Network

In addition to Exhibit A, Attachment 6, Provider Network, Contractor also agrees to the following:

A. Contract with a sufficient number of available CBAS Providers in Contractor's Services Area to meet the expected utilization without a waitlist and ensure timely access, within ~~on~~ **one (1)** hour's transportation time, for Members who meet the CBAS eligibility criteria in the ~~2020~~ **California CalAIM** ~~Waiver~~ **1115(a) Demonstration, Number 11-W-00193/9 (CalAIM Demonstration)** Special Terms and Conditions **(STC)**, **General Program Requirement (GPR)** ~~Section VIII~~.A.~~48~~ **19.a and d**. CBAS Providers must be appropriate for and proficient in addressing CBAS-eligible Members' specialized health care needs, and their acuity, communication, cultural**,** and language needs and preferences. **Contractor shall confirm that every subcontracted CBAS Provider is licensed, certified, enrolled in Medi-Cal, and meets Contractor's credentialing and quality standards, including required Medi-Cal enrollment of staff.**

B. **Ensure that every CBAS Provider within their Service Area certified 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, 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 may, but is not obligated to, contract with CBAS Providers licensed as **an** ADHC~~s~~ and certified by the CDA to provide CBAS on or after April 1, 2012.

C. If Contractor determines that Member needs for CBAS exceed~~s~~ Contractor's CBAS Provider capacity, **if there is insufficient CBAS Provider capacity due to closure(s) to satisfy demand in the Service**

Area, or if there is a 5% drop in the capacity in a county within the Service Area from April 1, 2012, Contractor shall arrange for access to unbundled services in accordance with the ~~2020 Waiver Special Terms and Conditions~~ **CalAIM Demonstration STCs**, ~~Section~~ **GPRs** V~~III~~.A.48**19**.b.**iii.1 and V.A.23.a.iv.**

E. ~~Contractor shall notify DHCS when unable to contract with a certified CBAS Provider or upon termination of a CBAS Provider contract:~~ **Contractor shall pay subcontracted CBAS Providers with a reimbursement structure that is either an all-inclusive rate per Member per day of attendance, or that is otherwise reflective of the acuity and/or level of care of the Member population served by CBAS Providers.**

1) ~~If Contractor and a CBAS Provider cannot agree on mutually agreeable terms, the Contractor must notify DHCS within five (5) working days of the Contractor's decision to exclude the CBAS Provider from its Provider Network. DHCS will attempt to resolve the contracting issue when appropriate.~~ **In addition to Exhibit A, Attachment 8, Provider Compensation Arrangements and in accordance with W & I Code Section 14184.201(d)(4), Contractor shall reimburse contracted CBAS Providers at the Fee-for-Service Medi-Cal rate, unless Contractor and the CBAS Provider mutually agree to a different reimbursement amount.**

2) ~~Contractor shall provide DHCS with notice of its termination of a CBAS Provider contract at least 60 days prior to the contract termination effective date.~~ **Contractor may include incentive payment adjustments and performance and/or quality standards in its reimbursement structure for CBAS Providers.**

2. Covered Services

In addition to Exhibit A, Attachment 10, Provision 1, Covered Services and in accordance with the ~~2020 Waiver, Special Terms and Conditions~~ **CalAIM Demonstration STCs**, ~~Sections~~ **GPRs** V~~III~~.A.~~49~~ **20.a** and ~~51~~ **b**, Contractor shall 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 ~~2020 Waiver Special Terms and Conditions~~ **CalAIM Demonstration STCs**, ~~Section~~ **GPR** V~~III~~.A.48**23**.~~d~~**b**, and Provision 3 below.

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 the Member if a certified CBAS Provider is not available or not contracted, or there is insufficient CBAS Provider capacity in the area. **Arranging for unbundled CBAS 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.** Unbundled services authorized by Contractor are limited to:

6) NEMT **and NMT**, only between a Member's home and the CBAS unbundled service Provider; and

7) ~~Behavioral Health Treatment (BHT) services for Members under 21 years of age~~ **Non-Specialty Mental Health Services and substance use disorder services that are Covered Services**.

D. Arrange for the provision of CBAS Emergency Remote Services (ERS), in response to a Member's needs, and in accordance with CalAIM Demonstration STCs, GPR V.A.21. CBAS ERS shall 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 Plan of Care (IPC). Members will be assessed at least every three (3) months for ERS as part of the reauthorization of the Member's IPC and a review for a continued need for ERS.

2) Telehealth delivery of ERS must meet HIPAA requirements, and the methodology must be approved by Contractor's HIPAA compliance officer.

3) Contractor shall 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.

3. Coordination of Care

In addition to Exhibit A, Attachment 11, Case Management and **External** Coordination of Care, Contractor also agrees to the following:

B. Contractor shall ensure that CBAS IPCs are consistent with the Members' overall care plans and goals**, based on Person-Centered Planning, and completed in accordance with CalAIM Demonstration STCs, GPR V.A.20., "Individual Plan of Care"**.

C. Contractor shall ensure that the initial assessment and reassessment procedures for Members requesting CBAS are done in accordance with the ~~2020 Waiver Special Terms and Conditions~~ **CalAIM Demonstration STCs**, ~~Section~~ **GPR** VIII.A.48.e., ~~Section~~ **GPR** V~~III~~.A.~~51~~**23**.b., and as follows:

1) ~~Conduct~~ **Within 30 calendar days from the initial eligibility inquiry request, Contractor shall conduct** the CBAS eligibility determination using a DHCS-approved assessment tool. CBAS eligibility determinations shall 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 has already determined through another process that the Member is clinically eligible for CBAS, and has a need for the start of CBAS to be expedited.**

5) Contractor shall notify Members in writing of the CBAS assessment determination in accordance with the timeframes identified in the ~~2020 Waiver Special Terms and Conditions~~ **CalAIM Demonstration STCs**, ~~Section~~ **GPR** V~~III~~.A.~~51~~**23**.b.**i.** Contractor's written notice shall be approved by DHCS and include procedures for Grievances and Appeals in accordance with current requirements identified in Exhibit A, Attachment 14, Member Grievance and Appeal System.

6) 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);

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 shall coordinate Member care with CBAS Providers to ensure the following:

1) **CBAS IPCs are consistent with Members' overall care plans and goals developed by Contractor.**

2) Exchange of the following information, conducted in a timely manner to facilitate care coordination: Member discharge plan information; reports of incidents that threaten the welfare, health and safety of the Member; and significant changes in the Member's condition.

~~2~~**3**) Clear communication pathways between the appropriate CBAS Provider staff and Contractor personnel responsible for CBAS

eligibility determination, authorization, and care planning, including identification of the lead care coordinator for Members who have a care team, and utilization management.

~~3~~**4**) Written notification of Contractor's policy and procedure changes, and a process to provide education and training for CBAS Providers regarding any substantive changes that may be implemented, prior to the policy and procedure changes taking effect.

E. In addition to the requirements for unbundled CBAS contained in Provision 2, and in accordance with Exhibit A, Attachment 11, Provision ~~5~~**3**, Out-of-Network Case Management and Coordination of Care, Contractor shall coordinate care for unbundled CBAS that are not Covered Services, based on the assessed needs of the Member eligible for CBAS, including:

6) ~~Behavioral Health Treatment (BHT) services for Members under 21 years of age~~ **Substance use disorder services that are not Covered Services**.

4. Required Reports for the CBAS Program

Contractor shall submit to DHCS the following reports 30 calendar days following the end of the reporting ~~quarter~~ **period** and in a format specified by DHCS.

A. Contractor shall report to DHCS **on a quarterly basis** how many Members have been assessed for CBAS, the total number of Members currently being provided with CBAS, both as a bundled or unbundled service.

B. In addition to the requirements in Exhibit A, Attachment 6, Provider Network, Provision 11, Provider Network Report, Contractor shall include CBAS Providers added to or deleted from Contractor's Provider Network, **and when there is a 5% drop in capacity,** within the quarterly Provider Network Report submission.

C. In addition to the requirements set forth in Exhibit A, Attachment 14, Provision 3, Grievance Log and Grievance Quarterly Reports, Contractor shall also include reports on the following areas:

6) Any reports pertaining to the health and welfare of Members utilizing CBAS.

D. On an annual basis, Contractor shall provide a list of its contracted CBAS Providers and its CBAS accessibility standards.

5. Community Participation

Contractor must ensure that engagement and community participation for Members receiving CBAS is supported to the fullest extent desired by each Member.

6. CBAS Program Integrity

Following a determination that a credible allegation of fraud exists involving a CBAS Provider, DHCS shall notify Contractor of the finding promptly. Contractor 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. DHCS may recoup payments from Contractor in accordance with CalAIM Demonstration STCs, GPR V.A.30.b.

XIII. Exhibit A, Attachment 20, BEHAVIORAL HEALTH SERVICES, is amended to add:

1. ~~Outpatient~~ Non-Specialty Mental Health Services (NSMHS) Providers

In addition to Exhibit A, Attachment 6, Provider Network, Provision 1. Network Capacity, Contractor shall also include ~~Outpatient~~ **Non-Specialty** Mental Health Services **(NSMHS)** Providers in its ~~Provider~~ Network in accordance with 42 CFR 438.206, 207, and 208, as applicable. The number of ~~Outpatient Mental Health Services~~ **NSMHS** Providers shall be adequate to serve Members within its Service Area and provide covered ~~Outpatient Mental Health Services~~ **NSMHS** benefits. Contractor's ~~Outpatient Mental Health Services~~ **NSMHS** Providers shall support current and desired service utilization trends for its Members.

A. Contractor shall increase the number of ~~Outpatient Mental Health Services~~ **NSMHS** Providers within its Network as necessary to accommodate ~~e~~**E**nrollment growth. Contractor may subcontract with any mental health care Provider **to provide services** within their scope of practice.

B. The number of ~~Outpatient Mental Health Services~~ **NSMHS** Providers available shall be sufficient to meet referral and appointment access standards for routine care and shall meet the Timely Access Regulation per Healthy and Safety Code, Section 1367.03, Rule 1300.67.2.2, in accordance with the requirements set forth in Exhibit A, Attachment 9,

Access and Availability, Provision 4. Access Standards.

1) Contractor may subcontract with a county mental health plan to ensure access to ~~Outpatient Mental Health Services~~ **NSMHS**. A ~~subcontracted~~ Network shall be deemed adequate upon submission and approval of Contractor's subcontract boilerplate for a county mental health plan.

2) In addition to Exhibit A, Attachment 4, Quality Improvement System, Provision 12, Credentialing and Recredentialing, Contractor shall consider ~~Outpatient Mental Health Services~~ **NSMHS** Providers as credentialed if the Provider has accreditation from NCQA.

3) In addition to Exhibit A, Attachment 4, Quality Improvement System, Provision 12, Credentialing and Recredentialing, Contractor shall develop and maintain policies and procedures that ensure that the credentials of licensed ~~Outpatient Mental Health Services~~ **NSMHS** Providers have been verified in accordance with 42 CFR 438.214 and APL 16-012.

4) Any time that a Member requires a Medically Necessary ~~Outpatient Mental Health Service~~ **NSMHS** that is not available within the ~~Provider~~ Network, Contractor shall ensure access to Out-of-Network Providers and Telehealth mental health Providers as necessary to meet access requirements.

5) Contractor shall develop and implement policies and procedures for the exchange of Member information with the county mental health plan in order to facilitate referrals and care coordination. The policies and procedures shall cover:

   c) Data tracking of Members receiving Medi-Cal ~~Outpatient Mental Health Services~~ **NSMHS.**

3. Provider Network Reports

B. Contractor shall submit monthly reports on ~~Outpatient Mental Health Services~~ **NSMHS** Providers for the first six (6) months of the implementation of this Amendment, or a new contract, and in a format specified by DHCS. Subsequent reports shall be consistent with the requirements of this Contract.

4. ~~Outpatient~~ Non-Specialty Mental Health Care Services

A. ~~Outpatient Mental Health Services~~ **NSMHS** are those services set forth in the Welfare and Institutions Code, Article 5.9, Section 14189, unless otherwise specifically excluded under the terms of this Contract.

B. In order to determine whether ~~Outpatient Mental Health Services~~ **NSMHS** and substance use disorder services are Medically Necessary, Contractor shall apply the criteria of Medical Necessity as stated in APL 17-016 and 17-018.

C. Contractor shall cover ~~Outpatient Mental Health Services~~ **NSMHS** and substance use disorder services that are within the scope of practice for licensed mental health care Providers as follows:

G. If a Member becomes eligible for Specialty Mental Health Services during the course of receiving medically necessary ~~Outpatient Mental Health Services~~ **NSMHS**, Contractor shall continue the provision of non-duplicative, Medically Necessary ~~Outpatient Mental Health Services~~ **NSMHS**.

6. No Wrong Door for Mental Health Services

Contractor shall 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 shall 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.

5) Outpatient laboratory, drugs, supplies, and supplements.

B. Contractor shall provide or arrange for the provision of the NSMHS listed above for the following populations after screening:

1) Members who are 21 years of age or older 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 under 21 years of age, to the extent that they are eligible for services through the EPSDT benefit as described in Exhibit A, Attachment 10, Provision 5.E 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 shall cover and pay for emergency room professional services as described in 22 CCR Section 53855.

D. In accordance with APL 21-014, Contractor shall, in a primary care setting, provide covered substance use disorder (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 shall 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 shall implement standardized Screening and Transition of Care Tools for Medi-Cal Mental Health Services in accordance with APLs 22-005 and XX-XXX. 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 who are age 21 years old or older shall be screened using the Adult Screening Tool and transitioned using the Adult Transition of Care Tool.

2) In accordance with APL 22-005, Members who are under 21 years of age shall be screened using the Youth Screening Tool and transitioned using the Youth Transition of Care Tool.

F. Consistent with W&I Code Section 14184.402(f) and APL 22-005, Contractor shall cover clinically appropriate and covered NSMHS prevention, screening, assessment, and treatment services even when:

1) Services are provided prior to determination of a diagnosis, during the assessment period, or prior to a determination of whether NSMHS or specialty mental health services (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 services are provided concurrently, if those services are coordinated and not duplicated.

XIV. Exhibit E, Attachment 1, DEFINITIONS, is amended to add:

Alternative Format Selection (AFS) means the choice a Member or a Member's authorized representative makes to receive information and materials in an alternate format, such as Braille, large font, and electronic media, including audio or data CDs.

CBAS Discharge Plan of Care means a discharge plan of care based on the Member's CBAS assessment that is prepared by the CBAS Provider pursuant to 22 C.C.R. § 78345 before the date of the Member's first reassessment, and reviewed and updated at the time of each reassessment and prior to discharge. ~~The CBAS Discharge Plan of Care and must include:~~

~~A. The Member's name and ID number~~

~~B. The name(s) of the Member's physician(s)~~

~~C. If applicable, the date the Notice of Action denying authorization for CBAS was issued~~

~~D. If applicable, the date the CBAS benefit will be terminated~~

~~E. Specific information about the Member's current medical condition, treatments, and medications~~

~~F. Potential referrals for Medically Necessary services and other services or community resources that the Member may need upon discharge~~

~~G. Contact information for the Member's case manager~~

~~H. A space for the Member or the Member's representative to sign and date the Discharge Plan~~

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.

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

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

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

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

D. Psychiatric consultation; and

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

~~**Outpatient Mental Health Services** means outpatient services that Contractor will provide for Members with mild to moderate mental health conditions requiring services not covered by the county mental health plan as specialty mental health services, including: individual or group mental health evaluation and treatment (psychotherapy); psychological testing when clinically indicated to evaluate a mental health condition; psychiatric consultation for medication management; and outpatient laboratory, supplies, and supplements.~~

XV. Exhibit E, Attachment 2, PROGRAM TERMS AND CONDITIONS, is amended to add:

9. Certifications

A. Contractor shall certify all data, information, and documentation submitted to DHCS pursuant to 42 CFR 438.604, APL 17-005, and as listed below, in a form and manner specified by DHCS:

7) The annual report of Overpayment recoveries as required in 42 CFR 438.608(d)(3); ~~and~~

8) Documentation confirming compliance with this Contract's interoperability requirements and APL 22-XXX that is certified by Contractor's CEO or CFO and in accordance with submission requirements in APL 17-005; and

~~8~~**9**) Any other data, documentation, or information requested by DHCS relating to the performance of Contractor's obligations under this Contract.

XVI. All rights, duties, obligations and liabilities of the parties hereto otherwise remain unchanged.

Category	Requirement	Sub-Regulatory Guidance
Alternative Format Selection (AFS)	-Maintain systems that can, at a minimum, perform the following functions: 1) Collect and store Member AFS, as well as the AFS of a Member's authorized representative. 2) Share Member AFS data with DHCS as specified in the Alternative Format Data Process Guide included in APL 22-002. 3) Track Member's authorized representative AFS data and submit to DHCS when requested. -CalOptima submitted all Member AFS data in a one-time file upload to the DHCS Alternate Formats database as specified in APL 22-002. -Submit to DHCS all new Member AFS at the time of the Member's request. -Utilize the weekly DHCS AFS file data to update records and provide Member materials in the requested alternative formats.	All – Plan Letter (APL) 22 – 002: Alternative Format Selection for Members with Visual Impairments
	-In determining what types of Auxiliary Aids and services to provide, CalOptima must give primary consideration to a Member's request for a particular Auxiliary Aid or service. -If a Member selects an electronic format, such as an audio or data CD, then CalOptima may provide the materials in an unencrypted format but only with the Member's informed consent. CalOptima 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. -Accommodate the communication needs of qualified individuals with disabilities, such as the Member's authorized representative or someone with whom it is appropriate for CalOptima to communicate, such as a Member's disabled spouse. For these qualified individuals, CalOptima shall be prepared to facilitate alternative format requests. -For visually impaired Members, the Notice of Action (NOA) must be provided in the Member's selected alternative format to be considered adequate notice.	APL 21-004: Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services (Supersedes APL 17-011 and Policy Letters 99-003 and 99-004)

CBAS Updates from the CalAIM Waiver STCs	-Confirm that every subcontracted CBAS Provider is licensed, certified, enrolled in Medi-Cal, and meets CalOptima's credentialing and quality standards, including required Medi-Cal enrollment of staff. -Ensure that every CBAS Provider within their Service Area certified by the California Department of Aging (CDA) as a CBAS Provider, is included in CalOptima's Network, to the extent that the CBAS Provider remains licensed as an Adult Day Health Care (ADHC) Center, certified and enrolled as a Medi-Cal Provider, is willing to enter into a Network Provider agreement with CalOptima on mutually agreeable terms, and meets CalOptima's credentialing and quality standards. -Arrange for access to unbundled services if CalOptima determines that Member needs for CBAS exceeds CalOptima's CBAS Provider capacity, if there is insufficient CBAS Provider capacity due to closure(s) to satisfy demand in the Service Area, or if there is a 5% drop in the capacity in a county within the Service Area from April 1, 2012. -Pay subcontracted CBAS Providers with a reimbursement structure that is either an all-inclusive rate per Member per day of attendance, or that is otherwise reflective of the acuity and/or level of care of the Member population served by CBAS Providers. -Reimburse contracted CBAS Providers at the Fee-for-Service Medi-Cal rate, unless CalOptima and the CBAS Provider mutually agree to a different reimbursement amount. CalOptima may include incentive payment adjustments and performance and/or quality standards in its reimbursement structure for CBAS Providers. -Arrange for the provision of CBAS Emergency Remote Services (ERS) in response to a Member's needs. CBAS ERS shall be provided in alternative service locations and/or via Telehealth, including telephone or virtual video conferencing, as clinically appropriate. -Conduct the CBAS eligibility determination using a DHCS-approved assessment tool within 30 calendar days from the initial eligibility inquiry request. -Ensure CBAS Individualized Plans of Care (IPCs) are consistent with Members' overall care plans and goals developed by CalOptima. -Ensure that engagement and community participation for Members receiving CBAS is supported to the fullest extent desired by each Member. -Submit policies and procedures (P&Ps) as outlined in the contract.	California CalAIM 1115(a) Demonstration, Number 11-W-00193/9 (CalAIM Demonstration) Special Terms and Conditions (STC)

	-Provide a list of its contracted CBAS Providers and its CBAS accessibility standards on an annual basis.	
Cognitive Health Assessment	-Ensure the provision of an annual brief 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.	
Home and Community-Based Services (HCBS) Program	-Continue to provide all services covered under this Contract to a Member when that Member is enrolled in, or applying to enroll in, receiving, or applying to receive a HCBS Program other than this Contract. -Continuously collaborate and exchange Member healthcare and medical information with all third-party entities providing the Member with Medi-Cal HCBS or administering a Medi-Cal-funded HCBS Program. Added requirements regarding collaboration with third-party entities.	
Interoperability Rule API	-Implement and maintain a publicly accessible, standards-based Patient Access Application Programming Interface (API) and a provider directory API. -Operate the API and include information as outlined in federal requirements. -Verify that data collected from Network Providers and Subcontractors to be made available through the API is accurate, complete, and timely, and collected in accordance with oversight and monitoring guidance. -Conduct routine testing and monitoring of API functions, and applying system updates as appropriate, to ensure that the API is compliant and functional. -Permit third-party applications to retrieve, with the approval and at the direction of the Member, Member records, including adjudicated claims, encounter data, clinical data, and information about coverage for administered drugs. Comply with time limits for including records in the API. -Submit P&Ps and documentation as outlined in the contract.	APL 17-005: Certification of Document and Data Submissions
No Wrong Door	-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. -Provide or arrange for the provision of Non-Specialty Mental Health Services (NSMHS). -In accordance with APL 21-014, CalOptima shall, in a primary care setting, provide covered substance use disorder (SUD) services, including alcohol and drug screening, assessments, brief interventions, and referral to treatment for Members aged 11 years old and older, including Members	APL 21-014: Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (Supersedes APL 18-014)

	who are pregnant. CalOptima shall 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. -Implement standardized Screening and Transition of Care Tools for Medi-Cal Mental Health Services. -Update and align P&Ps and MOUs with mental health plans to ensure compliance and communicate updates to Providers as necessary. -Cover clinically appropriate and covered NSMHS prevention, screening, assessment, and treatment services even when the scenarios outlined in the contract are met.	
Terminology Changes	-Update terms and definitions used in the agreement.	

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 4, 2022
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

9. Adopt Resolution Authorizing and Directing Execution of Contract MS-2223-41 with the California Department of Aging for the Multipurpose Senior Services Program

Contacts

Richard Pitts, D.O., Ph.D., Chief Medical Officer, (714) 246-8491
Kelly Giardina, Executive Director, Medical Management, (657) 900-1013

Recommended Action

Adopt Board Resolution No. 22-0804-02, authorizing and directing the Chairman of the CalOptima Board of Directors to execute Contract MS-2223-41 with the California Department of Aging (CDA) for the Multipurpose Senior Services Program (MSSP) for Fiscal Year (FY) 2022-23.

Background

The MSSP is a home and community-based services program, operated pursuant to a waiver in the State of California's Medi-Cal program. MSSP provides case management of social and health care as a cost-effective alternative to institutionalization of frail elderly adults.

The California Department of Health Care Services, through an interagency agreement, delegates the administration of the MSSP to the CDA. The CDA contracts with local government entities and private non-profit organizations for local administration of the MSSP in various areas of the state.

As the operator of the MSSP site for Orange County, CalOptima improves the quality of care for its aging population by linking frail elderly members to home and community-based services as an alternative to institutionalization and helps to contain long-term care costs by reducing unnecessary or inappropriate nursing facility placements. CalOptima has successfully implemented the MSSP program over the past 21 years for up to 455 members at any given point in time. As of January 1, 2022, the allocated member slots for CalOptima increased to 568. Currently, CalOptima serves 455 members, with the goal of serving 568 members by November 2022, by systematically admitting members month over month until the goal is achieved.

Discussion

CalOptima received the CDA contract, MS-2223-41, for execution by the Chairman of the CalOptima Board, which, upon the adoption of a Board resolution and execution of the contract, will extend the MSSP through June 30, 2023, with the maximum of the contract spend set at $3,042,208.

The scope of work and other obligations are consistent with existing contract obligations. There are some proposed clarifications regarding the active client count description. Additionally, the participant months language was rephrased, and calculations of participant slots over 12-month period were defined. The Additional Provisions Specific to Contractors Operating Under the Coordinate Care Initiative (CCI) Payment Model section was removed due to CCI carve out transitioning back to a fee-

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for-service payment model. Language pertaining to In-Home Support Services Plus Waiver was removed due to age of the information. Language pertaining to Adult Day Care Centers was added as required by the Centers for Medicare and Medicaid Services. Language was edited to reflect updated service code descriptions, and descriptions of unit types were removed because of the fiscal intermediary code conversion effective for FY 2022-23. More detail was added regarding the rate change process and the submission requirements.

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

Fiscal Impact
The recommended action is a budgeted item and included in the CalOptima FY 2022-23 Operating Budget approved by the Board on June 2, 2022.

Rationale for Recommendation
Adoption of Board Resolution No. 22-0804-02, authorizing and directing the Chairman of the Board to execute the FY 2022-23 contract with the CDA for the MSSP will allow CalOptima to continue to address the long-term community care needs of some of the frailest older adult CalOptima members by helping them to remain in their homes.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Board Resolution No. 22-0804-02, Execute Contract No. MS-2223-41, Amendment A1 with the State of California Department of Aging for the Multipurpose Senior Services Program
2. CDA MSSP Contract FY 2022-23

/s/ Michael Hunn *07/28/2022*
Authorized Signature **Date**

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RESOLUTION NO. 22-0804-02

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

EXECUTE CONTRACT NO. MS-2223-41
WITH THE STATE OF CALIFORNIA
DEPARTMENT OF AGING FOR THE
MULTIPURPOSE SENIOR SERVICES PROGRAM (MSSP)

WHEREAS, The Orange County Health Authority, d.b.a. CalOptima ("CalOptima") continues to provide services as a Multipurpose Senior Service Program Site under contract with the California Department of Aging; and,

WHEREAS, the California Department of Aging notified CalOptima of its intent to contract for the assignment of 568 MSSP participant slots to CalOptima; and,

WHEREAS, the California Department of Aging has requested the execution of Contract MS-2223-41; and,

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

NOW, THEREFORE, BE IT RESOLVED:

I. That CalOptima is hereby authorized to enter into contract MS-2223-41 with the State of California Department of Aging on the terms and conditions set forth in the form provided to this Board of Directors; and,

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

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a. CalOptima, this 4th day of August 2022.

AYES: _____

NOES: _____

ABSENT:_____

ABSTAIN: _____

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

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

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STATE OF CALIFORNIA
DEPARTMENT OF AGING
MSSP CONTRACT CHECKLIST
CDA 9007B (REV 05/2022)

All documents listed are required to execute your contract unless otherwise noted.

- All documents must identify the Contractor's legal name exactly as shown on the standard agreement or amendment (STD. 213 or 213A).
- Contract packages must be complete and able to stand alone. For example, if you have more than one contract with the California Department of Aging (CDA),you may have one Insurance Certificate to cover all contracts but must include acopy of the Certificate in each contract package returned to CDA.
- This checklist does not need to be submitted as part of the contract package.
- Return final contract packages to:
  California Department of Aging
  Attn: Contract Analyst
  2880 Gateway Oaks Drive, Suite 200
  Sacramento, CA 95833

☒ **Four (4) standard agreements or amendments (STD. 213 or 213A)** – Print, signand submit four copies of the Std. 213 or 213A (signature page) with ***original signatures*** (Blue ink is preferable). Signature stamps or copies of any type will not be accepted.

☒ **Agreement authorization document** – Submit a signed Board Resolution, Order, or Meeting Minutes that demonstrates the Organization's approval of each contract. The contract number(s) must be referenced in the document. If the document does not demonstrate authorization to sign amendments, another authorization documentwill be needed to amend the contract. If Board Meeting Minutes are used, they mustbe signed off as approved or the following Board Meeting Minutes must be submitted showing the previous Board Meeting Minutes were approved. For local governments and public entities, authorization is required from the Board of Supervisors or equivalent governing body. For Non-

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profits, authorization is required from the Board of Directors. [See MSSP Contract, Exhibit D, Article II, Section K.]

☒ **Information Integrity and Security Statement (CDA 1024)** – Print, sign and submitone copy of the CDA 1024 for each contract. The contract number must be referenced on the document. Resubmission of this document is not required for amendments. [See MSSP Contract, Exhibit D, Article XVII, Section F.]

☒ **Contractor Certification Clauses (CCC 4/2017)** – Print, sign, and submit a signed copy of the CCC 4/2017 certification, certifying your organization's compliance. Resubmission of this document is not required for amendments. [See MSSPContract Exhibit D, Article II, Section C.3]

☒ **California Civil Rights Laws Certification (CDA 9026)** – Print, sign and submit a signed copy of the CDA 9026 certification, certifying your Organization's compliance.Resubmission of this document is not required for amendments. [See MSSP Contract Exhibit D, Article II, Section C.3]

☒ **Insurance Requirements** – Submit a Certificate of Insurance or Letter of Self-Insurance for each contract. Insurance document(s) are required and must meet the General, Automobile and Professional liability coverages and conditions in thecontract. The Certificate or Letter of Self Insurance must reference the contract number(s) and demonstrate coverage for the entire term of the Contract. General and Automobile Liability coverages requires an additional insured statement naming the State of California as an additional insured entity. Resubmission of this document is not required for amendments. [See MSSP contract Exhibit D, Article XI.]

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STATE OF CALIFORNIA – DEPARTMENT OF GENERAL SERVICES

STANDARD AGREEMENT
STD 213 (Rev. 04/2020)

SCO ID: 4260-MS212241

AGREEMENT NUMBER	PURCHASING AUTHORITY NUMBER (If Applicable)
MS-2223-41	

1. This Agreement is entered into between the Contracting Agency and the Contractor named below:

CONTRACTING AGENCY NAME
California Department of Aging

CONTRACTOR NAME
ORANGE COUNTY HEALTH AUTHORITY, DBA CALOPTIMA

2. The term of this Agreement is:

START DATE
7/1/2022

THROUGH END DATE
6/30/2023

3. The maximum amount of this Agreement is:
$ 3,042,208 Three million forty-two thousand two hundred eight and 00/100 dollars

4. The parties agree to comply with the terms and conditions of the following exhibits, which are by this reference made a part of the Agreement.

Exhibits		Title	Pages
	Exhibit A	Scope of Work	19 pages
	Exhibit A, Attachment 1	General Information	1 page
	Exhibit B	Budget Detail and Payment Provisions	7 pages
	Exhibit B, Attachment 1	Budget Display	1 page
	Exhibit C	General Terms and Conditions – GTC-4/2017*	0 pages
	Exhibit D	Special Terms and Conditions	34 pages
	Exhibit E	Additional Provisions Specific to this MSSP Agreement	7 pages
	Exhibit F	HIPPA Business Associates Addendum	10 pages
	Exhibit G	Catchment Area Zip Codes	1 page

Items shown with an asterisk (*), are hereby incorporated by reference and made part of this agreement as if attached hereto.
These documents can be viewed at https://www.dgs.ca.gov/OLS/Resources

IN WITNESS WHEREOF, THIS AGREEMENT HAS BEEN EXECUTED BY THE PARTIES HERETO.

CONTRACTOR

CONTRACTOR NAME (if other than an individual, state whether a corporation, partnership, etc.)
ORANGE COUNTY HEALTH AUTHORITY, DBA CALOPTIMA

CONTRACTOR BUSINESS ADDRESS	CITY	STATE	ZIP
505 City Parkway West	Orange	CA	92868

PRINTED NAME OF PERSON SIGNING	TITLE
Andrew Do	Chair, CalOptima Board of Directors

CONTRACTOR AUTHORIZED SIGNATURE	DATE SIGNED

STATE OF CALIFORNIA

CONTRACTING AGENCY NAME
California Department of Aging

CONTRACTING AGENCY ADDRESS	CITY	STATE	ZIP
2880 Gateway Oaks Drive, Suite 200	Sacramento	CA	95833

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

CONTRACTING AGENCY AUTHORIZED SIGNATURE	DATE SIGNED

CALIFORNIA DEPARTMENT OF GENERAL SERVICES APPROVAL	EXEMPTION (If Applicable)
	AG OP 80-111

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

CONTRACTING AGENCY AUTHORIZED SIGNATURE	DATE SIGNED

CALIFORNIA DEPARTMENT OF GENERAL SERVICES APPROVAL	EXEMPTION (If Applicable)
	AG OP 80-111

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 4, 2022
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

9. Adopt Resolution Authorizing and Directing Execution of Contract MS-2223-41 with the California Department of Aging for the Multipurpose Senior Services Program

Contacts

Richard Pitts, D.O., Ph.D., Chief Medical Officer, (714) 246-8491
Kelly Giardina, Executive Director, Medical Management, (657) 900-1013

Recommended Action

Adopt Board Resolution No. 22-0804-02, authorizing and directing the Chairman of the CalOptima Board of Directors to execute Contract MS-2223-41 with the California Department of Aging (CDA) for the Multipurpose Senior Services Program (MSSP) for Fiscal Year (FY) 2022-23.

Background

The MSSP is a home and community-based services program, operated pursuant to a waiver in the State of California's Medi-Cal program. MSSP provides case management of social and health care as a cost-effective alternative to institutionalization of frail elderly adults.

The California Department of Health Care Services, through an interagency agreement, delegates the administration of the MSSP to the CDA. The CDA contracts with local government entities and private non-profit organizations for local administration of the MSSP in various areas of the state.

As the operator of the MSSP site for Orange County, CalOptima improves the quality of care for its aging population by linking frail elderly members to home and community-based services as an alternative to institutionalization and helps to contain long-term care costs by reducing unnecessary or inappropriate nursing facility placements. CalOptima has successfully implemented the MSSP program over the past 21 years for up to 455 members at any given point in time. As of January 1, 2022, the allocated member slots for CalOptima increased to 568. Currently, CalOptima serves 455 members, with the goal of serving 568 members by November 2022, by systematically admitting members month over month until the goal is achieved.

Discussion

CalOptima received the CDA contract, MS-2223-41, for execution by the Chairman of the CalOptima Board, which, upon the adoption of a Board resolution and execution of the contract, will extend the MSSP through June 30, 2023, with the maximum of the contract spend set at $3,042,208.

The scope of work and other obligations are consistent with existing contract obligations. There are some proposed clarifications regarding the active client count description. Additionally, the participant months language was rephrased, and calculations of participant slots over 12-month period were defined. The Additional Provisions Specific to Contractors Operating Under the Coordinate Care Initiative (CCI) Payment Model section was removed due to CCI carve out transitioning back to a fee-

for-service payment model. Language pertaining to In-Home Support Services Plus Waiver was removed due to age of the information. Language pertaining to Adult Day Care Centers was added as required by the Centers for Medicare and Medicaid Services. Language was edited to reflect updated service code descriptions, and descriptions of unit types were removed because of the fiscal intermediary code conversion effective for FY 2022-23. More detail was added regarding the rate change process and the submission requirements.

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

Fiscal Impact
The recommended action is a budgeted item and included in the CalOptima FY 2022-23 Operating Budget approved by the Board on June 2, 2022.

Rationale for Recommendation
Adoption of Board Resolution No. 22-0804-02, authorizing and directing the Chairman of the Board to execute the FY 2022-23 contract with the CDA for the MSSP will allow CalOptima to continue to address the long-term community care needs of some of the frailest older adult CalOptima members by helping them to remain in their homes.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Board Resolution No. 22-0804-02, Execute Contract No. MS-2223-41, Amendment A1 with the State of California Department of Aging for the Multipurpose Senior Services Program
2. CDA MSSP Contract FY 2022-23

/s/ Michael Hunn *07/28/2022*
Authorized Signature **Date**

RESOLUTION NO. 22-0804-02

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

EXECUTE CONTRACT NO. MS-2223-41
WITH THE STATE OF CALIFORNIA
DEPARTMENT OF AGING FOR THE
MULTIPURPOSE SENIOR SERVICES PROGRAM (MSSP)

WHEREAS, The Orange County Health Authority, d.b.a. CalOptima ("CalOptima") continues to provide services as a Multipurpose Senior Service Program Site under contract with the California Department of Aging; and,

WHEREAS, the California Department of Aging notified CalOptima of its intent to contract for the assignment of 568 MSSP participant slots to CalOptima; and,

WHEREAS, the California Department of Aging has requested the execution of Contract MS-2223-41; and,

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

NOW, THEREFORE, BE IT RESOLVED:

I. That CalOptima is hereby authorized to enter into contract MS-2223-41 with the State of California Department of Aging on the terms and conditions set forth in the form provided to this Board of Directors; and,

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

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a. CalOptima, this 4th day of August 2022.

AYES: _____

NOES: _____

ABSENT:_____

ABSTAIN: _____

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

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

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STATE OF CALIFORNIA
CALIFORNIA DEPARTMENT OF AGING
INFORMATION INTEGRITY AND SECURITY STATEMENT
CDA 1024 (REV 03/2020)

In compliance with California Government Code Section 11019.9, California Civil Code Section 1798 et seq., Department of General Services Management Memo 06-12, and Statewide Information Management Manual (SIMM) 5300 the California Department of Aging (CDA) hereby requires the Contractor/Vendor to:

ACKNOWLEDGE:

- Any wrongful access, inspection, use, or disclosure of Personal, Confidential or Sensitive Information (PSCI) is a crime and is prohibited under state and federal laws, including but not limited to California Penal Code Section 502, California Government Code Section 15619, California Civil Code Section 1798.53 and 1798.55, and the Health Insurance Portability and Accountability Act. Acknowledge.
- Any wrongful access, inspection, use, disclosure, or modification of PSCI information may result in termination of this Contract/Agreement.

MEET THE FOLLOWING REQUIREMENTS:

- PSCI information shall be protected from disclosure in accordance with all applicable laws, regulations, and policies.
- PSCI data be protected by authorized access using the principles of least privilege.
- Any occurrence that actually or potentially jeopardizes the confidentiality, integrity, or availability of an information system or the information the system processes, stores, or transmits or that constitutes a violation or imminent threat of violation of security policies, security procedures or acceptable use policies will immediately be reported to CDA by completing a Security Incident Report CDA (1025A and 1025B).
- All access codes which allow access to confidential information will be properly safeguarded.
- Obligations to protect PSCI information obtained under this Contract/Agreement will continue after termination of the Contract/Agreement with CDA.
- All employees/subcontractors of the Contractor/Vendor will complete the required Security Awareness Training module located at https://aging.ca.gov/Information_security/ within 30 days of the start date of the Contract/Agreement or within 30 days of the start date of any new employee or subcontractor. This training must be completed annually.
- All employees/subcontractors of the Contractor/Vendor must comply with CDA's confidentiality and data security requirements as outlined in the Contract/Agreement.
- All employees/subcontractors of the Contract/Vendor must comply with the Appendix D, section XVIII encryption and self-certification requirements as outlined in the contract.

STATE OF CALIFORNIA
CALIFORNIA DEPARTMENT OF AGING
INFORMATION INTEGRITY AND SECURITY STATEMENT
CDA 1024 (REV 03/2020)

CERTIFY:

To protect PSCI information by:

- Accessing, inspecting, using, disclosing or modifying PSCI information only for the purpose of performing official duties.
- Never accessing, inspecting, using, disclosing, or modifying PSCI information for curiosity, personal gain, or any non-business-related reason.
- Securing PSCI information in approved locations.
- Never removing PSCI information from the work site without authorization.

Meets the encryption requirements in Exhibit D Article 18:

☑ Is in full compliance with the 128 Encryption requirements.

☐ Is not in compliance with the 128 Encryption requirements and will achieve compliance by _____.

I hereby certify that I have reviewed this Confidentiality Statement and will comply with the above statements.

OC Health Authority, DBA CalOptima / Andrew Do, Chair, Board of Directors
Contractor/Vendor Printed Name and Title

Contractor/Vendor Signature

Date

CDA Program/Project

MS-2223-41
Contract Number

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Contractor Certification Clauses

CCC 04/2017

CERTIFICATION

I, the official named below, CERTIFY UNDER PENALTY OF PERJURY that I am duly authorized to legally bind the prospective Contractor to the clause(s) listed below. This certification is made under the laws of the State of California.

Contractor/Bidder Firm Name (Printed)	Federal ID Number
Orange County Health Authority, DBA CalOptima	330599891

By (Authorized Signature)

Printed Name and Title of Person Signing

Andrew Do, Chair, CalOptima Board of Directors

Date Executed	Executed in the County of
	Orange

CONTRACTOR CERTIFICATION CLAUSES

1. STATEMENT OF COMPLIANCE: Contractor has, unless exempted, complied with the nondiscrimination program requirements. (Gov. Code §12990 (a-f) and CCR, Title 2, Section 11102) (Not applicable to public entities.)

2. DRUG-FREE WORKPLACE REQUIREMENTS: Contractor will comply with the requirements of the Drug-Free Workplace Act of 1990 and will provide a drug-free workplace by taking the following actions:

a. Publish a statement notifying employees that unlawful manufacture, distribution, dispensation, possession or use of a controlled substance is prohibited and specifying actions to be taken against employees for violations.

b. Establish a Drug-Free Awareness Program to inform employees about:

1) the dangers of drug abuse in the workplace;

2) the person's or organization's policy of maintaining a drug-free workplace;

3) any available counseling, rehabilitation and employee assistance programs; and,

4) penalties that may be imposed upon employees for drug abuse violations.

c. Every employee who works on the proposed Agreement will:

1) receive a copy of the company's drug-free workplace policy statement; and,

2) agree to abide by the terms of the company's statement as a condition of employment on the Agreement.

Failure to comply with these requirements may result in suspension of payments under the Agreement or termination of the Agreement or both and Contractor may be ineligible for award of any future State agreements if the department determines that any of the following has occurred: the Contractor has made false certification, or violated the certification by failing to carry out the requirements as noted above. (Gov. Code §8350 et seq.)

3. NATIONAL LABOR RELATIONS BOARD CERTIFICATION: Contractor certifies that no more than one (1) final unappealable finding of contempt of court by a Federal court has been issued against Contractor within the immediately preceding two-year period because of Contractor's failure to comply with an order of a Federal court, which orders Contractor to comply with an order of the National Labor Relations Board. (Pub. Contract Code §10296) (Not applicable to public entities.)

4. CONTRACTS FOR LEGAL SERVICES $50,000 OR MORE- PRO BONO REQUIREMENT: Contractor hereby certifies that Contractor will comply with the requirements of Section 6072 of the Business and Professions Code, effective January 1, 2003.

Contractor agrees to make a good faith effort to provide a minimum number of hours of pro bono legal services during each year of the contract equal to the lessor of 30 multiplied by the number of full time attorneys in the firm's offices in the State, with the number of hours prorated on an actual day basis for any contract period of less than a full year or 10% of its contract with the State.

Failure to make a good faith effort may be cause for non-renewal of a state contract for legal services, and may be taken into account when determining the award of future contracts with the State for legal services.

5. EXPATRIATE CORPORATIONS: Contractor hereby declares that it is not an expatriate corporation or subsidiary of an expatriate corporation within the meaning of Public Contract Code Section 10286 and 10286.1, and is eligible to contract with the State of California.

6. SWEATFREE CODE OF CONDUCT:

a. All Contractors contracting for the procurement or laundering of apparel, garments or corresponding accessories, or the procurement of equipment, materials, or supplies, other than procurement related to a public works contract, declare under penalty of perjury that no apparel, garments or corresponding accessories, equipment, materials, or supplies furnished to the state pursuant to the contract have been laundered or produced in whole or in part by sweatshop labor, forced labor, convict labor, indentured labor under penal sanction, abusive forms of child labor or exploitation of children in sweatshop labor, or with the benefit of sweatshop labor, forced labor, convict labor, indentured labor under penal sanction, abusive forms of child labor or exploitation of children in sweatshop labor. The contractor further declares under penalty of perjury that they adhere to the Sweatfree Code of Conduct as set forth on the California Department of Industrial Relations website located at www.dir.ca.gov, and Public Contract Code Section 6108.

b. The contractor agrees to cooperate fully in providing reasonable access to the contractor's records, documents, agents or employees, or premises if reasonably

required by authorized officials of the contracting agency, the Department of Industrial Relations, or the Department of Justice to determine the contractor's compliance with the requirements under paragraph (a).

7. DOMESTIC PARTNERS: For contracts of $100,000 or more, Contractor certifies that Contractor is in compliance with Public Contract Code section 10295.3.

8. GENDER IDENTITY: For contracts of $100,000 or more, Contractor certifies that Contractor is in compliance with Public Contract Code section 10295.35.

DOING BUSINESS WITH THE STATE OF CALIFORNIA

The following laws apply to persons or entities doing business with the State of California.

1. CONFLICT OF INTEREST: Contractor needs to be aware of the following provisions regarding current or former state employees. If Contractor has any questions on the status of any person rendering services or involved with the Agreement, the awarding agency must be contacted immediately for clarification.

Current State Employees (Pub. Contract Code §10410):

1). No officer or employee shall engage in any employment, activity or enterprise from which the officer or employee receives compensation or has a financial interest and which is sponsored or funded by any state agency, unless the employment, activity or enterprise is required as a condition of regular state employment.

2). No officer or employee shall contract on his or her own behalf as an independent contractor with any state agency to provide goods or services.

Former State Employees (Pub. Contract Code §10411):

1). For the two-year period from the date he or she left state employment, no former state officer or employee may enter into a contract in which he or she engaged in any of the negotiations, transactions, planning, arrangements or any part of the decision-making process relevant to the contract while employed in any capacity by any state agency.

2). For the twelve-month period from the date he or she left state employment, no former state officer or employee may enter into a contract with any state agency if he or she was employed by that state agency in a policy-making position in the same general subject area as the proposed contract within the 12-month period prior to his or her leaving state service.

If Contractor violates any provisions of above paragraphs, such action by Contractor shall render this Agreement void. (Pub. Contract Code §10420)

Members of boards and commissions are exempt from this section if they do not receive payment other than payment of each meeting of the board or commission, payment for preparatory time and payment for per diem. (Pub. Contract Code §10430 (e))

2. LABOR CODE/WORKERS' COMPENSATION: Contractor needs to be aware of the provisions which require every employer to be insured against liability for Worker's Compensation or to undertake self-insurance in accordance with the provisions, and

Contractor affirms to comply with such provisions before commencing the performance of the work of this Agreement. (Labor Code Section 3700)

3. AMERICANS WITH DISABILITIES ACT: Contractor assures the State that it complies with the Americans with Disabilities Act (ADA) of 1990, which prohibits discrimination on the basis of disability, as well as all applicable regulations and guidelines issued pursuant to the ADA. (42 U.S.C. 12101 et seq.)

4. CONTRACTOR NAME CHANGE: An amendment is required to change the Contractor's name as listed on this Agreement. Upon receipt of legal documentation of the name change the State will process the amendment. Payment of invoices presented with a new name cannot be paid prior to approval of said amendment.

5. CORPORATE QUALIFICATIONS TO DO BUSINESS IN CALIFORNIA:

a. When agreements are to be performed in the state by corporations, the contracting agencies will be verifying that the contractor is currently qualified to do business in California in order to ensure that all obligations due to the state are fulfilled.

b. "Doing business" is defined in R&TC Section 23101 as actively engaging in any transaction for the purpose of financial or pecuniary gain or profit. Although there are some statutory exceptions to taxation, rarely will a corporate contractor performing within the state not be subject to the franchise tax.

c. Both domestic and foreign corporations (those incorporated outside of California) must be in good standing in order to be qualified to do business in California. Agencies will determine whether a corporation is in good standing by calling the Office of the Secretary of State.

6. RESOLUTION: A county, city, district, or other local public body must provide the State with a copy of a resolution, order, motion, or ordinance of the local governing body which by law has authority to enter into an agreement, authorizing execution of the agreement.

7. AIR OR WATER POLLUTION VIOLATION: Under the State laws, the Contractor shall not be*:* (1) in violation of any order or resolution not subject to review promulgated by the State Air Resources Board or an air pollution control district; (2) subject to cease and desist order not subject to review issued pursuant to Section 13301 of the Water Code for violation of waste discharge requirements or discharge prohibitions; or (3) finally determined to be in violation of provisions of federal law relating to air or water pollution.

8. PAYEE DATA RECORD FORM STD. 204: This form must be completed by all contractors that are not another state agency or other governmental entity.

STATE OF CALIFORNIA
CALIFORNIA DEPARTMENT OF AGING
CALIFORNIA CIVIL RIGHTS LAWS CERTIFICATION
CDA 9026 (NEW 04/2018)

Pursuant to Public Contract Code section 2010, a person that submits a bid or proposal to, or otherwise proposes to enter into or renew a contract with, a state agency with respect to any contract in the amount of $100,000 or above shall certify, under penalty of perjury, at the time the bid or proposal is submitted or the contract is renewed, all of the following:

1. CALIFORNIA CIVIL RIGHTS LAWS: For contracts executed or renewed after January 1, 2017, the contractor certifies compliance with the Unruh Civil Rights Act (Section 51 of the Civil Code) and the Fair Employment and Housing Act (Section 12960 of the Government Code); and

2. EMPLOYER DISCRIMINATORY POLICIES: For contracts executed or renewed after January 1, 2017, if a Contractor has an internal policy against a sovereign nation or peoples recognized by the United States government, the Contractor certifies that such policies are not used in violation of the Unruh Civil Rights Act (Section 51 of the Civil Code) or the Fair Employment and Housing Act (Section 12960 of the Government Code).

CERTIFICATION

I, the official named below, certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Contractor Name (Printed):	Federal ID Number:
Orange Cty.Health Authority, DBA CalOptima	33059989 1
By (Authorized Signature):	
Printed Name and Title of Person Signing: Andrew Do, Chair, CalOptima Board of Directors	
Date Executed:	Executed in the County and State of: Orange, California

Indicate all California Department of Aging contracts your organization participates in:

- ☐ Area Plan (AP)
- ☐ Financial Alignment (FA)
- ☐ HICAP (HI)
- ☐ MIPPA (MI)
- ☑ MSSP (MS)
- ☐ SNAP-Ed (SP)
- ☐ Title V (TV)

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CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 4/12/2022

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER Woodruff-Sawyer & Co. 50 California Street, Floor 12 San Francisco CA 94111	**CONTACT NAME:** Debbie Haworth **PHONE (A/C, No, Ext):** 415-402-6645 **FAX (A/C, No):** **E-MAIL ADDRESS:** dhaworth@woodruffsawyer.com
INSURED CALOPTI-01 CalOptima 505 City Parkway West Orange CA 92868	**INSURER(S) AFFORDING COVERAGE** — **NAIC #** **INSURER A :** Indian Harbor Insurance Company — 36940 **INSURER B :** Continental Insurance Company — 35289 **INSURER C :** Valley Forge Insurance Company — 20508 **INSURER D :** National Fire Insurance Company of Hartford — 20478 **INSURER E :** TDC National Assurance Company — 41050 **INSURER F :** Allied World Surplus Lines Insurance Company — 24319

COVERAGES **CERTIFICATE NUMBER:** 229341756 **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
B	X **COMMERCIAL GENERAL LIABILITY** CLAIMS-MADE X OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: X POLICY PRO-JECT LOC OTHER:	Y		6080046159	4/7/2022	4/7/2023	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	$ 1,000,000 $ 100,000 $ 15,000 $ 1,000,000 $ 2,000,000 $ 2,000,000
B	**AUTOMOBILE LIABILITY** X ANY AUTO OWNED AUTOS ONLY HIRED AUTOS ONLY SCHEDULED AUTOS NON-OWNED AUTOS ONLY	Y		6080046131	4/7/2022	4/7/2023	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	$ 1,000,000 $ $ $
B	X **UMBRELLA LIAB** X OCCUR **EXCESS LIAB** CLAIMS-MADE DED RETENTION $			6080046145	4/7/2022	4/7/2023	EACH OCCURRENCE AGGREGATE	$ 25,000,000 $ 25,000,000
C D	**WORKERS COMPENSATION AND EMPLOYERS' LIABILITY** ANYPROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? Y / N **(Mandatory in NH)** If yes, describe under DESCRIPTION OF OPERATIONS below	N / A		680046114 680046128	4/7/2022 4/7/2022	4/7/2023 4/7/2023	X PER STATUTE OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	 $ $1,000,000 $ $1,000,000 $ $1,000,000
A E F	Cyber Liability E&O Med Care MedMal Liability			MTP903849703 MCP001742203 03117585	4/7/2022 4/7/2022 4/7/2022	4/7/2023 4/7/2023 4/7/2023	Per Claim/Aggregate: Limit Per Claim/Agg	$10,000,000 $5,000,000 $1M/$3M

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

RE: MS-2223-41.

CA Department of Aging, MSSP. is included as Additional Insured with respect to the General Liability and Auto Liability to the extent provided in the selected pages of the attached forms.

CERTIFICATE HOLDER

CA Department of Aging
1300 National Drive, Suite 200
Sacramento, CA 95834

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

Debbie Haworth

DESIGNATED INSURED FOR COVERED AUTOS LIABILITY COVERAGE

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

This endorsement modifies insurance provided under the following:

AUTO DEALERS COVERAGE FORM

BUSINESS AUTO COVERAGE FORM

MOTOR CARRIER COVERAGE FORM

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

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

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

Named Insured: CALOPTIMA
Endorsement Effective Date:

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

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

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1. ADDITIONAL INSUREDS

a. **WHO IS AN INSURED** is amended to include as an **Insured** any person or organization described in paragraphs **A.** through **K.** below whom a **Named Insured** is required to add as an additional insured on this **Coverage Part** under a written contract or written agreement, provided such contract or agreement:

(1) is currently in effect or becomes effective during the term of this **Coverage Part**; and

(2) was executed prior to:

(a) the **bodily injury** or **property damage**; or

(b) the offense that caused the **personal and advertising injury**,

for which such additional insured seeks coverage.

b. However, subject always to the terms and conditions of this policy, including the limits of insurance, the Insurer will not provide such additional insured with:

(1) a higher limit of insurance than required by such contract or agreement; or

(2) coverage broader than required by such contract or agreement, and in no event broader than that described by the applicable paragraph **A.** through **K.** below.

Any coverage granted by this endorsement shall apply only to the extent permissible by law.

A. Controlling Interest

Any person or organization with a controlling interest in a **Named Insured**, but only with respect to such person or organization's liability for **bodily injury**, **property damage** or **personal and advertising injury** arising out of:

1. such person or organization's financial control of a **Named Insured**; or

2. premises such person or organization owns, maintains or controls while a **Named Insured** leases or occupies such premises;

provided that the coverage granted by this paragraph does not apply to structural alterations, new construction or demolition operations performed by, on behalf of, or for such additional insured.

B. Co-owner of Insured Premises

A co-owner of a premises co-owned by a **Named Insured** and covered under this insurance but only with respect to such co-owner's liability for **bodily injury**, **property damage** or **personal and advertising injury** as co-owner of such premises.

C. Grantor of Franchise

Any person or organization that has granted a franchise to a **Named Insured**, but only with respect to such person or organization's liability for **bodily injury**, **property damage** or **personal and advertising injury** as grantor of a franchise to the **Named Insured**.

D. Lessor of Equipment

Any person or organization from whom a **Named Insured** leases equipment, but only with respect to liability for **bodily injury**, **property damage** or **personal and advertising injury** caused, in whole or in part, by the **Named Insured's** maintenance, operation or use of such equipment, provided that the **occurrence** giving rise to such **bodily injury**, **property damage** or the offense giving rise to such **personal and advertising injury** takes place prior to the termination of such lease.

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E. Lessor of Land

Any person or organization from whom a **Named Insured** leases land but only with respect to liability for **bodily injury**, **property damage** or **personal and advertising injury** arising out of the ownership, maintenance or use of such land, provided that the **occurrence** giving rise to such **bodily injury**, **property damage** or the offense giving rise to such **personal and advertising injury** takes place prior to the termination of such lease. The coverage granted by this paragraph does not apply to structural alterations, new construction or demolition operations performed by, on behalf of, or for such additional insured.

F. Lessor of Premises

An owner or lessor of premises leased to the **Named Insured**, or such owner or lessor's real estate manager, but only with respect to liability for **bodily injury**, **property damage** or **personal and advertising injury** arising out of the ownership, maintenance or use of such part of the premises leased to the **Named Insured**, and provided that the **occurrence** giving rise to such **bodily injury** or **property damage**, or the offense giving rise to such **personal and advertising injury**, takes place prior to the termination of such lease. The coverage granted by this paragraph does not apply to structural alterations, new construction or demolition operations performed by, on behalf of, or for such additional insured.

G. Mortgagee, Assignee or Receiver

A mortgagee, assignee or receiver of premises but only with respect to such mortgagee, assignee or receiver's liability for **bodily injury**, **property damage** or **personal and advertising injury** arising out of the **Named Insured's** ownership, maintenance, or use of a premises by a **Named Insured**.

The coverage granted by this paragraph does not apply to structural alterations, new construction or demolition operations performed by, on behalf of, or for such additional insured.

H. State or Governmental Agency or Subdivision or Political Subdivisions – Permits

A state or governmental agency or subdivision or political subdivision that has issued a permit or authorization but only with respect to such state or governmental agency or subdivision or political subdivision's liability for **bodily injury**, **property damage** or **personal and advertising injury** arising out of:

1. the following hazards in connection with premises a **Named Insured** owns, rents, or controls and to which this insurance applies:

a. the existence, maintenance, repair, construction, erection, or removal of advertising signs, awnings, canopies, cellar entrances, coal holes, driveways, manholes, marquees, hoistaway openings, sidewalk vaults, street banners, or decorations and similar exposures; or

b. the construction, erection, or removal of elevators; or

c. the ownership, maintenance or use of any elevators covered by this insurance; or

2. the permitted or authorized operations performed by a **Named Insured** or on a **Named Insured's** behalf.

The coverage granted by this paragraph does not apply to:

a. **Bodily injury**, **property damage** or **personal and advertising injury** arising out of operations performed for the state or governmental agency or subdivision or political subdivision; or

b. **Bodily injury** or **property damage** included within the **products-completed operations hazard**.

With respect to this provision's requirement that additional insured status must be requested under a written contract or agreement, the Insurer will treat as a written contract any governmental permit that requires the **Named Insured** to add the governmental entity as an additional insured.

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I. Trade Show Event Lessor

1. With respect to a **Named Insured's** participation in a trade show event as an exhibitor, presenter or displayer, any person or organization whom the **Named Insured** is required to include as an additional insured, but only with respect to such person or organization's liability for **bodily injury**, **property damage** or **personal and advertising injury** caused by:

a. the **Named Insured's** acts or omissions; or

b. the acts or omissions of those acting on the **Named Insured's** behalf,

in the performance of the **Named Insured's** ongoing operations at the trade show event premises during the trade show event.

2. The coverage granted by this paragraph does not apply to **bodily injury** or **property damage** included within the **products-completed operations hazard**.

J. Vendor

Any person or organization but only with respect to such person or organization's liability for **bodily injury** or **property damage** arising out of **your products** which are distributed or sold in the regular course of such person or organization's business, provided that:

1. The coverage granted by this paragraph does not apply to:

a. **bodily injury** or **property damage** for which such person or organization is obligated to pay **damages** by reason of the assumption of liability in a contract or agreement unless such liability exists in the absence of the contract or agreement;

b. any express warranty unauthorized by the **Named Insured**;

c. any physical or chemical change in any product made intentionally by such person or organization;

d. repackaging, except when unpacked solely for the purpose of inspection, demonstration, testing, or the substitution of parts under instructions from the manufacturer, and then repackaged in the original container;

e. any failure to make any inspections, adjustments, tests or servicing that such person or organization has agreed to make or normally undertakes to make in the usual course of business, in connection with the distribution or sale of the products;

f. demonstration, installation, servicing or repair operations, except such operations performed at such person or organization's premises in connection with the sale of a product;

g. products which, after distribution or sale by the **Named Insured**, have been labeled or relabeled or used as a container, part or ingredient of any other thing or substance by or for such person or organization; or

h. **bodily injury** or **property damage** arising out of the sole negligence of such person or organization for its own acts or omissions or those of its employees or anyone else acting on its behalf. However, this exclusion does not apply to:

(1) the exceptions contained in Subparagraphs **d.** or **f.** above; or

(2) such inspections, adjustments, tests or servicing as such person or organization has agreed with the **Named Insured** to make or normally undertakes to make in the usual course of business, in connection with the distribution or sale of the products.

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2. This Paragraph **J.** does not apply to any insured person or organization, from whom the **Named Insured** has acquired such products, nor to any ingredient, part or container, entering into, accompanying or containing such products.

3. This Paragraph **J.** also does not apply:

a. to any vendor specifically scheduled as an additional insured by endorsement to this **Coverage Part**;

b. to any of **your products** for which coverage is excluded by endorsement to this **Coverage Part**; nor

c. if **bodily injury** or **property damage** included within the **products-completed operations hazard** is excluded by endorsement to this **Coverage Part**.

K. Other Person Or Organization

Any person or organization who is not an additional insured under Paragraphs **A.** through **J.** above. Such additional insured is an **Insured** solely for **bodily injury**, **property damage** or **personal and advertising injury** for which such additional insured is liable because of the **Named Insured's** acts or omissions.

The coverage granted by this paragraph does not apply to any person or organization:

1. for **bodily injury**, **property damage**, or **personal and advertising injury** arising out of the rendering or failure to render any professional service;

2. for **bodily injury** or **property damage** included within the **products-completed operations hazard**; nor

3. who is specifically scheduled as an additional insured on another endorsement to this **Coverage Part**.

2. ADDITIONAL INSURED - PRIMARY AND NON-CONTRIBUTORY TO ADDITIONAL INSURED'S INSURANCE

A. The **Other Insurance** Condition in the **COMMERCIAL GENERAL LIABILITY CONDITIONS** Section is amended to add the following paragraph:

If the **Named Insured** has agreed in writing in a contract or agreement that this insurance is primary and non-contributory relative to an additional insured's own insurance, then this insurance is primary, and the Insurer will not seek contribution from that other insurance. For the purpose of this Provision **2.**, the additional insured's own insurance means insurance on which the additional insured is a named insured.

B. With respect to persons or organizations that qualify as additional insureds pursuant to paragraph **1.K.** of this endorsement, the following sentence is added to the paragraph above:

Otherwise, and notwithstanding anything to the contrary elsewhere in this Condition, the insurance provided to such person or organization is excess of any other insurance available to such person or organization.

3. BODILY INJURY – EXPANDED DEFINITION

Under **DEFINITIONS**, the definition of **bodily injury** is deleted and replaced by the following:

Bodily injury means physical injury, sickness or disease sustained by a person, including death, humiliation, shock, mental anguish or mental injury sustained by that person at any time which results as a consequence of the physical injury, sickness or disease.

4. BROAD KNOWLEDGE OF OCCURRENCE/ NOTICE OF OCCURRENCE

Under **CONDITIONS**, the condition entitled **Duties in The Event of Occurrence, Offense, Claim or Suit** is amended to add the following provisions:

A. BROAD KNOWLEDGE OF OCCURRENCE

The **Named Insured** must give the Insurer or the Insurer's authorized representative notice of an **occurrence**, offense or **claim** only when the **occurrence**, offense or **claim** is known to a natural person **Named Insured**, to a

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partner, executive officer, manager or member of a **Named Insured**, or to an **employee** designated by any of the above to give such notice.

B. NOTICE OF OCCURRENCE

The **Named Insured's** rights under this **Coverage Part** will not be prejudiced if the **Named Insured** fails to give the Insurer notice of an **occurrence**, offense or **claim** and that failure is solely due to the **Named Insured's** reasonable belief that the **bodily injury** or **property damage** is not covered under this **Coverage Part**. However, the **Named Insured** shall give written notice of such **occurrence**, offense or **claim** to the Insurer as soon as the **Named Insured** is aware that this insurance may apply to such **occurrence**, offense or **claim**.

5. BROAD NAMED INSURED

WHO IS AN INSURED is amended to delete its Paragraph **3.** in its entirety and replace it with the following:

3. Pursuant to the limitations described in Paragraph **4.** below, any organization in which the **First Named Insured** has management control directly or indirectly:

a. on the effective date of this **Coverage Part**; or

b. by reason of a **Named Insured** creating or acquiring the organization during the **policy period**,

qualifies as a **Named Insured**, provided that there is no other similar liability insurance, whether primary, contributory, excess, contingent or otherwise, which provides coverage to such organization, or which would have provided coverage but for the exhaustion of its limit, and without regard to whether its coverage is broader or narrower than that provided by this insurance.

But this **BROAD NAMED INSURED** provision does not apply to any organization for which coverage is excluded by another endorsement attached to this **Coverage Part**.

For the purpose of this provision, and of this endorsement's **JOINT VENTURES / PARTNERSHIP / LIMITED LIABILITY COMPANIES** provision, management control means owning interests representing more than 50% of the voting, appointment or designation power for the selection of a majority of: the Board of Directors of a corporation; the management committee members of a joint venture; the management board of a limited liability company; the general partners of a limited partnership; or the partnership managers of a general partnership.

4. With respect to organizations which qualify as **Named Insureds** by virtue of Paragraph **3.** above, this insurance does not apply to:

a. **bodily injury** or **property damage** that first occurred prior to the date of management control, or that first occurs after management control ceases; nor

b. **personal or advertising injury** caused by an offense that first occurred prior to the date of management control or that first occurs after management control ceases.

5. The insurance provided by this **Coverage Part** applies to **Named Insureds** when trading under their own names or under such other trading names or doing-business-as names (dba) as any **Named Insured** should choose to employ.

6. ESTATES, LEGAL REPRESENTATIVES, AND SPOUSES

The estates, heirs, legal representatives and **spouses** of any natural person **Insured** shall also be insured under this policy; provided, however, coverage is afforded to such estates, heirs, legal representatives, and **spouses** only for **claims** arising solely out of their capacity or status as such and, in the case of a **spouse**, where such **claim** seeks **damages** from marital community property, jointly held property or property transferred from such natural person **Insured** to such **spouse**. No coverage is provided for any act, error or omission of an estate, heir, legal representative, or **spouse** outside the scope of such person's capacity or status as such, provided however that the **spouse** of a natural person **Named Insured** and the **spouses** of members or partners of joint venture or partnership

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Multipurpose Senior Services Program (MSSP)
Summary of CDA Standard Agreement Changes
Fiscal Year 2022-23

This document contains a summary of CDA Standard Agreement changes for Fiscal Year (FY) 2022-23. The FY 2022-23 MSSP CDA Standard Agreement contains the following Exhibits:

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

Below is a quick reference to the Articles contained within each Exhibit for FY 2022-23 followed by a detailed summary of CDA Standard Agreement changes:

Exhibit A:

- Article I – STD 213
- Article II – Multipurpose Senior Services Program Overview
- Article III – MSSP Program Operations
- ~~Article IV – Additional Provisions Specific to Contractors Operating Under the Coordinated Care Initiative (CCI) Payment Model~~ Section removed due to Coordinate Care Initiative (CCI) carve out transitioning back to Fee for Service (FFS) payment model
- Article IV – Medi-Cal Aid Definition & Codes
- Article V – Definitions of Services Provided Under the Waiver

Exhibit B:

- Article I – Invoicing and Payment
- Article II – Funds
- Article III – Budget and Budget Revision
- Article IV – Default Provisions
- ~~Article V – Additional Provisions Specific to Contractors Operating Under the CCI Payment Model~~ Section Removed due to CCI carve out transitioning back to FFS
- Attachment 1 – Site Specific Final Approved Budget

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Exhibit D:

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

Exhibit E:

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

Exhibit F:

- Section I – Recitals
- Section II – Definitions
- Section III – Terms of Agreement
- Section IV – Obligations of This Agreement

- Section V – Audits, Inspection and Enforcement
- Section VI – Termination
- Section VII – Miscellaneous Provisions

Exhibit G:

- Contains Zip Codes served by each individual MSSP Site

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

Updated address for CDA office relocation and minor spacing throughout Exhibits.

Scope of Work – Exhibit A

Exhibit A - Article III

- Section E - Clarified active client count description within the section
- Wait List reporting section moved under Section E Management Information Systems (MIS)
- Section F, Enrollment Levels - Participant months language rephrased and defined calculation of participant slots over 12-month period for Scope of Work

Exhibit A – Article IV - REMOVED

- Additional Provisions Specific to Contractors Operating Under the Coordinate Care Initiative (CCI) Payment Model Removed due to CCI carve out transitioning back to FFS payment model

Exhibit A - Article V

- Removed IHSS note containing language pertaining to IHSS Plus Waiver due to age of information.

Exhibit A - Article VI

- Added language pertaining to Adult Day Care centers as required by Centers for Medicaid Services (CMS)
- Article edited to reflect updated service code descriptions and removed descriptions of unit types as a result of the fiscal intermediary code conversion effective 7/1/2022.
- Possible EVV info to be added for 3.2 & 5.1 (Need legal feedback; hold marker until resolution)

Exhibit B – Budget Detail and Payment Provisions

Exhibit B - Article I

- Section E, Rate Adjustment - added more detail of the rate change process and the submission requirements.
- Section F, Advance Payments - removed lines about CCI sites being ineligible since CCI sites transition back to FFS as part of the carve out.

Exhibit B – Article V - REMOVED

- Article V – Additional Provisions Specific to Contractors Operating Under the CCI Payment Model Section removed due to CCI carve out transitioning back to FFS payment model.

Exhibit E – Additional Provisions

Exhibit E – Article VIII – Reporting Requirements Specific to This MSSP Agreement

- Section A - Added description and requirements pertaining to the Critical Incident Report.
- Section C - REMOVED, Additional Reporting Provisions Specific to Contractors Operating Under the Coordinated Care Initiative (CCI) Model Removed due to CCI carve out transitioning back into FFS.

Exhibit F – HIPAA Business Associate Addendum

- Awaiting revised Exhibit from Department of Health Care Services due to EVV changes and etc.

CALIFORNIA DEPARTMENT OF AGING
Multipurpose Senior Services Program
2880 Gateway Oaks Drive, Suite 200
Sacramento, CA 95833
www.aging.ca.gov
TEL 916-419-7500
FAX 916-928-2267
TTY1-800-735-2929

March 2, 2022

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

Dear Ms. Rounds,

The California Department of Aging, Multipurpose Senior Services Program (MSSP) Bureau has completed a review of your MSSP site budget for Fiscal Year (FY) 2022-2023. As a result of our review, the Department approves the projected expenditure of MSSP funds by budget category.

Enclosed is a copy of the signed and approved budget for your records. The original will be kept on file at the Department. If you have any questions, please contact your assigned program analyst.

Sincerely,

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

Enclosure

cc: Jeff Mercer, Program Analyst
Multipurpose Senior Services Program
California Department of Aging

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Site Name	41 - Orange County Health Authority (dba CalOptima)	Funded Slots	568	Date Submitted to CDA-MSSP	2-Mar-22

Fiscal Year 2022-23

A. Care Management

Line #	Position Title	Last Name	Base Salary	Salary Adjustment	FTE	Adjusted Salary
1	Nurse Care Manager	Baylis	$118,025	0.000%	1.000	$118,025
2	Nurse Care Manager	Flinn	$116,174	0.000%	1.000	$116,174
3	Nurse Care Manager	Nguyen V.	$112,270	0.000%	1.000	$112,270
4	Nurse Care Manager	TBH	$93,000	0.000%	1.000	$93,000
5	Nurse Care Manager	TBH	$93,000	0.000%	1.000	$93,000
6	Nurse Care Manager	TBH	$93,000	0.000%	1.000	$93,000
7	Social Work Care Manager	Dinh	$83,065	0.000%	1.000	$83,065
8	Social Work Care Manager	Fierro	$82,798	0.000%	1.000	$82,798
9	Social Work Care Manager	Nguyen F.	$69,288	0.000%	1.000	$69,288
10	Social Work Care Manager	Nguyen Se.	$82,703	0.000%	1.000	$82,703
11	Social Work Care Manager	Osorio	$82,824	0.000%	1.000	$82,824
12	Social Work Care Manager	Pratt	$75,276	0.000%	1.000	$75,276
13	Social Work Care Manager	Rakowski	$81,154	0.000%	1.000	$81,154
14	Social Work Care Manager	Vacant	$82,000	0.000%	1.000	$82,000
15	Social Work Care Manager	Vacant	$82,000	0.000%	1.000	$82,000
16			$0	0.000%	0.000	$0
17			$0	0.000%	0.000	$0
18			$0	0.000%	0.000	$0
19			$0	0.000%	0.000	$0
20			$0	0.000%	0.000	$0
21			$0	0.000%	0.000	$0
22			$0	0.000%	0.000	$0
23			$0	0.000%	0.000	$0
24			$0	0.000%	0.000	$0
25			$0	0.000%	0.000	$0
26					Subtotal Care Management Salaries	$1,346,578
27	Total Care Management (CM) FTE	15.00			Care Management Benefits	$257,870
28	Ratio	37.9				
29	**Total Care Management**			% Budget	53%	**$1,604,448**

B. Care Management Support/Administration

Salaries

Line #	Position Title	Last Name	Base Salary	Salary Adjustment	FTE	Adjusted Salary
30	Accounting Specialist	Hoang A.	$80,619	0.000%	0.750	$60,464
31	Medical Authorization Assistant	Castaneda	$51,467	0.000%	1.000	$51,467
32	Medical Authorization Assistant	Diaz De Leon	$49,251	0.000%	1.000	$49,251
33	Medical Authorization Assistant	Esparza	$50,121	0.000%	1.000	$50,121
34	Medical Authorization Assistant	TBH	$47,000	0.000%	1.000	$47,000
35	Site Director	Rounds	$140,546	0.000%	1.000	$140,546
36	Supervising Care Manager	Rivera	$106,092	0.000%	1.000	$106,092
37	Supervising Care Manager	Young (Bitterman)	$103,564	0.000%	1.000	$103,564
38	Supervising Care Manager	TBH	$103,000	0.000%	1.000	$103,000
39			$0	0.000%	0.000	$0
40			$0	0.000%	0.000	$0
41			$0	0.000%	0.000	$0
42			$0	0.000%	0.000	$0
43			$0	0.000%	0.000	$0
44			$0	0.000%	0.000	$0
45			$0	0.000%	0.000	$0
46			$0	0.000%	0.000	$0
47			$0	0.000%	0.000	$0
48					Subtotal CMS/Administration Salaries	$711,504
49					CMS/Administration Benefits	$136,253
50	Total CMS/Administration FTE	8.75				
51					Total CMS/Administration Salaries	**$847,757**

Operating Costs

52	Consultation, Professional Services		$66,000
53	Facility, Rent & Operations		$0
54	Equipment Cost equal to or greater than $5,000 per Unit (Any Computing Equipment regardless of Cost)		$0
55	Equipment, Maintenance & Rental Costs; Supplies		$40,000
56	Travel (In & Out of State)		$10,000
57	Training without Associated Travel Costs		$2,000
58	Subscriptions, Membership Dues		$6,000
59	Insurance		$0
60	Communication, Postage, Internet		$20,000
61			$0
62			$0
63	Indirect Costs (Indirect Costs/Base) - 15% maximum	2%	$50,516
64	Base = Salaries & Benefits	$2,452,205	
65			$0
66			$0
67		Total CMS/Administration Operating Costs	$194,516
68	**Total CMS/Admin**	% Budget 34%	**$1,042,273**

C. Waived Services

69	**Total Waived Services**	% Budget 13%	**$395,487**

D. Total Budget Amounts

70	**Fiscal Year Total Allocation**	**$3,042,208**

By completing Part I, I understand that this is an electronic signature and by checking the box I certify that all the provided information is believed to be accurate, reliable and complete to the best of my knowledge and ability to confirm it.

Full Name	Title	Date	Check box to indicate agreement with information provided in report.
Evelyn Rounds	Site Director	March 02, 2022	☑

For CDA Use Only.

Approved by:

Sarah Hinkson — Analyst Signature

3/2/2022 — Date

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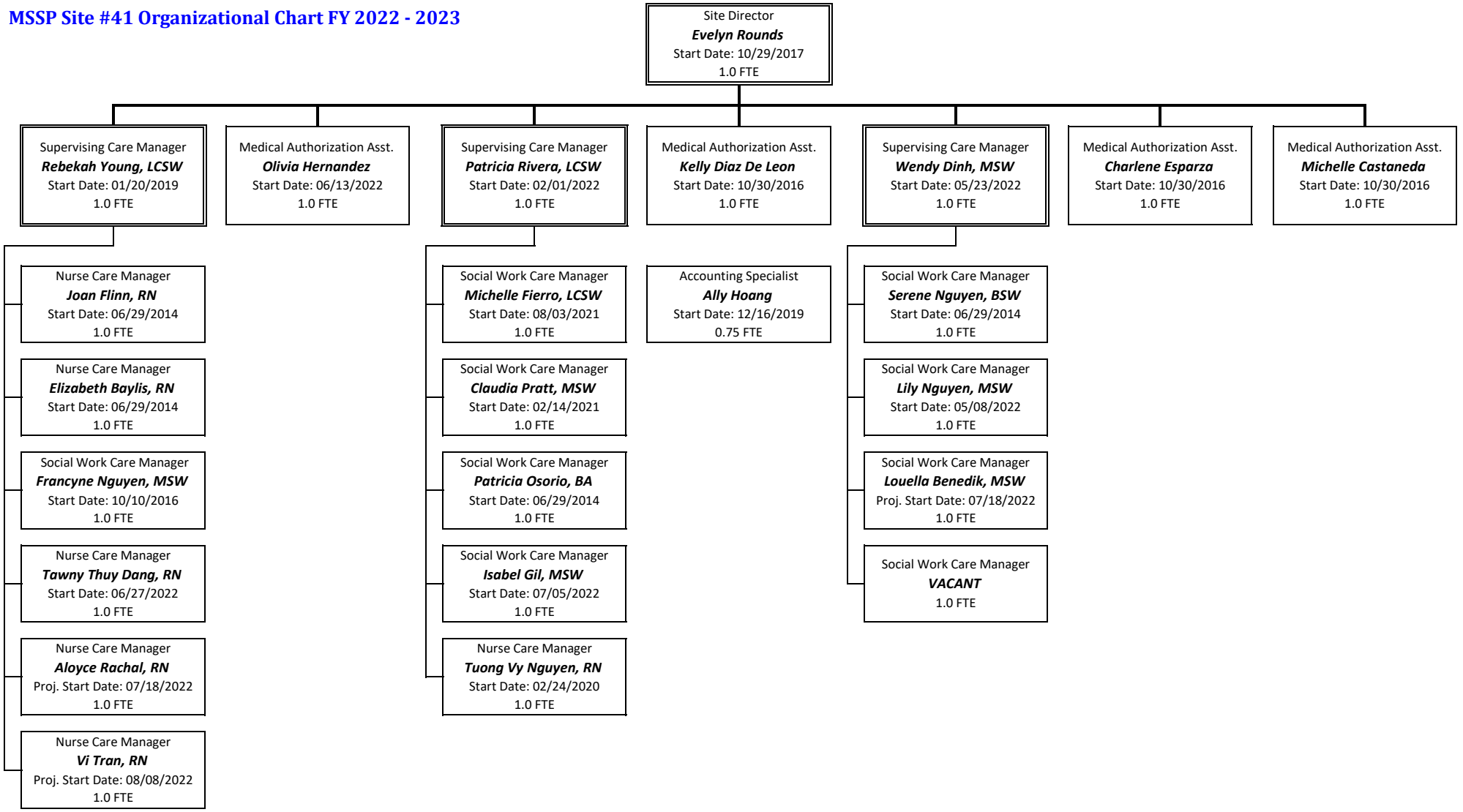
MSSP Site #41 Organizational Chart FY 2022 - 2023



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STATE OF CALIFORNIA
CALIFORNIA DEPARTMENT OF AGING
MSSP AGENCY CONTRACTS REPRESENTATIVE (ACR)
CDA 9028 (NEW 03/2020)

MSSP Site Number(s): 41	Submission Date: 08/04/22

CONTRACTOR INFORMATION:	*** Change Requires STD 204**
*Legal Name: Orange County Health Authority	
*DBA Name: CalOptima	
*Business Address: 505 City Parkway West	City, State, Zip: Orange, CA 92868
*Mailing Address: Same as above	City, State, Zip:
General Email: erounds@caloptima.org	Website: caloptima.org
Public Line: (714) 246-8400	Fax:

ACR CONTACT INFORMATION:		
First Name: Scott	Last Name: Robinson	Title: Director, LTSS
Email: scott.robinson@caloptima.org	Business: (657) 900-1457	Fax:
Role: MSSP Agency Contract Representative		

PROJECT REPRESENTATIVE CONTACT INFORMATION:		
First Name: Ally	Last Name: Hoang	Title: Accountant
Email: ally.hoang@caloptima.org	Business: (714) 796-6133	Fax:
Role: ☐ MSSP Site Director ☐ Program Director		

Authorized Signature: Evelyn Rounds, LCSW Print Name: Evelyn Rounds

Title: SIte Director Phone: (714) 246-9288 Date: 08/04/22

Once completed, email this form to CDA Business Services: CDABusinessServices@aging.ca.gov.

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STATE OF CALIFORNIA
CALIFORNIA DEPARTMENT OF AGING
MSSP AGENCY CONTRACTS REPRESENTATIVE (ACR)
CDA 9028 (NEW 03/2020)

Background and Instructions

What we are requesting from you and why?

The California Department of Aging (CDA) is requesting that you fill in the Authorized Contract Representative (ACR) Form to update CDA's MSSP contract contact database. The information collected is placed in your MSSP Site contract with CDA.

Who is the ACR and what do they do?

The ACR is the person designated by the MSSP site to handle all questions regarding the documents needed to execute a MSSP contract. The ACR will be the person CDA contacts first to handle any documents required to complete final execution of your MSSP Contract.

The ACR may be anyone ranging from a site Director to site support staff. The ACR is not required to be the person who signs (Director, Board Member) the contract. This allows the Contractor the flexibility to designate a separate staff member to bring together required contract documents, gather required signatures and mail final documents to CDA.

Who is the Project Representative and what do they do?

The Project Representative is the person designated by the MSSP site to handle all questions regarding the MSSP contracted services. The Project Representative manages the contract at service level and works with CDA MSSP staff regarding performance of the contracted services, etc. Other names for a Project Representative may be Contract/Program Administrator/Manager.

The Project Manager is typically a Site Director or Upper level Manager directly supervising services or sub-contracts.

How often is this form completed?

This form is completed on a yearly basis or as needed. CDA will send out ACR form requests once per year or upon a change request by a MSSP site.

May I designate a separate ACR for my AAA and MSSP contracts?

Yes, if your organization participates in both AAA programs and the MSSP Program, you will designate an ACR as follows:

- For AAA Programs use CDA 045 process outlined in your AAA contracts (Exhibit D, Article XVII, Section B)
- For MSSP use CDA 9028 MSSP process outlined in your MSSP contract (Exhibit D, Article XVII, Section B)

Additional Questions?

Additional questions are encouraged! If you have any additional questions, please feel free to contact me at CDABusinessService@aging.ca.gov, by replying to my original e-mail request, or by phone at (916) 419-7157.

ARTICLE II. MULTIPURPOSE SENIOR SERVICES PROGRAM (MSSP) OVERVIEW

The MSSP is a Medi-Cal Home and Community Based Services Waiver, Control Number CA.0141.R06.00 authorized pursuant to Section 1915(c) of Title XIX of the Social Security Act (HCBS Waiver). The primary objectives of the MSSP are to:

1. Avoid the premature placement of frail older persons in nursing facilities

2. Foster independent living in their communities

Pursuant to an Interagency Agreement between Department of Health Care Services (DHCS) and California Department of Aging (CDA), CDA contracts with local government entities and private nonprofit organizations for local administration of the MSSP throughout the State. The Contractor is responsible for arranging for and monitoring community services to the MSSP Waiver Participant population in the catchment area identified in Exhibit G of this Agreement. Individuals eligible for MSSP must be age sixty-five (65) or older; meet the eligibility criteria as a Medi-Cal recipient with an eligible Medi-Cal Aid Code for MSSP as described in the MSSP Medi-Cal Aid Codes, Article V of this Exhibit; be certifiable for placement in a nursing facility; live within a site's catchment area; be served within the program's cost limitations; and be appropriate for care management services.

The Contractor uses a care management team to assess eligibility and need and provide for delivery of services. The Contractor is reimbursed for expenditures through a claims process operated by the State's Medi-Cal Fiscal Intermediary (see definition in Article VI of this Exhibit).

ARTICLE III. MSSP PROGRAM OPERATIONS

The Contractor shall be responsible for all care management obligations including processing Waiver Participant applications, determining eligibility, conducting assessments, developing care plans, case recording and documentation, and providing follow-up. The Contractor shall directly provide or arrange for the continuous availability and accessibility of all services identified in each Waiver Participant's care plan. The Contractor shall also ensure that the administrative integrity of the MSSP is maintained at all times. In order to maintain adequate administrative control, the Contractor shall incorporate the following components into the scope of operations:

A. Care Management Team

1. The Contractor shall maintain and have on file a written description and an organizational chart that outlines the structure of authority, responsibility, and accountability within the MSSP and the MSSP parent organization. The Contractor shall provide to its assigned CDA analyst, a copy of the organization chart within thirty (30) days of the execution of this Agreement.

2. The Contractor shall employ a care management team, which consists of a social worker and a registered nurse, that meet the qualifications set forth in

ARTICLE III. MSSP PROGRAM OPERATIONS (Continued)

the Waiver. The care management team shall determine Waiver Participant eligibility based on the criteria specified in the MSSP Site Manual. This team shall work with the Waiver Participant throughout the care management process (e.g., assessment, care plan development, service coordination, and service delivery).

3. The care management team shall: 1) provide information, education, counseling, and advocacy to the Waiver Participant and family, and 2) identify resources to help assure the timely, effective, and efficient mobilization and allocation of all services, regardless of the source, to meet the Waiver Participant's care plan goals.

4. The Contractor shall annually self-certify that staff meet the requirements as outlined in the MSSP Site Manual as well as participate in required trainings.

B. Care Plan

1. The Contractor's Care Management Team shall perform the MSSP Waiver Participant's assessments and work with the MSSP Waiver Participant, family, managed care plans, and others to develop a care plan covering the full range of required psycho-social and health services. The Care Management Team shall continue to work with the MSSP Waiver Participant to assure that the Waiver Participant is receiving and benefiting from the services and to determine if modification of the care plan is required.

2. Such MSSP subcontracts shall specify terms and conditions and payment amount and shall assure that subcontractors shall not seek additional or outstanding unpaid amounts from the MSSP Participant.

C. Purchased Waiver Services

"Purchased Waiver Services" means goods and services approved for purchase under Title XIX of the Social Security Act, 1915(c) Home and Community Based Waiver authority. The list of MSSP Purchased Waiver Services is included in Article VI. The Contractor may purchase MSSP Purchased Waiver Services when necessary to support the well-being of a MSSP Waiver Participant.

1. Prior to purchasing services, the Contractor shall verify, and document its efforts, that alternative resources are not available (e.g. family, friends and other community resources)

2. The Contractor may either enter into contracts with subcontractors to provide Purchased Waiver Services or directly purchase items through the use of a purchase order.

ARTICLE III. MSSP PROGRAM OPERATIONS (Continued)

3. The Contractor shall maintain written, signed and dated, subcontracts for the following array of Purchased Waiver Services as defined in MSSP Site Manual at all times during the terms of this Agreement:

   a) Adult Day Care (ADC)
   b) Minor Home Repair/Maintenance Services
   c) Supplemental Homemaker, Personal Care and Protective Supervision Services
   d) Consultative Clinical Services
   e) Respite Care
   f) Transportation
   g) Meal Services
   h) Counseling and Therapeutic Services
   i) Communication Services

4. The Contractor shall assure that its subcontractors have the license(s), credentials, qualifications or experience to provide services to the MSSP Participant.

5. The Contractor shall be responsible for coordinating and tracking MSSP Purchased Waiver Services for a MSSP Waiver Participant.

6. The Contractor shall operate a Multipurpose Senior Services Program at a location and in a manner approved by the State, ensuring that Waiver Participant inquiries and requests for service(s) receive prompt response.

D. Case Files

The Contractor shall maintain an up-to-date, centralized, and secured case file record for each Waiver Participant, consisting, at a minimum, of the following documents prescribed by CDA:

1. Application for the MSSP

2. MSSP Authorization for Use and Disclosure of Protected Health Information

3. Participant Enrollment/Termination Information

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

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

ARTICLE III. MSSP PROGRAM OPERATIONS (Continued)

6. Care Plan and Service Planning and Utilization Summary (SPUS)

7. Waiver Participant monthly progress notes and other Waiver Participant-related information (e.g., correspondence, medical/psychological/social records, service delivery verification)

8. Denial or discontinuance letters (Notice of Action)

9. Termination documents

10. Fair Hearing documentation

E. Management Information Systems (MIS)

The Contractor shall maintain and operate an MIS at its site. The Contractor shall:

1. Maintain office space with proper security and climate control for on-site computer hardware, e.g., terminals, processors, modems, and printers.

2. Provide adequate staff for timely, accurate, and complete MIS data input, including but not limited to:

   a. Waiver Participant name, MSSP Waiver Participant number, Medi-Cal aid code, county code, Medicare and Social Security numbers, birth date, level of care, emergency contact information, physician information, and demographic information

   b. Tracking of Waiver Services and costs

   c. Enrollment and termination dates

   d. Provider Index Report

3. Accommodate State-required changes in MIS procedures which may be necessary from time to time.

4. Generate reports as required by the State.

5. Submit to CDA by the 5th working day of the month (unless otherwise specified by CDA), the active Waiver Participant count for the preceding month. The active Waiver Participant count consists of the number of Waiver Participants actively enrolled in MSSP on the last (business) day of the reporting month. This does not include Waiver Participant cases closed (or terminated) during the reporting month.

ARTICLE III. MSSP PROGRAM OPERATIONS (Continued)

6. Submit to CDA, by the 5th working day of the month (unless otherwise specified by CDA), the Wait List of Participants as of the last day of the previous month. "Wait List" means a list of potential MSSP Participants, established, and maintained by the Contractor, when the Contractor has reached its capacity. To ensure compliance with MSSP Waiver requirements and Centers for Medicare and Medicaid Services (CMS) direction, MSSP sites must develop and implement a wait list policy and procedure. The policy and procedure must include provisions for: prescreening individuals to determine eligibility; managing applicants' placement on and removal from the wait list; periodically reviewing the eligibility and identified needs of applicants on the wait list; and assigning priority for enrollment based on identified needs and level of risk. The Contractor determines the priority of enrollment into the MSSP in accordance with CDA and CMS requirements.

7. Verify all service data within ninety (90) calendar days of the date of service. The Contractor shall submit this data to CDA by the 5th calendar day of the following month ninety-five (95) days from the end of the month of services).

8. Submit claims to the State's Medi-Cal Fiscal Intermediary (FI), per instructions stated in the Medi-Cal Provider Manual.

F. Enrollment Levels

The Contractor shall maintain a caseload of no less than 95 percent or more than 105 percent of the specified number of participant slots for the term of contract (12 months). This is a performance requirement to ensure compliance with the terms and conditions of this Agreement and Waiver requirements. If the Contractor's active participant count falls below ninety-five percent (95%) of the number of budgeted participant slots for more than three (3) consecutive months, the Contractor shall be required to submit an enrollment plan for review, approval and monitoring by CDA.

"Participant slot" means a position, whether vacant or filled, which is funded according to a Contractor's site budget and allocated for a participant during a given month.

G. Emergency Preparedness

1. The Contractor shall prepare and implement an emergency preparedness plan that ensures the provision of services to meet the emergency needs of Waiver Participants they are charged to serve during medical or natural disasters: a pandemic, earthquake, fire, flood, or public emergencies, such as riot, energy shortage, hazardous material spill, etc. This plan shall conform to any statewide requirements issued by any applicable State or local authority.

ARTICLE III. MSSP PROGRAM OPERATIONS (Continued)

2. The Contractor shall adopt policies and procedures that address emergency situations and ensure that there are safeguards in place to protect and support Waiver Participants in the event of natural disasters or other public emergencies.

3. The Contractor shall ensure that emergency preparedness policies and procedures are clearly communicated to site staff and subcontractors in order to provide care under emergency conditions and to provide for back-up in the event that usual care is unavailable.

4. The Contractor shall develop an emergency preparedness training plan to be provided to all staff at least annually or as needed when new staff are hired. The training shall consist of:

   a. Familiarity with telephone numbers of fire, police, and ambulance services for the geographic area served by the provider

   b. Techniques to obtain vital information from older individuals who require emergency assistance

   c. Written emergency procedures for all staff that have contact with older individuals

5. The Contractor shall develop a method for documenting the emergency preparedness training provided for all staff.

6. The Contractor shall develop a program for testing its emergency preparedness plan at least annually.

H. Other Provisions

1. The Contractor is relieved of all obligations to arrange for and provide services to a Waiver Participant under this Agreement after the Waiver Participant has been terminated from the MSSP and has exhausted his/her appeal rights.

2. The Contractor shall provide a notice of termination to a Waiver Participant prior to terminating the Participant from the MSSP and shall reference the MSSP Site Manual to determine how many days notice are required based on the type of termination code that is used.

3. The Contractor shall administer a subcontractor appeal and adjudication process. The subcontractor appeal and adjudication process must be included in all subcontracts. This process shall assure fair consideration and disposition of subcontractor claims against the Contractor. Final authority to decide claims shall be vested with the Contractor. The subcontractor has no right of appeal to CDA.

ARTICLE III. MSSP PROGRAM OPERATIONS (Continued)

4. The Contractor shall serve participants in the Catchment Area as defined in Exhibit G of this Agreement.

5. The Contractor shall abide by the MSSP Site Manual, training manuals, and other guidance issued by the CDA MSSP Branch. The Contractor shall comply with any and all changes to State and federal law. The Contractor shall include this requirement in each of its subcontracts.

6. The Contractor shall make staff available to CDA for training and meetings which CDA may find necessary from time to time.

ARTICLE IV. MEDI-CAL AID DEFINITION & CODES

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

1. CASH GRANT

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

2. PICKLE ELIGIBLES/20 PERCENT SOCIAL SECURITY DISREGARDS

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

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

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

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

3. MEDICALLY NEEDY/NO SHARE OF COST

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

4. MEDICALLY NEEDY/SHARE OF COST

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

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

5. AGED AND DISABLED FEDERAL POVERTY LEVEL PROGRAM

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

6. INSTITUTIONAL DEEMING

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

7. CONTINUED ELIGIBILITY – REDETERMINATION

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

ARTICLE V. DEFINITIONS OF SERVICES PROVIDED UNDER THE WAIVER

Services Provided Under the Waiver – Contractors must have the ability to provide the following services to MSSP Waiver Participants:

Definitions of each of the services approved by the Centers for Medicare and Medicaid Services of the Department of Health and Human Services under the existing 1915(c) Home and Community-Based Services Waiver are as follows. The numbers in parentheses are program code designations for the particular service.

1. **Adult Day Care** (1.1): Will be provided to MSSP Waiver Participants who are identified in their plan of care as benefiting from being in a social setting with less intense supervision and fewer professional services than offered in an adult day health support center. Adult Day Care services will be provided when the Waiver Participant's plan of care indicates that the service is necessary to reach a therapeutic goal. Adult day care centers are community-based programs that provide nonmedical care to persons eighteen (18) years of age or older in need of personal care services, supervision, or assistance essential for sustaining the activities of daily living or for the protection of the individual on less than a 24-hour basis. The Department of Social Services (DSS) licenses these centers as community care facilities.

   Adult Day Care centers are subject to Federal Home and Community-Based Settings (HCBS) requirements, meaning they must:
   - Support access to the greater community;
   - Be selected by the participant from among setting options;
   - Ensure individual rights of privacy, dignity and respect, and freedom from coercion and restraint;
   - Optimize autonomy and independence in making life choices;
   - Facilitate choice regarding services and who provides them; and
   - Be physically accessible.

   Vendor contracts with Adult Day Care centers must contain language that addresses Home and Community-Based Settings requirements as specified in 42 CFR 441.301(c)(4).

2. **Minor Home Repairs and Maintenance** (2.2): Minor Home Repairs do not involve major structural changes or repairs to a dwelling. Maintenance is defined as those services necessary for accessibility (e.g., ramps, grab bars, handrails, items above what is covered by the State Plan, and installation), safety (e.g., electrical wiring, smoke alarms), or security (e.g., locks). Eligible Waiver Participants are those whose health and/or safety or independence are jeopardized because of deficiencies in their place of residence. This service is limited to Waiver Participants who are owners/occupiers of their own home, or those in rental housing where the owner refuses to make needed repairs or otherwise alter the residence to adapt to special Waiver Participant needs. Written permission from the landlord (including provision for removal of modifications, if necessary) is required before undertaking repairs or maintenance on leased premises. All services shall be provided in accordance with applicable State or local building codes.

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

3. **Non-medical Home Equipment** (2.3): Includes equipment and supplies which address a Waiver Participant's functional limitation and/or condition, are necessary to assure the Waiver Participant's health, safety, and independence, and are not otherwise provided through this Waiver or through the State Plan.

   Allowable items:
   Small appliances; Large appliances; Furniture; Home safety devices; Clothing related items; Paperwork related; Organizing items; Household items (Items that are not specifically designed for home safety, but are necessary to maintain independence and safety in the home); Kitchenware; Bedding/Bath items; Exercise equipment; Social support/ Therapeutic activity supplies; Personal care items (Items related to personal care and the prevention of skin breakdown); Health related supplies (Items that have a health component, but are not covered by the State Plan); Incontinence supplies (gloves, wipes, washcloths and creams)

   Experimental or prohibited treatments are excluded as well as those items and services solely for entertainment or recreation. The costs associated with delivery and repairs of the items allowable under this service are also included.

4. **Community Transition Services-** (2.4): These services allow for non-recurring moving and/or set-up expenses for individuals who make the transition from an institution to their own home or apartment in the community. Eligible Waiver Participants are those who reside in a facility/institution or care provider-owned residence and are transitioning from a facility/institution to their own home or apartment in the community where the person is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and may include: (a) security deposits that are required to obtain a lease on an apartment or home; (b) essential household furnishings required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens; (c) set-up fees or deposits for utility or service access, including telephone, electricity, heating and water; (d) services necessary for the Waiver Participant's health and safety such as pest eradication and one-time cleaning prior to occupancy; (e) moving services, which may include materials and necessary labor; (f) activities to assess need, arrange for and procure need resources. Community Transition Services do not include monthly rental or mortgage expense; food, regular utility charges; and/or household appliances or items that are intended for purely diversional/recreational purposes.

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

5. **Assistive Technology** (2.6): Assistive technology means an item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of participants. Assistive technology service means a service that directly assists a Waiver Participant in the selection, acquisition, or use of an assistive technology device. Assistive technology includes: (A) the evaluation of the assistive technology needs of a Waiver Participant, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the participant in the customary environment of the Waiver Participant; (B) services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for participants; applying, maintaining, repairing, or replacing assistive technology devices; (C) services consisting of selecting, designing, fitting, customizing, adapting; (D) coordination and use of necessary therapies, interventions, or services with assistive technology devices, such as therapies, interventions, or services associated with other services in the care plan; (E) the costs associated with delivery and repairs of the items allowable under this service are also included.

   Examples include, but are not limited to, a transfer pole, grabber/reacher, dressing aid or sock aid, etc.

6. **Supplemental Homemaker Services** (3.1): Is for purposes of household support and applies to the performance of household tasks rather than to the care of the Waiver Participant. Homemaker activities are limited to: household cleaning, laundry (including the services of a commercial laundry or dry cleaner), shopping, food preparation, and household maintenance. Waiver Participant instruction in performing household tasks and meal preparation may also be provided.

   The care manager completes a health and psychosocial assessment which assess all Waiver Participant needs including the need for homemaker services and personal care. The assessments also consider IHSS services in place and whether the Waiver Participant's needs are being met.

   Supplemental Homemaker Services under the MSSP Waiver are limited to additional services not otherwise covered under the State Plan or under IHSS, but consistent with the Waiver objectives of avoiding institutionalization.

   Services purchased using 3.1 can supplement but not supplant IHSS.

7. **Supplemental Personal Care** (3.2): This service provides assistance to maintain bodily hygiene, personal safety, and activities of daily living (ADL). These tasks are limited to nonmedical personal services: feeding, bathing, oral hygiene, grooming, dressing, care of and assistance with prosthetic devices, rubbing skin to promote circulation, turning in bed and other types of

repositioning, assisting the individual with walking, and moving the individual from place to place (e.g., transferring). Waiver Participant instruction in self-care may also be provided; may also include assistance with preparation of meals but does not include the cost of the meals themselves.

Supplemental Personal Care under the MSSP Waiver is limited to additional services not otherwise covered under the State Plan or under IHSS, but consistent with the Waiver objectives of avoiding institutionalization. Services are provided when personal care services furnished under the approved State Plan limits are exhausted. The scope and nature of these services do not differ from personal care services furnished under the State Plan. The provider qualifications specified in the State Plan apply.

Services purchased using 3.2 can supplement but not supplant IHSS.

Personal care service providers may be paid while the Waiver Participant is institutionalized. This payment is made to retain the services of the care provider and is limited to seven (7) calendar days per institutionalization.

8. **Counseling & Therapeutic Services- Therapeutic Services** (3.3): This service addresses unmet needs of Waiver Participants when such care is not otherwise available under the State Plan. These services will be provided based on the following criteria: The Waiver Participant assessment identifies need for this support and the care plan reflects the required service(s). MSSP Waiver Participants are extremely frail and, on occasion, in need of services that cannot be provided under that cannot be provided under Medi-Cal. This MSSP service supplements but does not supplant benefits provided by the State Plan. Therapeutic Services includes the following: foot care, massage therapy, and swim therapy.

9. **Supplemental Protective Supervision** (3.7): Ensures provision of supervision in the absence of the usual care provider to persons residing in their own homes, who are very frail or otherwise may suffer a medical emergency. Such supervision serves to prevent immediate placement in an acute care hospital, skilled nursing facility, or other 24-hour care facility. Such supervision does not require medical skills and can be performed by an individual trained to summon aid in the event of an emergency. This service may also provide a visit to the Waiver Participant's home to assess a medical situation during an emergency (e.g., natural disaster). Waiver Service funds may not be used to purchase this service until existing county Title XX Social Services and Title XIX Medi-Cal resources have been fully utilized and an unmet need remains.

Waiver Participants that receive Supplemental Protective Supervision may also receive a room monitor under Communication: Device; however, are not allowed to also receive Emergency Response System (ERS) services.

Services purchased using 3.7 can supplement but not supplant IHSS.

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

10. **Care Management**: Assists Waiver Participants in gaining access to needed Waiver and other State Plan services, as well as needed medical, social, and other services, regardless of the funding source. Care managers are responsible for ongoing monitoring of the provision of services included in the Waiver Participant's plan of care. Additionally, care managers initiate and oversee the process of assessment and reassessment of Waiver Participant level of care and the monthly review of plans of care.

    a) **Care Management** (50): The MSSP care management system vests responsibility for assessing, care planning, authorizing, locating, coordinating, and monitoring a package of long-term care services for community-based Waiver Participants with a local MSSP site contractor and specifically with the site care management team. The care management teams at each of the local sites are trained professionals working under the job titles of nurse care manager and social work care manager; these professionals may be assisted by care manager aides. The teams are responsible for care management services including the assessment, care plan development, service authorization/delivery, monitoring, and follow-up components of the program. Case records must document all Waiver Participant contact activity each month.

    b) **Deinstitutional Care Management (DCM)** (4.6): This service is used ONLY with individuals who are institutionalized. It allows care management and Waiver Services to begin up to one hundred eighty (180) days prior to an individual's discharge from an institution. It may be used in two situations, as follows:

        - Where MSSP has gone into a facility (nursing facility or acute hospital) to begin working with a resident to facilitate their discharge into the community
        - Where an established MSSP Waiver Participant is institutionalized and MSSP services are necessary for the person to be discharged back into the community

    In either situation, all services (monthly Administration and Care Management, plus any purchased services) provided during this period are combined into one unit of DCM and billed upon discharge. For those individuals who do not successfully transition to the Waiver, all services provided are combined into one unit of DCM and billed at the end of the month the decision is made to cease MSSP activity. For those individuals who do not successfully transition to the Waiver, billing is disallowed, as Federal Financial Participation (FFP) cannot be claimed for DCM services where the participant does not transition into the Waiver. No care management services available under the State Plan will be duplicated under the MSSP Waiver.

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

11. **Consultative Clinical Services** (4.3): This service addresses the unmet needs of Waiver Participants when such care is not otherwise available under the State Plan. These services will be provided based on the following criteria:

    - The Waiver Participant assessment identifies need for this support and the care plan reflects the required service(s).

    - MSSP utilizes all of the services available under the State Plan prior to purchasing these services as Waiver Services. MSSP's Waiver Participants are extremely frail and, on occasion, in need of services that cannot be provided under Medi-Cal. This service is especially critical for persons recently discharged from acute hospitals or who are otherwise recovering at home from an acute illness or injury. This MSSP service supplements, but does not supplant, benefits provided by the State Plan.

    In addition to the provision of care, Waiver Participants and their families/caregivers are trained in techniques which will enable them (or their caregivers) to carry out their own care whenever possible.

    Allowable services are:
    • Social services consultation
    • Legal and paralegal professionals' consultation
    • Dietitian/Nutrition consultation
    • Pharmacy consultation
    • Vital sign monitoring

12. **Respite** (5.1, 5.2): The State Plan does not provide for respite care. By definition, the purpose of respite care is to relieve the Waiver Participant's informal caregiver and thereby prevent breakdown in the informal support system. Respite service will include the supervision and care of a Waiver Participant, while the family or other individuals who normally provide primary care take short-term relief or respite which allows them to continue as caregivers. Respite may also be needed in order to cover emergencies and extended absences of the caregiver. As dictated by the Waiver Participant's circumstances, services will be provided In-Home (5.1) or Out-of-Home (5.2) through appropriate available resources such as board and care facilities, skilled nursing facilities, etc. Federal Financial Participation will not be claimed for the cost of room and board except when provided as part of respite care in a facility approved by the State that is not a private residence. Individuals providing services in the Waiver Participant's residence shall be trained and experienced in homemaker services, personal care, or home health services, depending on the requirements in the Waiver Participant's plan of care.

13. **Transportation** (6.3 and 6.4): These services provide access to the community (e.g., non-emergency medical transportation to health and social service providers) and special events for Waiver Participants who do not have means

for transportation or whose mobility is limited, or who have functional disabilities requiring specialized vehicles and/or escort. These services are in contrast to the transportation service authorized by the State Plan which is limited to medical services, or Waiver Participants who have documentation from their physician that they are medically unable to use public or ordinary transportation. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge will be utilized.

Transportation services are usually provided under public paratransit or public social service programs (e.g., Title III of the Older Americans Act) and shall be obtained through these sources without the use of MSSP resources, except in situations where such services are unavailable or inadequate. Service providers may be paratransit subsystems or public mass transit; specialized transport for the older adults and adults with disabilities; private taxicabs where no form of public mass transit or paratransit is available or accessible; or private taxicabs when they are subsidized by public programs or local government to service frail older adults and handicapped (e.g., in California, some counties provide reduced fare vouchers for trips made via private taxicabs for frail older adults and handicapped).

Escort services will be provided when necessary to assure the safe transport of the Waiver Participant. Escort services may be authorized for those Waiver Participants who cannot manage to travel alone and require assistance beyond what is normally offered by the transportation provider. This service will be provided by trained paraprofessionals or professionals, depending on the Waiver Participant's condition and care plan requirements.

14. **Nutritional Services** (7.1, 7.2, and 7.3): These services may be provided daily, but are not to constitute a full nutritional regimen (three (3) meals a day).

    a) **Congregate Meals** (7.1): Meals served in congregate meal settings for Waiver Participants who are able to leave their homes or require the social stimulation of a group environment in order to maintain a balanced diet. Congregate meals can be a preventive measure for the frail older person who has few (if any) informal supports, as well as a rehabilitative activity for people who have been physically ill or have suffered emotional stress due to losses associated with aging. This service should be available to MSSP Waiver Participants through Title III of the Older Americans Act. MSSP funds shall only be used to supplement congregate meals when funding is unavailable or inadequate through Title III or other public or private sources.

    Congregate Meal Sites are subject to Federal Home and Community-Based Settings (HCBS) requirements, meaning they must:

    - Support access to the greater community;
    - Be selected by the participant from among setting options;

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

- Ensure individual rights of privacy, dignity and respect, and freedom from coercion and restraint;
- Optimize autonomy and independence in making life choices;
- Facilitate choice regarding services and who provides them; and
- Be physically accessible.

Vendor contracts with Congregate Meal Sites must contain language that addresses Home and Community-Based Settings requirements as specified in 42 CFR 441.301(c)(4).

b) **Home Delivered Meals** (7.2): Meals for Waiver Participants who are homebound, unable to prepare their own meals and have no caregiver at home to prepare meals for them. As with Congregate Meals, the primary provider of this service is Title III of the Older Americans Act. MSSP funds shall only be used to supplement home-delivered meals when they are unavailable or inadequate through Title III or other public or private sources.

c) Oral Nutritional Supplements (7.3): If oral nutritional supplements (ONS) are to be purchased using Waiver Service funds, the following actions must occur and be documented in the Participant record:

- The Nurse Care Manager (NCM) must assess the Waiver Participant's nutritional needs and determine that an ONS is advisable.
- The use of home-prepared drinks/supplements (instant breakfast, pureed food) has been explored and found not to meet the Participant's needs.
- All other options for payment of an ONS have been exhausted (Waiver Participant, family, etc.).

If all three criteria have been satisfied, an ONS may be purchased initially for a period of three (3) months. If an ONS needs to be continued beyond the three-month timeframe, a physician order must be obtained. Upon annual reassessment, if all criteria, including a new nutritional screen, are satisfied and the previous physician order has expired, another three months may be purchased. The physician's order must be renewed on an annual basis.

15. **Counseling & Therapeutic Services** (8.3, 8.4, and 8.5): These services include protection for Waiver Participants who are isolated and homebound due to health conditions; who suffer from depression and other psychological problems; individuals who have been harmed or threatened with harm (physical or mental) by other persons or by their own actions; or those whose cognitive functioning is impaired to the extent they require assistance and support in making and carrying out decisions regarding personal finances.

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

a. **Social Support** (8.3): Includes periodic telephone contact, visiting, or other social and reassurance services to verify that the individual is not in medical, psychological, or social crisis, or to offset isolation. Such services shall be provided based on need, as designated in the Waiver Participant's plan of care. The MSSP has found that isolation and lack of social interaction can seriously impact some Waiver Participants' capacity to remain independent. Lack of motivation or incentive or the lack of any meaningful relationships can contribute to diminishing functional capacity and premature institutionalization.

   These services are often provided by volunteers or through Title III of the Older Americans Act; however, these services may not be available in a particular community and do, infrequently, require purchase. The Waiver will be used to purchase friendly visiting only if the service is unavailable in the community or is inadequate as provided under other public or private programs.

b. **Therapeutic Counseling** (8.4): Includes individual or group counseling to assist with social, psychological, or medical problems which have been identified in the assessment process and included in the Waiver Participant's care plan. The MSSP has found that therapeutic counseling is essential for preventing some Waiver Participants from being placed in a nursing facility. This service may be utilized in situations where Waiver Participants or their caretakers may face crises, severe anxiety, emotional exhaustion, personal loss/grief, confusion, and related problems. Counseling by licensed or certified counselors in conjunction with other services (e.g., respite, IHSS, meals) may reverse some states of confusion and greatly enhance the ability of a family to care for the Waiver Participant in the community, or allow the Waiver Participant to cope with increasing impairment or loss.

c. **Money Management** (8.5): This service assists the Waiver Participant with activities related to managing money and the effective handling of personal finances. Services may be either periodic or as full-time substitute payee. Services may be provided by organizations or individuals specializing in financial management or performing substitute payee functions.

16. **Communication (9.1 and 9.2)**: Waiver Participants who receive these services are those with special communication problems such as vision, hearing, or speech impairments and persons with physical impairments likely to result in a medical emergency. Services shall be provided by organizations such as: speech and hearing clinics; organizations serving blind individuals; hospitals; senior citizens centers; and providers specializing in communications equipment for disabled or at-risk persons. Services shall be available on a routine or emergency basis as designated in the Waiver Participant's plan of care.

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

a. **Translation** (9.1): The provision of translation and interpretive services for purposes of instruction, linkage with social or medical services, and conduct of business is essential to maintaining independence and carrying out the ADL and Instrumental Activities of Daily Living (IADL) functions.

For non-English speaking Waiver Participants, this service is the link to the entire in-home and community-based service delivery system. MSSP resources shall be used to support this service only where family and community resources are unable to meet the need, and as described in the care plan.

b. **Device** (9.2): The rental/purchase of 24-hour emergency assistive services, or installation of a telephone to assist in communication (excluding monthly telephone charges) for Waiver Participants who are at risk of institutionalization due to physical conditions likely to result in a medical emergency. Purchase of Emergency Response Systems (ERS) is limited to those Waiver Participants who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision. The following are allowable:

(i) 24-hour answering/paging
(ii) Medic-alert type bracelets/pendants
(iii) Intercoms
(iv) Emergency Response System
(v) Room/two-way monitors
(vi) Light fixture adaptations (blinking lights, etc.)
(vii) Telephone adaptive devices not available from the telephone company

This service is limited to additional services and items not otherwise covered under the State Plan but are consistent with Waiver objectives of avoiding institutionalization. Telephone installation or reactivation of service will only be authorized to enable the use of telephone-based electronic response systems where the Waiver Participant has no telephone, or for the isolated Waiver Participant who has no telephone and who resides where the telephone is the only means of communicating health needs. This service will only be authorized when the Waiver Participant has a medical/health condition that makes him/her vulnerable to medical emergency.

Waiver Participants that receive Supplemental Protective Supervision may also receive a room monitor under Communication: Device; however, are not allowed to also receive ERS services. These types of devices are intended to assist in keeping at-risk Waiver Participants safe in the home and are not intended to replace an in-person support staff.

ARTICLE I. INVOICING AND PAYMENT

A. To receive payment under the fee-for-service (FFS) payment model, the Contractor shall prepare and submit electronic claims through the State's Fiscal Intermediary (FI) as set forth in the Medi-Cal Provider Manual.

B. Payments shall be made in accordance with the following provisions:

1. The Contractor shall submit claims to Medi-Cal FI, based upon the month of service and only for actual expenses. On each claim, the Contractor shall show the amount billed for each service code

2. Failure to provide data and reports specified by this Agreement will result in the delay of payment of invoices

C. Payment will be made in accordance with, and within the time specified in, California Government Code, Chapter 4.5, commencing with Section 927.

D. Reimbursement for Performance

The Contractor shall be entitled to monthly payment for actual services delivered to the Contractor's monthly active participants. This amount may vary from month to month but total annual payments to the Contractor shall not exceed the amount of the Contractor's total participant slot budget for the year.

E. Rate Adjustment

Any rate adjustments must be submitted to CDA for approval. The rate change request should be submitted to MSSPService@aging.ca.gov and include the following information in their rate change request:

- Billing Code
- Effective Date
- Current Rate
- Requested Rate

F. Advance Payments

1. CDA may authorize an advance payment during the term of the Agreement pursuant to the Welfare and Institutions Code Section 9566 for Contractors providing services under the FFS payment model. Upon approval of this Agreement, the Contractor may request an advance not to exceed twenty-five percent (25%) of the total contract amount.

2. A request for an advance payment shall be on the Contractor's letterhead and include both an original signature of authorized designee and the Agreement number. Requests for advances will not be accepted after the first day of that fiscal year unless otherwise authorized by CDA.

3. Any funds advanced under this Agreement, plus interest earned on same, shall be deducted from amounts due the Contractor. If, after settlement of the Contractor's final claim, the California Department of Health Care Services (DHCS) or CDA determines an amount is owed DHCS or CDA hereunder, DHCS or CDA shall notify the Contractor and the Contractor shall refund the requested amount within ten (10) working days of the date of the State's request.

4. The Contractor may at any time repay all or any part of the funds advanced hereunder. Whenever either party gives prior written notice of termination of this Agreement, the Contractor shall repay to DHCS, within ten (10) working days of such notice, the unliquidated balance of the advance payment.

5. Repayment of advances will be recovered from claims submitted to the State's FI after January 1st of each fiscal year and be collected at fifty percent (50%) of each claim submitted until the amount advanced is repaid. The Contractor may at any time be required to repay to DHCS all or any part of the advance.

6. Repayment of any remaining advances funds not collected through the process described in subsection 6 above, will be recovered through the Closeout process.

ARTICLE II. FUNDS

A. Expenditure of Funds

1. The Contractor shall expend all funds received hereunder in accordance with this Agreement.

2. Any reimbursement for authorized travel and per diem shall be at rates not to exceed those amounts paid by the State in accordance with the California Department of Human Resources' (CalHR) rules and regulations.

ARTICLE II. FUNDS (Continued)

In State:

- Mileage/Per Diem (meals and incidentals)/Lodging

Out of State:

- Travel and Relocation Policy-Human Resource Manual

This is not to be construed as limiting the Contractor from paying any differences in costs, from funds other than those provided by CDA, between the CalHR rates and any rates the Contractor is obligated to pay under other contractual agreements. No travel outside the State of California shall be reimbursed unless prior written authorization is obtained from the State. [2 CCR 599.615 et seq.]

The Contractor agrees to include these requirements in all contracts it enters into with subcontractors/vendors to provide services pursuant to this Agreement.

3. DHCS and CDA reserve the right to refuse payment to the Contractor or later disallow costs for any expenditure as determined by DHCS or CDA to be out of compliance with this Agreement; unrelated or inappropriate to contract activities; when adequate supporting documentation is not presented; or where prior approval was required but was either not requested or granted.

4. The Contractor agrees that any refunds, rebates, credits, or other amounts (including any interest thereon) accruing to or received by the Contractor under this Contract, shall be paid by the Contractor to DHCS to the extent that they are properly allocable to costs for which the Contractor has been reimbursed by DHCS under this Contract.

5. CDA may require prior approval and may control the location, cost, dates, agenda, instructors, instructional materials, and attendees at any reimbursable training seminar workshop or conference conducted by the Contractor in relation to the program funded through this Contract. CDA may also maintain control over any reimbursable publicity, or education materials to be made available for distribution. The Contractor is required to acknowledge the support of CDA in writing, whenever publicizing the work under this Agreement in any media.

ARTICLE II. FUNDS (Continued)

6. Any overpayment of funds must be deposited into an interest-bearing account.

B. The Contractor shall maintain accounting records for funds received under the terms and conditions of this Agreement. These records shall be separate from those for any other funds administered by the Contractor and shall be maintained in accordance with Generally Accepted Accounting Principles and Procedures and Office of Management and Budget's– Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards. [2 CFR Part 200]

C. Upon termination, cancellation, or expiration of this Agreement or dissolution of the entity, the Contractor, upon written demand, shall immediately return to DHCS any funds provided under this Agreement, which are not payable for goods or services delivered prior to the termination, cancellation, or expiration of this Agreement or the dissolution of the entity.

D. Interest Earned

1. Interest earned on federal advance payments deposited in interest-bearing accounts must be remitted annually to the Department of Health and Human Services, Payment Management System, Rockville, MD 20852. Interest amounts up to $500 per year may be retained by the non-Federal entity for administrative expense. [2 CFR § 200.305(b)(9)]

2. The Contractor must maintain advance payments of Federal awards in interest-bearing accounts, unless the following apply.

   a. The Contractor receives less than $120,000 in Federal awards per year.

   b. The best reasonably available interest-bearing account would not be expected to earn interest in excess of $500 per year on federal cash balances.

   c. The depository would require an average or minimum balance so high that it would not be feasible within the expected federal and non-federal cash resources.

   d. A foreign government or banking system prohibits or precludes interest bearing accounts.

ARTICLE III. BUDGET AND BUDGET REVISION

Payment for performance by the Contractor under this contract may be dependent upon the availability of future appropriations by the Legislature or Congress for the purposes of this contract. No legal liability on the part of the State for any payment may arise under this contract until funds are made available and until the Contractor has received notice of funding availability, which will be confirmed in writing.

A. Funding Reduction in Subsequent Fiscal Years

1. If funding for any State fiscal year is reduced or deleted by the Legislature, Congress, or Executive Branch of State Government for the purposes of this program, the State shall have the option to either:

   a. Terminate the Contract pursuant to Exhibit D, Article XIII., A

   b. Offer a contract amendment to the Contractor to reflect the reduced funding for this contract

2. In the event that the State elects to offer an amendment, it shall be mutually understood by both parties that the State reserves the right to determine which contracts, if any, under this program shall be reduced and that some contracts may be reduced by a greater amount than others. The State shall determine, at its sole discretion, the amount that any or all of the contracts shall be reduced for the fiscal year.

B. The Contractor shall be reimbursed for category expenses only as itemized in the most recent approved or revised Budget.

C. Category amounts stipulated in the Budget, a part of Exhibit B, are the maximum amounts that may be reimbursed by DHCS under this Agreement or the actual category expenditures whichever is less.

D. The budget shall include the following line items:

1. Personnel Costs - monthly, weekly, or hourly rates, as appropriate and personnel classifications together with the percentage of time to be charged to this Agreement.

2. Fringe Benefits.

3. Consultation, Professional Services-Contractual Costs, subcontract and consultant cost detail.

ARTICLE III. BUDGET AND BUDGET REVISION (CONTINUED)

4. Facility, Rent & Operations – specify square footage and rate.

5. Equipment - detailed descriptions and unit costs.

6. Travel (Include: In State and Out of State) – mileage reimbursement rate, lodging, per diem and other costs.

7. Supplies.

8. Indirect Costs shall not exceed fifteen percent (15%) of direct salaries plus benefits.

9. Other Costs - a detailed list of other operating expenses.

E. The Contractor must obtain prior written approval from CDA to transfer funds between the Care Management and Care Management Support categories if the transfer amount is equal to or greater than five percent (5%) of the approved or revised total budget or $10,000, whichever is less. The Contractor must obtain prior written approval from CDA to transfer any funds into or out of the Purchased Waiver Service category.

F. Budgeting processes and conditions will be subject to instructions that will be issued to the Contractor under separate cover.

G. Equipment/Property with per unit cost of $5,000 or more, all computing devices regardless of cost (including but not limited to, workstations, servers, laptops, personal digital assistants, notebook computers, tablets, smartphones, and cellphones), and all portable electronic storage media regardless of cost (including but not limited to, thumb/flash drives and portable hard drives) requires justification and approval from CDA and must be included in its approved MSSP budget.

ARTICLE IV. DEFAULT PROVISIONS

The State, without limiting any rights which it may otherwise have, may, at its discretion and upon written notice to the Contractor, withhold further payments under this Agreement, and/or demand immediate repayment of the unliquidated balance of any advance payment hereunder, upon occurrence of any one of the following events:

A. Termination or suspension of this Agreement

B. A finding by the State that the Contractor:

ARTICLE IV. DEFAULT PROVISIONS (CONTINUED)

1. Has failed to observe any of the covenants, conditions, or warrants of these provisions, or has failed to comply with any material provisions of this Agreement or

2. Has failed to make progress, or is in such unsatisfactory financial condition, as to endanger performance of this Agreement or

3. Has allocated inventory to this Agreement substantially exceeding reasonable requirements or

4. Is delinquent in payment of taxes or of the cost of performance of this Agreement in the ordinary course of business

C. Appointment of a trustee, receiver, or liquidator for all or a substantial part of the Contractor's property, or institution of bankruptcy, reorganization, or arrangement of liquidation proceedings by or against the Contractor.

D. Service of any writ of attachment, levy, or execution, or commencement of garnishment proceeding or

E. The commission of an act of bankruptcy.

ARTICLE I. DEFINITIONS AND RESOLUTIONS OF LANGUAGE CONFLICTS

A. General Definitions

1. “Agreement” or “Contract” means the Standard Agreement (Std. 213), Exhibits A, B, C, D, E, F and G, an approved Budget as identified in Exhibit B, and if applicable, a Work Plan or Budget Summary, which are hereby incorporated by reference, amendments, and any other documents incorporated by reference; unless otherwise provided for in this Article.

2. "Contractor" means the governmental or nonprofit entity contracted with CDA to provide MSSP Waiver Services to eligible Medi-Cal beneficiaries on behalf of DHCS pursuant to an Interagency Agreement between DHCS and CDA.

3. “CCR” means California Code of Regulations.

4. “CFR” means Code of Federal Regulations.

5. “DUNS” means the nine-digit, Data Universal Numbering System number established and assigned by Dun and Bradstreet, Inc., to uniquely identify business entities.

6. “Cal. Gov. Code” means California Government Code.

7. “OMB” means the federal Office of Management and Budget.

8. “Cal. Pub. Con. Code” means the California Public Contract Code.

9. “Cal. Civ. Code” means California Civil Code

10. “Reimbursable item” also means “allowable cost” and “compensable item.”

11. “State” and “Department” mean the State of California and the California Department of Aging (CDA) interchangeably.

12. “Subcontractor” means the legal entity that receives funds from the Contractor to provide waiver services identified in this Agreement.

13. “Subcontract” means any form of legal agreement between the Contractor and the Subcontractor, including an agreement that the Contractor considers a contract, including vendor type Agreements for providing goods or services under this Agreement.

14. “Vendor” means an entity selling goods or services to the Contractor or Subcontractor during the Contractor or Subcontractor’s performance of the Agreement.

ARTICLE I. DEFINITIONS AND RESOLUTIONS OF LANGUAGE CONFLICTS (Continued)

15. "Waiver Participant" means any individual who has met MSSP eligibility requirements and been enrolled in the MSSP program.

16. "USC" means United States Code.

17. "OAA" means Older Americans Act.

18. "Allocation" means the process of assigning a cost, or a group of costs, to one or more cost objective(s), in reasonable proportion to the benefit provided or other equitable relationship. The process may entail assigning a cost(s) directly to a final cost objective or through one or more intermediate cost objectives. (2 CFR 200.4)

19. "Disallowed costs" means those charges determined to be unallowable, in accordance with the applicable Federal statutes, regulations, or the terms and conditions of the Federal award. (2 CFR 200.31)

20. "Questioned Costs" means a cost that is questioned by the auditor because of an audit finding which resulted from a violation or possible violation of a statute, regulation, or the terms and conditions of a Federal award, including for funds used to match Federal funds; where the costs, at the time of the audit, are not supported by adequate documentation; or where the costs incurred appear unreasonable and do not reflect the actions a prudent person would take in the circumstances. (2 CFR 200.84).

21. "Recoverable cost" means the state and federal share of the questioned cost.

22. "DHCS" means the Department of Health Care Services.

23. "HHS" means United States Department of Health and Human Services.

B. Resolution of Language Conflicts

The terms and conditions of this Agreement have the following order of precedence, if there is any conflict in what they require:

1. Section 1915(c) of Title XIX of the Social Security Act, 42 USC 1396n, and other applicable federal statutes and their implementing regulations.

2. The Interagency Agreement Terms and Conditions.

ARTICLE I. DEFINITIONS AND RESOLUTIONS OF LANGUAGE CONFLICTS (Continued)

3. As applicable, Welfare and Institutions Code Sections 9560 to 9568 and other California State codes and regulations governing the MSSP.

4. Standard Agreement (Std. 213), all Exhibits and any amendments thereto.

5. Any other documents incorporated herein by reference including, but not limited to, the MSSP Site Manual.

6. Program memos and other guidance issued by CDA.

ARTICLE II. ASSURANCES

A. Law, Policy and Procedure, Licenses, and Certificates

The Contractor agrees to administer this Agreement and require any subcontractors to administer their subcontracts in accordance with this Agreement, and with all applicable local, State, and federal laws and regulations including, but not limited to, discrimination, wages and hours of employment, occupational safety, and to fire, safety, health, and sanitation regulations, directives, guidelines, and/or manuals related to this Agreement and resolve all issues using good administrative practices and sound judgment. The Contractor and its subcontractors shall keep in effect all licenses, permits, notices, and certificates that are required by law.

B. Subcontracts

The Contractor shall require language in all subcontracts to require all subcontractors to comply with all applicable State and federal laws.

C. Nondiscrimination

The Contractor shall comply with all federal statutes relating to nondiscrimination. These include those statutes and laws contained in the Contractor Certification Clauses (CCC 307), which is hereby incorporated by reference. In addition, the Contractor shall comply with the following:

1. Equal Access to Federally Funded Benefits, Programs and Activities

The Contractor shall ensure compliance with Title VI of the Civil Rights Act of 1964 [42 USC 2000d; 45 CFR 80], which prohibits recipients of federal financial assistance from discriminating against persons based on race, color, religion, or national origin.

ARTICLE II. ASSURANCES (Continued)

2. Equal Access to State-Funded Benefits, Programs and Activities

The Contractor shall, unless exempted, ensure compliance with the requirements of Cal. Gov. Code § 11135 et seq., and 2 CCR § 11140 et seq., which prohibit recipients of state financial assistance from discriminating against persons based on race, national origin, ethnic group identification, religion, age, sex, sexual orientation, color, or disability. [22 CCR § 98323]

3. California Civil Rights Laws

The Contractor shall, ensure compliance with the requirements of California Public Contract Code § 2010 by submitting a completed California Civil Rights Laws Certification, prior to execution of this Agreement.

The California Civil Rights Laws Certification ensures Contractor compliance with the Unruh Civil Rights Act (Cal. Civ. Code § 51) and the Fair Employment and Housing Act (Cal. Gov. Code § 12960) and ensures that Contractor internal policies are not used in violation of California Civil Rights Laws.

4. The Contractor assures the State that it complies with the Americans with Disabilities Act (ADA) of 1990, which prohibits discrimination on the basis of disability, as well as all applicable regulations and guidelines issued pursuant to the ADA. [42 USC 12101 et seq.]

5. The Contractor agrees to include these requirements in all contracts it enters into with subcontractors to provide services pursuant to this Agreement.

D. Standards of Work

The Contractor agrees that the performance of work and services pursuant to the requirements of this Agreement shall conform to accepted professional standards.

E. Conflict of Interest

1. The Contractor shall prevent employees, consultants, or members of governing bodies from using their positions for purposes including, but not limited to, the selection of subcontractors, that are, or give the appearance of being, motivated by a desire for private gain for themselves or others,

ARTICLE II. ASSURANCES (Continued)

such as family, business, or other ties. In the event that the State determines that a conflict of interest exists, any increase in costs associated with the conflict of interest may be disallowed by the State and such conflict may constitute grounds for termination of the Agreement.

2. This provision shall not be construed to prohibit employment of persons with whom the Contractor's officers, agents, or employees have family, business, or other ties, so long as the employment of such persons does not result in a conflict of interest (real or apparent) or increased costs over those associated with the employment of any other equally qualified applicant, and such persons have successfully competed for employment with the other applicants on a merit basis.

F. Covenant Against Contingent Fees

1. The Contractor warrants that no person or selling agency has been employed or retained to solicit this Agreement. There has been no agreement to make commission payments in order to obtain this Agreement.

2. For breach or violation of this warranty, CDA shall have the right to terminate this Agreement without liability or at its discretion to deduct from the Agreement price or consideration, or otherwise recover, the full amount of such commission, percentage, brokerage, or contingency fee.

G. Payroll Taxes and Deductions

The Contractor shall promptly forward payroll taxes, insurances, and contributions, including State Disability Insurance, Unemployment Insurance, Old Age Survivors Disability Insurance, and federal and State income taxes withheld, to designated governmental agencies as required by law.

H. Facility Construction or Repair

This section applies only to Title III funds and not to other funds allocated to other Titles under the OAA. Title III funds may be used for facility construction or repair.

1. When applicable for purposes of construction or repair of facilities, the Contractor shall comply with the provisions contained in the following and shall include such provisions in any applicable agreements with subcontractors:

ARTICLE II. ASSURANCES (Continued)

a. Copeland "Anti-Kickback" Act. [18 USC 874, 40 USC 3145] [29 CFR 3]

b. Davis-Bacon Act. [40 USC 3141 et seq.] [29 CFR 5]

c. Contract Work Hours and Safety Standards Act. [40 USC 3701 et seq.] [29 CFR 5, 6, 7, 8]

d. Executive Order 11246 of September 14, 1965, entitled "Equal Employment Opportunity" as amended by Executive Order 11375 of October 13, 1967, as supplemented in Department of Labor Regulations. [41 CFR 60]

2. Payments are not permitted for construction, renovation, alteration, improvement, or repair of privately-owned property which would enhance the owner's value of such property except where permitted by law and by CDA.

3. When funding is provided for construction and non-construction activities, the Contractor must obtain prior written approval from CDA before making any fund or budget transfers between construction and non-construction.

I. Contracts in Excess of $100,000

If all funding provided herein exceeds $100,000, the Contractor shall comply with all applicable orders or requirements issued under the following laws:

1. Clean Air Act, as amended. [42 USC 7401]

2. Federal Water Pollution Control Act, as amended. [33 USC 1251 et seq.]

3. Environmental Protection Agency Regulations. [40 CFR 29] [Executive Order 11738]

4. State Contract Act [Cal. Pub. Con. Code §10295 et seq.]

5. Unruh Civil Rights Act [Cal. Pub. Con. Code § 2010]

J. Debarment, Suspension, and Other Responsibility Matters

1. The Contractor certifies to the best of its knowledge and belief, that it and its subcontractors:

ARTICLE II. ASSURANCES (Continued)

a. Are not presently debarred, suspended, proposed for disbarment, declared ineligible, or voluntarily excluded from covered transactions by any federal department or agency.

b. Have not, within a three-year period preceding this Agreement, been convicted of, or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, State, or local) transaction or contract under a public transaction; violation of federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification, or destruction of records, making false statements, or receiving stolen property.

c. Are not presently indicted for, or otherwise criminally or civilly charged by a governmental entity (federal, State, or local) with commission of any of the offenses enumerated in paragraph (1)(b) of this certification.

d. Have not, within a three-year period preceding this Agreement, had one or more public transactions (federal, State, or local) terminated for cause or default.

2. The Contractor shall report immediately to CDA in writing, any incidents of alleged fraud and/or abuse by either the Contractor or subcontractors.

3. The Contractor shall maintain any records, documents, or other evidence of fraud and abuse until otherwise notified by CDA.

4. The Contractor agrees to timely execute any and all amendments to this Agreement or other required documentation relating to the Subcontractor's debarment/suspension status.

K. Agreement Authorization

1. If a public entity, the Contractor shall submit to CDA a copy of an approved resolution, order, or motion referencing this Agreement number authorizing execution of this Agreement. If a private nonprofit entity, the Contractor shall submit to CDA an authorization by the Board of Directors to execute this Agreement, referencing this Agreement number.

2. These documents, including minute orders must also identify the action taken.

ARTICLE II. ASSURANCES (Continued)

3. Documentation in the form of a resolution, order, or motion by the Governing Board is required for the original and each subsequent amendment to this Agreement. This requirement may also be met by a single resolution from the Governing Board of the Contractor authorizing the Director or designee to execute the original and all subsequent amendments to this Agreement.

L. Contractor's Staff

1. The Contractor shall maintain adequate staff to meet the Contractor's obligations under this Agreement.

2. This staff shall be available to the State for training and meetings which the State may find necessary from time to time.

M. DUNS Number and Related Information

1. The DUNS number must be provided to CDA prior to the execution of this Agreement. Business entities may register for a DUNS number.

2. The Contractor must register the DUNS number and maintain an "Active" status within the federal System for Award Management.

3. If CDA cannot access or verify "Active" status the Contractor's DUNS information, which is related to this federal subaward on the Federal Funding Accountability and Transparency Act Subaward Reporting System (SAM.gov) due to errors in the Contractor's data entry for its DUNS number, the Contractor must immediately update the information as required.

N. Corporate Status

1. The Contractor shall be a public entity, private nonprofit entity, or Joint Powers Authority (JPA). If a private nonprofit corporation or JPA, the Contractor shall be in good standing with the Secretary of State of California and shall maintain that status throughout the term of this Agreement.

2. The Contractor shall ensure that any subcontractors providing services under this Agreement shall be of sound financial status.

3. Any subcontracting private entity or JPA shall be in good standing with the Secretary of State of California and shall maintain that status throughout the term of this Agreement.

ARTICLE II. ASSURANCES (Continued)

4. Failure to maintain good standing by the contracting entity shall result in suspension or termination of this Agreement with CDA until satisfactory status is restored. Failure to maintain good standing by a subcontracting entity shall result in suspension or termination of the subcontract by the Contractor until satisfactory status is restored.

O. Lobbying Certification

The Contractor, by signing this Agreement, hereby certifies to the best of its knowledge and belief, that:

1. No federally appropriated funds have been paid or will be paid, by or on behalf of the Contractor, to any person for influencing or attempting to influence an officer or employee of any agency; a Member of Congress; an officer or employee of Congress; or an employee of a Member of Congress; in connection with the awarding of any federal contract; the making of any federal grant; the making of any federal loan; the entering into of any cooperative agreement; and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

2. If any funds other than federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any federal agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this federal contract, grant, loan, or cooperative agreement, the Contractor shall complete and submit Standard Form-LLL, Disclosure Form to Report Lobbying, in accordance with its instructions.

3. The Contractor shall require that the language of this certification be included in the award documents for all subcontracts at all tiers (including contracts under grants, loans, and cooperative agreements which exceed $100,000) and that all subcontractors shall certify and disclose accordingly.

4. This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into.

5. This certification is a prerequisite for making or entering into this transaction imposed by 31 USC 1352.

6. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

ARTICLE II. ASSURANCES (Continued)

P. The Contractor and its Subcontractor/Vendors shall comply with Governor's Executive Order 2-18-2011, which bans expenditures on promotional and marketing items colloquially known as "S.W.A.G." or "Stuff We All Get."

ARTICLE III. AGREEMENT

A copy of this executed Agreement is on file and available for inspection at the California Department of Aging, 2880 Gateway Oaks Drive, Suite 200, Sacramento, California 95833.

ARTICLE IV. COMMENCEMENT OF WORK

Should the Contractor or subcontractor begin work in advance of receiving notice that this Agreement is approved, that work may be considered as having been performed at risk as a mere volunteer and may not be reimbursed or compensated.

ARTICLE V. SUBCONTRACTS

A. The Contractor is responsible for carrying out the terms of this Agreement, including the satisfaction, settlement, and resolution of all administrative, programmatic, and fiscal aspects of the program(s), including issues that arise out of any subcontracts, and shall not delegate or contract these responsibilities to any other entity. This includes, but is not limited to, disputes, claims, protests of award, or other matters of a contractual nature. The Contractor's decision is final, and the Subcontractor has no right of appeal to CDA.

B. The Contractor shall, in the event any subcontractor is utilized by the Contractor for any portion of this Agreement, retain the prime responsibility for all the terms and conditions set forth, including but not limited to, the responsibility for preserving the State's copyrights and rights in data in accordance with Article XIX of this Exhibit, for handling property in accordance with Article VII. of this Exhibit, and ensuring the keeping of, access to, availability of, and retention of records of subcontractors in accordance with Article VI. of this Exhibit.

C. The Contractor shall not obligate funds for this Agreement in any subcontracts for services beyond the ending date of this Agreement.

D. The Contractor shall have no authority to contract for, or on behalf of, or incur obligations on behalf of the State.

E. The Contractor shall maintain on file copies of subcontracts, memorandums and/or Letters of Understanding which shall be made available for review at the request of CDA.

ARTICLE V. SUBCONTRACTS (Continued)

F. The Contractor shall monitor the insurance requirements of its subcontractors in accordance with Article XI of this Exhibit.

G. The Contractor shall require language in all subcontracts to require all subcontractors to indemnify, defend, and save harmless the Contractor, its officers, agents, and employees from any and all claims and losses accruing to or resulting from any subcontractors, suppliers, laborers, and any other person, firm, or corporation furnishing or supplying work services, materials, or supplies in connection with any activities performed for which funds from this Agreement were used and from any and all claims and losses accruing or resulting to any person, firm, or corporation who may be injured or damaged by the Subcontractor(s) in the performance of this Agreement.

H. The Contractor shall require all subcontractors to maintain adequate staff to meet the Subcontractor's Agreement with the Contractor. This staff shall be available to the State for training and meetings which the State may find necessary from time to time.

I. If a private nonprofit corporation, the Subcontractor shall be in good standing with the Secretary of State of California and shall maintain that status throughout the term of the Agreement.

J. The Contractor shall refer to 2 CFR 200.330, Subpart D - Subrecipient and Contractor Determinations and 45 CFR 75.351, Subpart D - Subrecipient and Contractor Determinations in making a determination if a subcontractor relationship exists. If such a relationship exists, then the Contractor shall follow the procurement requirements in the applicable OMB Circular.

K. The Contractor shall utilize procurement procedures as follows:

The Contractor shall obtain goods and services through open and competitive awards. Each Contractor shall have written policies and procedures, including application forms, for conducting an open and competitive process, and any protests resulting from the process.

ARTICLE VI. RECORDS

A. The Contractor shall maintain complete records which shall include, but not be limited to, accounting records, contracts, agreements, a reconciliation of the "Financial Closeout Report" (CDA Closeout) to the audited financial statements, single audit report, and general ledgers, and a summary worksheet identifying the results of performing an audit resolution of its subcontractors in accordance with Article X of this Exhibit. This includes the following: Letters of Agreement, insurance documentation, memorandums and/or Letters of Understanding, Waiver Participant records, and electronic files of its activities and expenditures

ARTICLE VI. RECORDS (Continued)

hereunder in a form satisfactory to CDA. All records pertaining to this Agreement must be made available for inspection and audit by the State or its duly authorized agents, at any time during normal business hours.

B. All such records, including confidential records, must be maintained and made available by the Contractor: (1) until an audit has occurred and an audit resolution has been issued or unless otherwise authorized in writing by CDA's or DHCS' Audit Branch, (2) for such longer period, if any, as is required by applicable statute, by any other clause of this Agreement, or by Sections A and C of this Article, and (3) for such longer period as CDA deems necessary.

C. If this Agreement is completely or partially terminated, the records relating to the work terminated shall be preserved and made available for the same periods as specified in Section A above. The Contractor shall ensure that any resource directories and all Waiver Participant records remain the property of CDA upon termination of this Agreement and are returned to CDA or transferred to another contractor as instructed by CDA.

D. In the event of any litigation, claim, negotiation, audit exception, or other action involving the records, all records relative to such action shall be maintained and made available until every action has been cleared to the satisfaction of CDA and DHCS and is so stated in writing to the Contractor.

E. Adequate source documentation of each transaction shall be maintained relative to the allowability of expenditures reimbursed by the DHCS under this Agreement. If the allowability of expenditures cannot be determined because records or documentation of the Contractor are nonexistent or inadequate according to guidelines set forth in 2 CFR 200.302 and 45 CFR 75.302, the expenditures will be questioned in the audit and may be disallowed by CDA during the audit resolution process.

F. All records containing confidential information shall be handled in a confidential manner in accordance with the requirements for information integrity and security, and in accordance with guidelines set forth in this Article, and Article XVIII. After the authorized period has expired, confidential records shall be shredded and disposed of in a manner that will maintain confidentiality.

ARTICLE VII. PROPERTY

A. Unless otherwise provided for in this Article, property refers to all assets used in operation of this Agreement.

1. Property includes land, buildings, improvements, machinery, vehicles, furniture, tools, and intangibles, etc.

ARTICLE VII. PROPERTY (Continued)

2. Property does not include consumable office supplies such as paper, pencils, toner cartridges, file folders, etc.

3. Property, for the purpose of this MSSP Agreement, does not include any equipment or supplies acquired on behalf of the Waiver Participant.

B. Property acquired under this agreement, which meets any of the following criteria is subject to the reporting requirements:

1. Has a normal useful life of at least one (1) year and has a unit acquisition cost of at least $5,000 (a desktop or laptop setup, is considered a unit, if purchased as a unit).

2. All computing devices, regardless of cost (including but not limited to, workstations, servers, laptops, personal digital assistants, notebook computers, tablets, smartphones and cellphones).

3. All Portable electronic storage media, regardless of cost (including but not limited to, thumb/flash drives and portable hard drives).

C. Additions, improvements, and betterments to assets meeting all of the conditions in Section B above must also be reported. Additions typically involve physical extensions of existing units. Improvements and betterments typically do not increase the physical size of the asset. Instead, improvements and betterments enhance the condition of an asset (e.g., extend life, increase service capacity, and lower operating costs). Examples of assets that might be improved and bettered include roads, bridges, curbs and gutters, tunnels, parking lots, streets and sidewalks, drainage, and lighting systems.

D. Intangibles are property which lack physical substance but give valuable rights to the owner. Examples of intangible property include patents, copyrights, leases, and computer software. By contrast, hardware consists of tangible equipment (e.g., computer printer, terminal, etc.). Costs include all amounts incurred to acquire and to ready the intangible asset for its intended use. Typical intangible property costs include the purchase price, legal fees, and other costs incurred to obtain title to the asset.

E. The Contractor shall keep track of property purchased with funds from this Agreement and submit to CDA a Property Acquisition Form (CDA 9023) for all property furnished or purchased by either the Contractor or the Subcontractor with funds awarded under the terms of this Agreement, as instructed by CDA. The Contractor shall certify their reported property inventory annually by completing the Program Property Inventory Certification (CDA 9024).

ARTICLE VII. PROPERTY (Continued)

The Contractor shall record, at minimum, the following information when property is acquired:

1. Date acquired.

2. Item description (include model number).

3. CDA tag number or other tag identifying it as State of California property.

4. Serial number (if applicable).

5. Purchase cost or other basis of valuation.

6. Fund source.

F. Disposal of Property

1. Prior to disposal of any property purchased by the Contractor or the Subcontractor with funds from this Agreement or any predecessor Agreement, the Contractor must obtain approval from CDA for all reportable property as defined in Section B of this Article. Disposition, which includes sale, trade-in, discarding, or transfer to another agency may not occur until approval is received from CDA. The Contractor shall email to CDA the electronic version of the Request to Dispose of Property (CDA 248). CDA will then instruct the Contractor on disposition of the property. Once approval for disposal has been received from CDA and the Contractor has reported to CDA the Property Survey Report's (STD 152) Certification of Disposition, the item(s) shall be removed from the Contractor's inventory report.

2. The Contractor must remove all confidential, sensitive, or personal information from CDA property prior to disposal, including removal or destruction of data on computing devices with digital memory and storage capacity. This includes, but is not limited to magnetic tapes, flash drives, personal computers, personal digital assistants, cell or smart phones, multi-function printers, and laptops.

G. Any loss, damage, or theft of equipment shall be investigated, fully documented and the Contractor shall promptly notify CDA.

H. The State reserves title to all State-purchased or financed property not fully consumed in the performance of this Agreement, unless otherwise required by federal law or regulations or as otherwise agreed by the parties.

ARTICLE VII. PROPERTY (Continued)

I. The Contractor shall exercise due care in the use, maintenance, protection, and preservation of such property during the period of the project and shall assume responsibility for replacement or repair of such property during the period of the project, or until the Contractor has complied with all written instructions from CDA regarding the final disposition of the property.

J. In the event of the Contractor's dissolution or upon termination of this Agreement, the Contractor shall provide a final property inventory to the State. The State reserves the right to require the Contractor to transfer such property to another entity, or to the State.

K. To exercise the above right, no later than one hundred twenty (120) days after termination of this Agreement or notification of the Contractor's dissolution, the State will issue specific written disposition instructions to the Contractor.

L. The Contractor shall use the property for the purpose for which it was intended under the Agreement. When no longer needed for that use, the Contractor shall use it, if needed, and with written approval of the State for other purposes in this order:

1. For another CDA program providing the same or similar service.

2. For another CDA-funded program.

M. The Contractor may share use of the property and equipment or allow use by other programs, upon written approval from CDA. As a condition of the approval, CDA may require reimbursement under this Agreement for its use.

N. The Contractor or subcontractors shall not use equipment or supplies acquired under this Agreement with federal and/or State monies for personal gain or to usurp the competitive advantage of a privately-owned business entity.

O. If purchase of equipment is a reimbursable item, the equipment to be purchased will be specified in the Budget.

P. The Contractor shall include the provisions contained in this Article in all its subcontracts awarded under this Agreement.

ARTICLE VIII. ACCESS

The Contractor shall provide access to the federal or State contracting agency, the California State Auditor, the Comptroller, General of the United States, or any of their duly authorized federal or State representatives to any books, documents, papers, and records of the Contractor or subcontractor which are directly pertinent to this specific

ARTICLE VIII. ACCESS (Continued)

Agreement for the purpose of making an audit, examination, excerpts, and transcriptions. The Contractor shall include this requirement in its subcontracts.

ARTICLE IX. MONITORING AND EVALUATION

A. Authorized State representatives shall have the right to monitor and evaluate the Contractor's administrative, fiscal and program performance pursuant to this Agreement. Said monitoring and evaluation may include, but is not limited to, administrative processes, fiscal, data and procurement components. This will include policies, procedures, procurement, audits, inspections of project premises, interviews of project staff and participants, and when applicable, inspection of food preparation sites.

B. The Contractor shall cooperate with the State in the monitoring and evaluation processes, which include making any administrative, program and fiscal staff available during any scheduled process.

C. The Contractor shall monitor contracts and subcontracts to ensure compliance with laws, regulations, and the provisions of contracts that may have a direct and/or material effect on each of its CDA/DHCS funded programs.

D. The Contractor is responsible for maintaining supporting documentation including financial and statistical records, contracts, subcontracts, monitoring reports, and all other pertinent records until an audit has occurred and an audit resolution has been issued or unless otherwise authorized in writing by CDA.

ARTICLE X. AUDIT REQUIREMENTS

A. General

1. Any duly authorized representative of the federal or State government, which includes but is not limited to the State Auditor, CDA Staff, and any entity selected by State to perform inspections, shall have the right to monitor and audit Contractor and all subcontractors providing services under this Agreement through on-site inspections, audits, and other applicable means the State determines necessary. In the event that CDA is informed of an audit by an outside federal or State government entity affecting the Contractor, CDA will provide timely notice to Contractor.

2. Contractor shall make available all reasonable information necessary to substantiate that expenditures under this agreement are allowable and allocable, including, but not limited to books, documents, papers, and records. Contractor shall agree to make such information available to the federal government, the State, or any of their duly authorized

ARTICLE X. AUDIT REQUIREMENTS (Continued)

representatives, including representatives of the entity selected by State to perform inspections, for examination, copying, or mechanical reproduction, on or off the premises of the appropriate entity upon a reasonable request.

3. All agreements entered into by Contractor and subcontractors with audit firms for purposes of conducting independent audits under this Agreement shall contain a clause permitting any duly authorized representative of the federal or State government access to the supporting documentation of said audit firm(s).

4. The Contractor shall cooperate with and participate in any further audits which may be required by the State, including CDA fiscal and compliance audits.

B. CDA Fiscal and Compliance Audits

1. The CDA Audits and Risk Management Branch shall perform fiscal and compliance audits of Contractors in accordance with Generally Accepted Government Auditing Standards (GAGAS) to ensure compliance with applicable laws, regulations, grants, and contract requirements.

2. The CDA fiscal and compliance audits may include, but not be limited to, a review of:

   a. Financial closeouts (2 CFR 200.16)

   b. Internal controls (2 CFR 200.303)

   c. Allocation of expenditures (2 CFR 200.4)

   d. Allowability of expenditures (2 CFR 200.403)

   e. Equipment expenditures and approvals, if required (2 CFR 200.439)

C. Single Audit Reporting Requirements (2 CFR 200 Subpart F and 45 CFR 75 Subpart F)

1. Contractor Single Audit Reporting Requirements

   a. Contractors that expend $750,000 or more in federal funds shall arrange for an audit to be performed as required by the Single Audit Act of 1984, Public Law 98-502; the Single Audit Act Amendments

ARTICLE X. AUDIT REQUIREMENTS (Continued)

of 1996, Public Law 104-156; and 2 CFR 200.501 to 200.521. A copy shall be submitted to the:

California Department of Aging
Attention: Audits Branch
2880 Gateway Oaks Drive, Suite 200
Sacramento, California 95833

b. The copy shall be submitted within thirty (30) days after receipt of the Auditor's report or nine (9) months after the end of the audit period, whichever occurs first, or unless a longer period is agreed to in advance by the cognizant or oversight agency.

c. For purposes of reporting, the Contractor shall ensure that State-funded expenditures are displayed discretely along with the related federal expenditures in the single audit report's "Schedule of Expenditures of Federal Awards" (SEFA) under the Catalog of Federal Domestic Assistance (CFDA) number.

d. For State contracts that do not have CFDA numbers, the Contractor shall ensure that the State-funded expenditures are discretely identified in the SEFA by the appropriate program name, identifying grant/contract number, and as passed through CDA.

2. The Contractor shall perform a reconciliation of the "Financial Closeout Report" to the audited financial statements, single audit, and general ledgers. The reconciliation shall be maintained and made available for CDA review.

3. Contract Resolution of Contractor's Subrecipients

The Contractor shall have the responsibility for resolving its contracts with subcontractors to determine whether funds provided under this Agreement are expended in accordance with applicable laws, regulations, and provisions of contracts or agreements. The Contractor shall, at a minimum, perform Contract resolution within fifteen (15) months of the "Financial Closeout Report."

4. The Contractor shall ensure that subcontractor single audit reports meet 2 CFR 200, Subpart F-Audit Requirements

ARTICLE X. AUDIT REQUIREMENTS (Continued)

5. Contract resolution includes:

   a. Ensuring that subcontractors expending $750,000 or more in federal awards during the subcontractor's fiscal year have met the audit requirements of 2 CFR 200.501 - 200.521.

   b. Issuing a management decision on audit findings within six (6) months after receipt of the Subcontractor's single audit report and ensuring that the Subcontractor takes appropriate and timely corrective action.

   c. Reconciling expenditures reported to the Contractor to the amounts identified in the single audit or other type of audit if the subcontractor was not subject to the single audit requirements. For a subcontractor who was not required to obtain a single audit and did not obtain another type of audit, the reconciliation of expenditures reported to CDA must be accomplished through performing alternative procedures (e.g., risk assessment [2 CFR 200.331], documented review of financial statements, and documented expense verification, including match, etc.).

6. When alternative procedures are used, the Contractor shall perform financial management system testing, which provides, in part, for the following:

   a. Accurate, current, and complete disclosure of the financial results of each federal award or program.

   b. Records that identify adequately the source and application of funds for each federally funded activity.

   c. Effective control over, and accountability for, all funds, property, and other assets to ensure these items are used solely for authorized purposes.

   d. Comparison of expenditures with budget amounts for each federal award.

   e. Written procedures to implement the requirements of 2 CFR 200.305.

   f. Written procedures for determining the allowability of costs in accordance with 2 CFR Part 200, Subpart E - Cost Principles. [2 CFR 200.302]

ARTICLE X. AUDIT REQUIREMENTS (Continued)

g. The Contractor shall document system and expense testing to show an acceptable level of reliability, including a review of actual source documents.

h. Determining whether the results of the reconciliations performed necessitate adjustment of the Contractor's own records.

7. The Contractor shall ensure that subcontractor single audit reports meet 2 CFR 200, Subpart F - Audit Requirements:

a. Performed timely – not less frequently than annually and a report submitted timely. The audit is required to be submitted within thirty (30) days after receipt of the Auditor's report or nine (9) months after the end of the audit period, whichever occurs first. [2 CFR 200 512]

b. Properly procured – use procurement standards for auditor selection. [2 CFR 200.509]

c. Performed in accordance with Generally Accepted Government Auditing Standards. [2 CFR 200.514]

d. All inclusive – includes an opinion (or disclaimer of opinion) of the financial statements; a report on internal control related to the financial statements and major programs; an opinion (or disclaimer of opinion) on compliance with laws, regulations, and the provisions of contracts; and the schedule of findings and questioned costs. [2 CFR 200.515]

e. Performed in accordance with provisions applicable to this program as identified in 2 CFR Part 200, Subpart F, Audit Requirements.

8. Requirements identified in Sections D and E of this Article shall be included in contracts with the Subcontractor. Further, the Subcontractor shall be required to include in its contract with the independent Auditor that the Auditor will comply with all applicable audit requirements/standards; CDA shall have access to all audit reports and supporting work papers, and CDA has the option to perform additional work, as needed.

ARTICLE X. AUDIT REQUIREMENTS (Continued)

9. The Contractor shall prepare a summary worksheet of results from the contract resolutions performed of all subcontractors. The summary worksheet shall include, but not be limited to, contract amounts; amounts resolved; amounts of match verified, resolution of variances; recovered amounts; whether an audit was relied upon or the Contractor performed an independent expense verification review (alternative procedures) of the Subcontractor in making a determination; whether audit findings were issued; and, if applicable, issuance date of the management letter; and any communication or follow-up performed to resolve the findings.

10. A reasonably proportionate share of the costs of audits required by, and performed in, accordance with the Single Audit Act Amendments of 1996, as implemented by requirements of this part, are allowable. However, the following audit costs are unallowable:

    a. Any costs when audits required by the Single Audit Act and 2 CFR 200, Subpart F – Audit Requirements have not been conducted or have been conducted but not in accordance therewith; and

    b. Any costs of auditing a non-federal entity that is exempted from having an audit conducted under the Single Audit Act and 2 CFR 200, Subpart F – Audit Requirements because its expenditures under federal awards are less than $750,000 during the non-federal entity's fiscal year.

        i. The costs of a financial statement audit of a non-federal entity that does not currently have a federal award may be included in the indirect cost pool for a cost allocation plan or indirect cost proposal.

        ii. Pass-through entities may charge federal awards for the cost of agreed-upon-procedures engagements to monitor subcontractors who are exempted from the requirements of the Single Audit Act and 2 CFR 200, Subpart F – Audit Requirements. This cost is allowable only if the agreed-upon procedures engagements are conducted in accordance with Generally Accepted Government Auditing Standards (GAGAS) attestation standards, paid for and arranged by the pass-through entity, and limited in scope to one or more of the following types of compliance requirements: activities allowed or not allowed; allowable costs/cost principles; eligibility; and reporting.

        [2 CFR 200.425]

ARTICLE X. AUDIT REQUIREMENTS (Continued)

D. The Contractor shall cooperate with and participate in any further audits which may be required by the State.

ARTICLE XI. INSURANCE

A. Prior to commencement of any work under this Agreement, the Contractor shall provide for the term of this Agreement, the following insurance:

1. General liability of not less than $1,000,000 per occurrence for bodily injury and property damage combined. Higher limits may be required by the State in cases of higher than usual risks.

2. Automobile liability including non-owned auto liability, of not less than $1,000,000 for volunteers and paid employees providing services supported by this Agreement.

3. If applicable, or unless otherwise amended by future regulation, the Contractor and subcontractors shall comply with the Public Utilities Commission General Order No. 115-F which requires higher levels of insurance for charter-party carriers of passengers and is based on seating capacity as follows:

   a. $750,000 if seating capacity is under 8

   b. $1,500,000 if seating capacity is 8 – 15

   c. $5,000,000 if seating capacity is over 15

4. Professional liability of not less than $1,000,000 as it appropriately relates to the services rendered. Coverage shall include medical malpractice and/or errors and omissions. (All programs except Title V).

B. The insurance will be obtained from an insurance company acceptable to the Department of General Services, Office of Risk and Insurance Management (DGS, ORIM), or be provided through partial or total self-insurance acceptable to the Department of General Services (DGS).

C. Evidence of insurance shall be in a form and content acceptable to DGS, ORIM.

D. The Contractor shall notify the State within five (5) business days of any cancellation, non-renewal, or material change that affects required insurance coverage.

ARTICLE XI. INSURANCE (Continued)

E. Insurance obtained through commercial carriers shall meet the following requirements:

1. The Certificate of Insurance shall provide the statement: "The Department of Aging, State of California, its officers, agents, employees, and servants are included as additional insureds, with respect to work performed for the State of California under this Agreement." Professional liability coverage is exempt from this requirement.

2. CDA shall be named as the certificate holder and CDA's address must be listed on the certificate.

F. The insurance provided herein shall be in effect at all times during the term of this Agreement. In the event the insurance coverage expires during the term of this Agreement, the Contractor agrees to provide CDA, at least thirty (30) days prior to the expiration date, a new Certificate of Insurance evidencing insurance coverage as provided herein for a period not less than the remaining Agreement term or for a period not less than one (1) year. In the event the Contractor fails to keep in effect at all times said insurance coverage, CDA may, in addition to any other remedies it may have, terminate this Agreement.

G. The Contractor shall require its subcontractors under this Agreement, other than units of local government which are similarly self-insured, to maintain adequate insurance coverage for general liability, Worker's Compensation liabilities, and if appropriate, auto liability including non-owned auto and professional liability, and further, the Contractor shall require all of its subcontractors to hold the Contractor harmless. The Subcontractor's Certificate of Insurance for general and auto liability shall also name the Contractor, not the State, as the certificate holder and additional insured. The Contractor shall maintain Certificates of Insurance for all of its subcontractors.

H. A copy of each appropriate Certificate of Insurance or letter of self-insurance, referencing this Agreement number shall be submitted to CDA with this Agreement.

I. The Contractor shall be insured against liability for Worker's Compensation or undertake self-insurance in accordance with the provisions of the Labor Code and the Contractor affirms to comply with such provisions before commencing the performance of the work under this Agreement. [Labor Code § 3700]

ARTICLE XII. TERMINATION

A. Termination Without Cause

CDA may terminate performance of work under this Agreement, in whole or in part, without cause, if CDA determines that a termination is in the State's best interest. CDA may terminate the Agreement upon ninety (90) days written notice to the Contractor. The Notice of Termination shall specify the extent of the termination and shall be effective ninety (90) days from the delivery of the Notice. The parties agree that if the termination of the Contract is due to a reduction or deletion of funding by the Department of Finance (DOF), Legislature or Congress, the Notice of Termination shall be effective thirty (30) days from the delivery of the Notice. The Contractor shall submit to CDA a Transition Plan as specified in Exhibit E of this Agreement. The parties agree that for the terminated portion of the Agreement, the remainder of Agreement shall be deemed to remain in effect and is not void.

B. Termination for Cause

CDA may terminate, in whole or in part, for cause the performance of work under this Agreement. CDA may terminate the Agreement upon thirty (30) days written notice to the Contractor. The Notice of Termination shall be effective thirty (30) days from the delivery of the Notice of Termination unless the grounds for termination are due to threat to life, health, or safety of the public and in that case, the termination shall take effect immediately. The Contractor shall submit to CDA a Transition Plan as specified in Exhibit E of this Agreement. The grounds for termination for cause shall include, but are not limited to, the following:

1. In case of threat of life, health, or safety of the public, termination of the Agreement shall be effective immediately.

2. A violation of the law or failure to comply with any condition of this Agreement.

3. Inadequate performance or failure to make progress so as to endanger performance of this Agreement.

4. Failure to comply with reporting requirements.

5. Evidence that the Contractor is in an unsatisfactory financial condition as determined by an audit of the Contractor or evidence of a financial condition that endangers performance of this Agreement and/or the loss of other funding sources.

6. Delinquency in payment of taxes or payment of costs for performance of this Agreement in the ordinary course of business.

ARTICLE XII. TERMINATION (Continued)

7. Appointment of a trustee, receiver, or liquidator for all or a substantial part of the Contractor's property, or institution of bankruptcy, reorganization, or the arrangement of liquidation proceedings by or against the Contractor.

8. Service of any writ of attachment, levy of execution, or commencement of garnishment proceedings against the Contractor's assets or income.

9. The commission of an act of bankruptcy.

10. Finding of debarment or suspension. [Article II J]

11. The Contractor's organizational structure has materially changed.

12. CDA determines that the Contractor may be considered a "high risk" agency as described in 2 CFR 200.205 and 45 CFR 75.205. If such a determination is made, the Contractor may be subject to special conditions or restrictions.

C. Contractor's Obligation After Notice of Termination

After receipt of a Notice of Termination, and except as directed by CDA, the Contractor shall immediately proceed with the following obligations, as applicable, regardless of any delay in determining or adjusting any funds due under this clause.

The Contractor shall:

1. Stop work as specified in the Notice of Termination.

2. Place no further subcontracts for materials or services, except as necessary, to complete the continued portion of the Contract.

3. Terminate all subcontracts to the extent they relate to the work terminated.

4. Settle all outstanding liabilities and termination settlement proposals arising from the termination of subcontracts, (the approval or ratification of which will be final for purposes of this clause).

D. Effective Date

Termination of this Agreement shall take effect immediately in the case of an emergency such as threat to life, health, or safety of the public. The effective date for Termination with Cause or for funding reductions is thirty (30) days and Termination without Cause is ninety (90) days subsequent to written notice to the Contractor. The notice shall describe the action being taken by CDA, the reason

ARTICLE XII. TERMINATION (Continued)

for such action and, any conditions of the termination, including the date of termination.

E. Voluntary Termination of Area Plan Agreement (Title III Only)

Pursuant to 22 CCR 7210, the Contractor may voluntarily terminate its contract prior to its expiration either by mutual agreement with CDA or upon thirty (30) days written notice to CDA. In case of voluntary termination, the Contractor shall allow CDA up to one hundred eighty (180) days to transition services. The Contractor shall submit a Transition Plan in accordance with Exhibit E of this Agreement.

F. Notice of Intent to Terminate by Contractor (All other non-Title III Programs)

In the event the Contractor no longer intends to provide services under this Agreement, the Contractor shall give CDA Notice of Intent to Terminate. Such notice shall be given in writing to CDA at least one hundred eighty (180) days prior to the proposed termination date. Unless mutually agreed upon, the Contractor does not have the authority to terminate the Agreement. The Notice of Intent to Terminate shall include the reason for such action and the anticipated last day of work. The Contractor shall submit a Transition Plan in accordance with Exhibit E.

G. In the Event of a Termination Notice

CDA will present written notice to the Contractor of any condition, such as, but not limited to, transfer of Waiver Participants, care of Waiver Participants, return of unspent funds; and disposition of property, which must be met prior to termination.

ARTICLE XIII. REMEDIES

The Contractor agrees that any remedy provided in this Agreement is in addition to and not in derogation of any other legal or equitable remedy available to CDA as a result of breach of this Agreement by the Contractor, whether such breach occurs before or after completion of the project.

ARTICLE XIV. DISSOLUTION OF ENTITY

The Contractor shall notify CDA immediately of any intention to discontinue existence of the entity or to bring an action for dissolution.

ARTICLE XV. AMENDMENTS, REVISIONS OR MODIFICATIONS

A. No amendment or variation of the terms of this Agreement shall be valid unless made in writing, signed and approved through the State amendment process in accordance with the State Contract Manual. No oral understanding or agreement not incorporated in this Agreement is binding on any of the parties.

B. The State reserves the right to revise, waive, or modify the Agreement to reflect any restrictions, limitations, or conditions enacted by Congress or the Legislature or as directed by the Executive Branch of State government.

ARTICLE XVI. NOTICES

A. Any notice to be given hereunder by either party to the other may be effected by personal delivery in writing or by registered or certified mail, overnight mail, postage prepaid, return receipt requested, provided the Contractor retains receipt, and shall be communicated as of actual receipt.

B. The Contractor must notify CDA of any change of legal name, main address, or name of the Director. This notice shall be addressed to the MSSP Branch Manager on the Contractor's letterhead.

1. The Contractor must notify CDA within thirty-five (35) days of relocation.
2. In addition, any change of address or name also requires an Agency Contract Representative form to be submitted to Business Management Branch as stated in Exhibit D, Article XVII.

C. All other notices with the exception of those identified in Section B of this Article shall be addressed to the California Department of Aging, Multipurpose Senior Services Program Branch, 2880 Gateway Oaks, Suite 200, Sacramento, California, 95833. Notices mailed to the Contractor shall be to the address indicated on the coversheet of this Agreement.

D. Either party may change its address by written notice to the other party in accordance with this Article.

ARTICLE XVII. DEPARTMENT CONTACT

A. The name of CDA's contact to request revisions, waivers, or modifications affecting this Agreement, will be provided by the State to the Contractor upon full execution of this Agreement.

B. The Contractor shall, upon request from CDA, submit the name of its Agency Contract Representative (ACR) for this Agreement by submitting an Agency Contract Representative form to CDA's Business Management Branch (BMB). This form requires the ACR's address, phone number, email address, and FAX number to be included on this form. For any change in this information, the

ARTICLE XVII. DEPARTMENT CONTACT (Continued)

Contractor shall submit an amended Agency Contract Representative form to the same address. This form may be requested from CDA's BMB.

ARTICLE XVIII. INFORMATION INTEGRITY, AND SECURITY

A. Information Assets

The Contractor, and its Subcontractors/Vendors, shall have in place operational policies, procedures, and practices to protect State information assets, including those assets used to store or access Personal Health Information (PHI), Personal Information (PI) and any information protected under the Health Insurance Portability and Accountability Act (HIPAA), (i.e., public, confidential, sensitive and/or personal identifying information) as specified in the State Administrative Manual, 5300 to 5365.3; Cal. Gov.
Code § 11019.9, DGS Management Memo 06-12; DOF Budget Letter 06-34; and CDA Program Memorandum 07-18 Protection of Information Assets and the Statewide Health Information Policy Manual.

Information assets may be in hard copy or electronic format and may include but is not limited to:

1. Reports
2. Notes
3. Forms
4. Computers, laptops, cellphones, printers, scanners
5. Networks (LAN, WAN, WIFI) servers, switches, routers
6. Storage media, hard drives, flash drives, cloud storage
7. Data, applications, databases

B. Encryption of Computing Devices

The Contractor, and its Subcontractors/Vendors, are required to use 128-Bit encryption for data collected under this Agreement that is confidential, sensitive, and/or personal information including data stored on all computing devices (including but not limited to, workstations, servers, laptops, personal digital assistants, notebook computers and backup media) and/or portable electronic storage media (including but not limited to, discs, thumb/flash drives, portable hard drives, and backup media).

ARTICLE XVIII. INFORMATION INTEGRITY, AND SECURITY (Continued)

C. Disclosure

1. The Contractor, and its Subcontractors/Vendors, shall ensure that all confidential, sensitive and/or personal identifying information is protected from inappropriate or unauthorized access or disclosure in accordance with applicable laws, regulations, and State policies.

2. The Contractor, and its Subcontractors/Vendors, shall protect from unauthorized disclosure, confidential, sensitive and/or personal identifying information such as names and other identifying information concerning persons receiving services pursuant to this Agreement, except for statistical information not identifying any participant.

3. "Personal Identifying information" shall include, but not be limited to: name; identifying number; social security number; state driver's license or state identification number; financial account numbers; and symbol or other identifying characteristic assigned to the individual, such as finger or voice print or a photograph.

4. The Contractor, and its Subcontractors/Vendors, shall not use confidential, sensitive and/or personal identifying information above for any purpose other than carrying out the Contractor's obligations under this Agreement. The Contractor and its Subcontractors are authorized to disclose and access identifying information for this purpose as required by OAA.

5. The Contractor and its Subcontractors/Vendors, shall not, except as otherwise specifically authorized or required by this Agreement or court order, disclose any identifying information obtained under the terms of this Agreement to anyone other than CDA without prior written authorization from CDA. The Contractor may be authorized, in writing, by a participant to disclose identifying information specific to the authorizing participant.

6. The Contractor, and its Subcontractors/Vendors, may allow a participant to authorize the release of information to specific entities, but shall not request or encourage any participant to give a blanket authorization or sign a blank release, nor shall the Contractor accept such blanket authorization from any participant.

D. Security Awareness Training

1. The Contractor's employees, Subcontractors/Vendors, and volunteers handling confidential, sensitive and/or personal identifying information must complete the required CDA Security Awareness Training module within thirty (30) days of the start date of the Contract/Agreement, within thirty (30) days of the start date of any new employee, Subcontractor, Vendor or volunteer's employment and annually thereafter.

ARTICLE XVIII. INFORMATION INTEGRITY, AND SECURITY (Continued)

2. The Contractor must maintain certificates of completion on file and provide them to CDA upon request.

E. Health Insurance Portability and Accountability Act (HIPAA)

The Contractor agrees to comply with the privacy and security requirements of HIPAA and ensure that Subcontractors/Vendors comply with the privacy and security requirements of HIPAA.

F. Information Integrity and Security Statement

The Contractor shall sign and return an Information Integrity and Security Statement (CDA 1024) form with this Agreement. This is to ensure that the Contractor is aware of, and agrees to comply with, their obligations to protect CDA information assets from unauthorized access and disclosure.

G. Security Incident Reporting

A security incident occurs when CDA information assets are or reasonably believed to have been accessed, modified, destroyed, or disclosed without proper authorization, or are lost or stolen. The Contractor, and its Subcontractors/Vendors, must comply with CDA's security incident reporting procedure.

H. Security Breach Notifications

Notice must be given by the Contractor, and/or its Subcontractors/Vendors to anyone whose confidential, sensitive and/or personal identifying information could have been breached in accordance with HIPAA, the Information Practices Act of 1977, and State policy.

I. Software Maintenance

The Contractor, and its Subcontractors/Vendors, shall apply security patches and upgrades in a timely manner and keep virus software up to date on all systems on which State data may be stored or accessed.

J. Electronic Backups

The Contractor, and its Subcontractors/Vendors, shall ensure that all electronic information is protected by performing regular backups of files and databases and ensure the availability of information assets for continued business. The Contractor, and its Subcontractors/Vendors, shall ensure that all data, files and backup files are encrypted.

ARTICLE XVIII. INFORMATION INTEGRITY, AND SECURITY (Continued)

K. Provisions of this Article

The provisions contained in this Article shall be included in all contracts of both the Contractor and its Subcontractors/Vendors.

ARTICLE XIX. COPYRIGHTS AND RIGHTS IN DATA

A. Copyrights

1. If any material funded by this Agreement is subject to copyright, the State reserves the right to copyright such material and the Contractor agrees not to copyright such material, except as set forth in Section B of this Article.

2. The Contractor may request permission to copyright material by writing to the Director of CDA. The Director shall grant permission or give reason for denying permission to the Contractor in writing within sixty (60) days of receipt of the request.

3. If the material is copyrighted with the consent of CDA, the State reserves a royalty-free, non-exclusive, and irrevocable license to reproduce, prepare derivative works, publish, distribute and use such materials, in whole or in part, and to authorize others to do so, provided written credit is given to the author.

4. The Contractor certifies that it has appropriate systems and controls in place to ensure that State funds will not be used in the performance of this contract for the acquisition, operation, or maintenance of computer software in violation of copyright laws.

B. Rights in Data

1. The Contractor shall not publish or transfer any materials, as defined in paragraph 2 below, produced or resulting from activities supported by this Agreement without the express written consent of the Director of CDA. That consent shall be given, or the reasons for denial shall be given, and any conditions under which it is given or denied, within thirty (30) days after the written request is received by CDA. CDA may request a copy of the material for review prior to approval of the request. This subsection is not intended to prohibit the Contractor from sharing identifying Waiver Participant information authorized by the participant or summary program information which is not Waiver Participant specific.

ARTICLE XIX. COPYRIGHTS AND RIGHTS IN DATA (Continued)

2. As used in this Agreement, the term "subject data" means writings, sound recordings, pictorial reproductions, drawings, designs or graphic representations, procedural manuals, forms, diagrams, workflow charts, equipment descriptions, data files and data processing or computer programs, and works of any similar nature (whether or not copyrighted or copyrightable) which are first produced or developed under this Agreement. The term does not include financial reports, cost analyses and similar information incidental to contract administration.

3. Subject only to other provisions of this Agreement, the State may use, duplicate, or disclose in any manner, and have or permit others to do so subject to State and federal law, all subject data delivered under this Agreement.

ARTICLE XX. BILINGUAL AND LINGUISTIC PROGRAM SERVICES

A. Needs Assessment

1. The Contractor shall conduct a cultural and linguistic group-needs assessment of the eligible Waiver Participant population in the Contractor's service area to assess the language needs of the population and determine what reasonable steps are necessary to ensure meaningful access to services and activities to eligible individuals. [22 CCR 98310, 98314]

   The group-needs assessment shall take into account the following four (4) factors:

   a. Number or proportion of persons with Limited English Proficiency (LEP) eligible to be served or encountered by the program.

   b. Frequency with which LEP individuals come in contact with the program.

   c. Nature and importance of the services provided.

   d. Local or frequently used resources available to the Contractor.

   This group-needs assessment will serve as the basis for the Contractor's determination of "reasonable steps" and provide documentary evidence of compliance with Cal. Gov. Code § 11135 et seq.; 2 CCR 11140, 2 CCR 11200 et seq., and 22 CCR98300 et seq.

2. The Contractor shall prepare and make available a report of the findings of the group-needs assessment that summarizes:

ARTICLE XX. BILINGUAL AND LINGUISTIC PROGRAM SERVICES (Continued)

a. Methodologies used.

b. The linguistic and cultural needs of non-English speaking or LEP groups.

c. Services proposed to address the needs identified and a timeline for implementation. [22 CCR 98310]

3. The Contractor shall maintain a record of the group-needs assessment on file at the Contractor's headquarters at all times during the term of this Agreement. [22 CCR 98310, 98313]

B. Provision of Services

1. The Contractor shall take reasonable steps, based upon the group-needs assessment identified in Section A of this Article, to ensure that "alternative communication services" are available to non-English speaking or LEP beneficiaries of services under this Agreement. [22 CCR 11162]

2. "Alternative communication services" include, but are not limited to, the provision of services and programs by means of the following:

a. Interpreters or bilingual providers and provider staff.

b. Contracts with interpreter services.

c. Use of telephone interpreter lines.

d. Sharing of language assistance materials and services with other providers.

e. Translated written information materials, including but not limited to, enrollment information and descriptions of available services and programs.

f. Referral to culturally and linguistically appropriate community service programs.

3. Based upon the findings of the group-needs assessment, the Contractor shall ensure that reasonable alternative communication services are available to meet the linguistic needs of identified eligible Waiver Participant population groups at key points of contact. Key points of contact include, but are not limited to, telephone contacts, office visits and in-home visits. [22 CCR 11162]

ARTICLE XX. BILINGUAL AND LINGUISTIC PROGRAM SERVICES (Continued)

The Contractor shall self-certify to compliance with the requirements of this section and shall maintain the self-certification record on file at the Contractor's office at all times during the term of this Agreement. [22 CCR 98310]

4. The Contractor shall notify its employees of Waiver Participants' rights regarding language access and the Contractor's obligation to ensure access to alternative communication services where determined appropriate based upon the needs assessment conducted by the Contractor. [22 CCR 98324]

5. Noncompliance with this section may result in suspension or termination of funds and/or termination of this Agreement. [22 CCR 98370]

C. Compliance Monitoring

1. The Contractor shall develop and implement policies and procedures for assessing and monitoring the performance of individuals and entities that provide alternative communication services to non-English and LEP Waiver Participants. [22 CCR 98310]

2. The Contractor shall monitor, evaluate, and take effective action to address any needed improvement in the delivery of culturally and linguistically appropriate services. [22 CCR 98310]

3. The Contractor shall permit timely access to all records of compliance with this section. Failure to provide access to such records may result in appropriate sanctions. [22 CCR 98314]

D. Notice to Eligible Beneficiaries of Contracted Services

1. The Contractor shall designate an employee to whom initial complaints or inquiries regarding national origin can be directed. [22 CCR 98325]

2. The Contractor shall make available to ultimate beneficiaries of contracted services and programs information regarding CDA's procedure for filing a complaint and other information reg13arding the provisions of Cal. Gov. Code § 11135 et seq. [22 CCR 98326]

3. The Contractor shall notify CDA immediately of a complaint alleging discrimination based upon a violation of State or federal law. [2 CCR 11162, 22 CCR 98310, 98340]

ARTICLE I. SUBCONTRACTING PROVISIONS SPECIFIC TO THIS MSSP AGREEMENT

A. The Contractor shall ensure that all subcontractors of Waiver Services complete a CDA-approved Vendor Application.

B. The Contractor shall ensure that the subcontractor's selection process is based upon equitable criteria that provides for adequate publicity, screens out unqualified subcontractors who would not be able to provide the needed services and provide for awards to the lowest responsible and responsive bidder(s) as defined in California State Contracting Manuals.

C. Subcontracts for Purchased Waiver Services shall consist of standard format language consistent with this Agreement.

D. Subcontracts shall require all subcontractors to report immediately in writing to the Contractor any incidents of fraud or abuse to Waiver Participants, in the delivery of services, in subcontractors' operations.

E. The Contractor shall require all subcontracts to comply with the Health Insurance Portability and Accountability Act (HIPAA) Business Associate requirements in Exhibit F, as it appropriately relates to services rendered.

F. The Contractor shall make timely payments to its subcontractors under this agreement.

ARTICLE II. RECORDS PROVISIONS SPECIFIC TO THIS MSSP AGREEMENT

Waiver Participant records are to be kept as long as the case is open and active. Following case termination, Waiver Participant records will be maintained for a period of seven (7) years following case closure, or for a longer period if deemed necessary by CDA. A longer period of retention may be established by individual sites.

ARTICLE III. PROPERTY PROVISIONS SPECIFIC TO THIS MSSP AGREEMENT

A physical inventory of the property must be taken, and the results reconciled with the property records at least once every two (2) years.

ARTICLE IV. AUDIT REQUIREMENT PROVISIONS SPECIFIC TO THIS MSSP AGREEMENT

A. Unless prohibited by law, the cost of audits completed in accordance with provisions of Single Audit Act Amendments of 1996, are allowable charges to Federal Awards. The costs may be considered a direct cost, or an allocated indirect cost, as determined in accordance with provisions of applicable OMB cost principal circulars.

B. The Contractor may not charge to federal awards the cost of any audit under the Single Audit Act Amendments of 1996 not conducted in accordance with the Act.

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ARTICLE IV. AUDIT REQUIREMENT PROVISIONS SPECIFIC TO THIS MSSP AGREEMENT (Continued)

C. CDA and DHCS shall have access to all audit reports of Contractors and have the option to perform audits and/or additional work, as needed.

D. All audits shall be performed in accordance with and address all issues contained in any federal OMB Compliance Supplement that applies to this program.

E. The Contractor shall include in its contract with an independent auditor a clause permitting access by the State to the work papers of the independent auditor.

F. Audits to be performed shall be, minimally, financial and compliance audits, and may include economy and efficiency and/or program results audits.

G. The Contractor shall cooperate with, and participate in, any further audits which may be required by DHCS.

H. The Contractor agrees that CDA, DHCS, the Department of General Services, the California State Auditor, or their designated representative shall, at all times, have the right to review and to copy any records and supporting documentation pertaining to the performance of this Agreement. Contractor agrees to maintain such records for possible audit for a minimum of three (3) years after final payment unless a longer period of records retention is required and until after CDA's Audits and Risk Management Branch has completed an audit. The Contractor agrees to provide CDA or its delegate with any relevant information requested and shall permit the awarding agency or its delegate access to its premises, upon reasonable notice, during normal business hours for the purpose of interviewing employees and inspecting and copying such books, records, accounts, and other material that may be relevant to a matter under investigation for the purpose of determining compliance with Government Code, Section 8546.7 et seq. Further, the Contractor agrees to include a similar right of CDA and DHCS to audit records and interview staff in any subcontract related to performance of this Agreement. [Cal. Gov. Code § 8546.7, Cal. Pub. Con. Code 10115 et seq.], [CCR Title 2, Section 1896]

I. The Catalog of Federal Domestic Assistance Number is 93.778, Grantor Medical Assistance Program.

ARTICLE V. TERMINATION OBLIGATIONS SPECIFIC TO THIS MSSP AGREEMENT

A. After the California Department of Aging's (CDA) Notice of Termination or the Contractor's Notice of Intent to Terminate (pursuant to Exhibit D, Article XII of this Agreement) and except as directed by CDA, the Contractor shall immediately proceed with the following obligations, as applicable, regardless of any delay in determining or adjusting any funds due under this clause.

ARTICLE V. TERMINATION OBLIGATIONS SPECIFIC TO THIS MSSP AGREEMENT (Continued)

The Contractor shall:

1. Take immediate steps to ensure the health and safety of Waiver Participants in MSSP managed by the Contractor. Contractor agrees to refer MSSP Waiver Participants to other local resources.

2. Maintain staff to provide services to Waiver Participants during the course of Waiver Participant transition.

3. Deliver updated Waiver Participant records to the subsequent MSSP contractor or as directed by CDA.

4. With assistance from CDA, develop a written Transition Plan, to locate alternative services for each Waiver Participant through another MSSP site or community agency in accordance with this Agreement.

5. Be responsible for providing all necessary Waiver Participant services until termination or expiration of the Contract and shall remain liable for the processing and payment of invoices and statements for covered services provided to Waiver Participants prior to such expiration or termination.

6. Submit a full accounting and closeout of the Contractor's existing budget.

7. Place no further subcontracts/vendor agreements for materials, or services, except as necessary to complete the continued portion of the Contract.

8. Settle all outstanding liabilities and termination settlement proposals arising from the termination of subcontracts/vendor agreements (the approval or ratification of which will be final for purposes of this clause).

9. Submit a Transition Plan as specified in Article VII of this Exhibit.

ARTICLE VI. INFORMATION INTEGRITY AND SECURITY PROVISIONS SPECIFIC TO THIS MSSP AGREEMENT

A. Contractor acknowledges that it has been provided a copy of the Health Insurance Portability and Accountability Act (HIPAA) Business Associate Agreement between CDA and DHCS ("Exhibit F"). Contractor and its Subcontractors/Vendors, agrees that it must meet the requirements imposed on CDA, and all applicable provisions of HIPAA, the HITECH Act, the HIPAA regulations, and the Final Omnibus Rule, including the requirement to implement reasonable and appropriate administrative, physical, and technical safeguards to protect PHI and PI.

ARTICLE VI. INFORMATION INTEGRITY AND SECURITY PROVISIONS SPECIFIC TO THIS MSSP AGREEMENT (Continued)

B. Contractor, and its Subcontractors/Vendors, agrees that any security incidents or breaches of unsecured PHI or PI will be immediately reported to DHCS in the manner described in Exhibit F.

ARTICLE VII. TRANSITION PLANS SPECIFIC TO THIS MSSP AGREEMENT

A. The Contractor shall submit a transition plan to CDA within fifteen (15) days of delivery of the written Notice to Terminate the Contract (pursuant to Exhibit D, Article XII of this Agreement). The Transition Plan must be approved by CDA and shall, at a minimum, include the following:

1. A current Waiver Participant count and identifying Waiver Participant information upon request.

2. A description of how Waiver Participants will be notified about the change in their MSSP provider.

3. A plan to communicate with other MSSP sites, local agencies and advocacy organizations that can assist in locating alternative services for MSSP Waiver Participants.

4. A plan to inform community referral sources of the pending termination of this MSSP contract and what alternatives, if any, exist for future referrals.

5. A plan to evaluate the health and safety of Waiver Participants in order to assure appropriate placement.

6. A plan to transfer confidential Waiver Participant records to a new contractor or care management agency.

7. A plan to maintain adequate staff to provide continued care to MSSP Waiver Participants through the term of the Contract.

8. A full inventory and plan to dispose or, transfer, or return to CDA all property purchased during the entire operation of the Contract.

9. Additional information as necessary to affect a safe transition of Waiver Participants to other MSSP or community care management programs.

B. The Contractor shall implement the Transition Plan as approved by CDA. CDA will monitor the Contractor’s progress in carrying out all elements of the Transition Plan.

ARTICLE VII. TRANSITION PLANS SPECIFIC TO THIS MSSP AGREEMENT (Continued)

C. If the Contractor fails to provide and implement a transition plan as required by Section A of this Article, the Contractor agrees to implement a transition plan submitted by CDA to the Contractor following the Contractor's Notice of Termination.

D. Phase-out Requirements for this Agreement:

1. Consist of the processing, payment, and monetary reconciliation necessary to pay claims for Waiver Services.

2. Consist of the resolution of all financial and reporting obligations of the Contractor. The Contractor shall remain liable for the processing and payment of invoices and other claims for payment for Waived Services and other services provided to Waiver Participants pursuant to this Contract prior to the expiration or termination. The Contractor shall submit to CDA all reports required.

3. Require all data and information provided by the Contractor to CDA be accompanied by a letter, signed by the responsible authority, certifying, under penalty of perjury, to the accuracy and completeness of the materials supplied.

ARTICLE VIII. REPORTING REQUIREMENTS SPECIFIC TO THIS MSSP AGREEMENT

A. The Contractor shall submit written reports, on a format prescribed by the State, to the State, as follows:

1. Quarterly Status Reports

a. Reports are due no later than the 30th of the month, following the close of the quarter unless otherwise specified by CDA.

b. Reports are a snapshot of each quarter and shall include an overview of significant developments during the report period, identified problems, and solutions. The report narrative should be concise and informative. The subject areas to be addressed are:

- Care Management Staffing – Including the Full Time Equivalent (FTEs) for each position and staffing ratio. Also including staff exemptions and self-certification of staff meeting program requirements

- Care Management Activity – Including staff turnover, training, quality assurance, Waiver Participant grievances and Fair Hearings, Critical Incident reporting, internal/external program reviews and corrective action plans, Waiver Participant satisfaction surveys, policy changes, and contract compliance regarding contracted caseload

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ARTICLE VIII. REPORTING REQUIREMENTS SPECIFIC TO THIS MSSP AGREEMENT (Continued)

- Management Information System – Problems/issues with the Medi-Cal fiscal intermediary billing system and Medi-Cal fiscal intermediary technical support
- Monthly Active Waiver Participant Count
- Staff Roster
- Self-Certified Training
- Wait List – Including the number of potential MSSP Participants waiting for enrollment
- Critical Incident Reporting – Report is used for the entire fiscal year and is submitted quarterly for review by CDA. The report shall include all critical incidents and statuses should be updated in each quarter for any previously listed incidents. The comments section should be concise, but informative to get detail of the incident that occurred with actions or interventions placed with corresponding dates.
- Fiscal Reporting – Expenditure data by budget category and receivables by budget category

2. Ad Hoc Reports

The Contractor shall submit Ad Hoc Reports as may be required from time to time by CDA. Typical subject areas may include, but are not limited to:

a. General site operations
b. Facility and equipment
c. Emergency care
d. Availability of care
e. Waiver Participant satisfaction
f. MIS operations
g. Administrative procedures
h. Database
i. Possible noncompliance with this Agreement
j. Fiscal year closeout

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ARTICLE VIII. REPORTING REQUIREMENTS SPECIFIC TO THIS MSSP AGREEMENT (Continued)

3. Fiscal Closeout Reports

As part of the closeout procedures for this contract, the Contractor shall submit a closeout package which must include the following documents:

a. Final Accounting Reconciliation
b. Closeout Budget
c. Fiscal Summary Report for the State

CDA will transmit specific closeout instructions, including the Closeout Report due dates.

4. Monthly Active Waiver Participant Count

Reports are due on the 5th working day of each month, unless otherwise specified by CDA.

B. The Contractor, at its discretion, may at any time prepare and submit reports and correspondence to CDA summarizing problems and concerns.

Business Associate Addendum

1. This Agreement has been determined to constitute a business associate relationship under the Health Insurance Portability and Accountability Act (HIPAA) and its implementing privacy and security regulations at 45 Code of Federal Regulations, Parts 160 and 164 (collectively, and as used in this Agreement)

2. The term “Agreement” as used in this document refers to and includes both this Business Associate Addendum and the contract to which this Business Associate Agreement is attached as an exhibit, if any.

3. For purposes of this Agreement, the term “Business Associate” shall have the same meaning as set forth in 45 CFR section 160.103.

4. The Department of Health Care Services (DHCS) intends that Business Associate may create, receive, maintain, transmit or aggregate certain information pursuant to the terms of this Agreement, some of which information may constitute Protected Health Information (PHI) and/or confidential information protected by Federal and/or state laws.

4.1 As used in this Agreement and unless otherwise stated, the term “PHI” refers to and includes both “PHI” as defined at 45 CFR section 160.103 and Personal Information (PI) as defined in the Information Practices Act (IPA) at California Civil Code section 1798.3(a). PHI includes information in any form, including paper, oral, and electronic.

4.2 As used in this Agreement, the term “confidential information” refers to information not otherwise defined as PHI in Section 4.1 of this Agreement, but to which state and/or federal privacy and/or security protections apply.

5. Contractor (however named elsewhere in this Agreement) is the Business Associate of DHCS acting on DHCS's behalf and provides services or arranges, performs or assists in the performance of functions or activities on behalf of DHCS, and may create, receive, maintain, transmit, aggregate, use or disclose PHI (collectively, “use or disclose PHI”) in order to fulfill Business Associate’s obligations under this Agreement. DHCS and Business Associate are each a party to this Agreement and are collectively referred to as the "parties.”

6. The terms used in this Agreement, but not otherwise defined, shall have the same meanings as those terms in HIPAA and/or the IPA. Any reference to statutory or regulatory language shall be to such language as in effect or as amended.

7. Permitted Uses and Disclosures of PHI by Business Associate

Except as otherwise indicated in this Agreement, Business Associate may use or disclose PHI, inclusive of de-identified data derived from such PHI, only to perform functions, activities or services specified in this Agreement on behalf of DHCS, provided that such use or disclosure would not violate HIPAA or other applicable laws if done by DHCS.

7.1 Specific Use and Disclosure Provisions

Except as otherwise indicated in this Agreement, Business Associate may use and disclose PHI if necessary for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate. Business Associate may disclose PHI for this purpose if the disclosure is required by law, or the Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will be held confidentially and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person. The person shall notify the Business Associate of any instances of which the person is aware that the confidentiality of the information has been breached, unless such person is a treatment provider not acting as a business associate of Business Associate.

8. Compliance with Other Applicable Law

8.1 To the extent that other state and/or federal laws provide additional, stricter and/or more protective (collectively, more protective) privacy and/or security protections to PHI or other confidential information covered under this Agreement beyond those provided through HIPAA, Business Associate agrees:

8.1.1 To comply with the more protective of the privacy and security standards set forth in applicable state or federal laws to the extent such standards provide a greater degree of protection and security than HIPAA or are otherwise more favorable to the individuals whose information is concerned; and

8.1.2 To treat any violation of such additional and/or more protective standards as a breach or security incident, as appropriate, pursuant to Section 18. of this Agreement.

8.2 Examples of laws that provide additional and/or stricter privacy protections to certain types of PHI and/or confidential information, as defined in Section 4. of this Agreement, include, but are not limited to the Information Practices Act, California Civil Code sections 1798-1798.78, Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, Welfare and Institutions Code section 5328, and California Health and Safety Code section 11845.5.

8.3 If Business Associate is a Qualified Service Organization (QSO) as defined in 42 CFR section 2.11, Business Associate agrees to be bound by and comply with subdivisions (2)(i) and (2)(ii) under the definition of QSO in 42 CFR section 2.11.

9. Additional Responsibilities of Business Associate

9.1 Nondisclosure

9.1.1 Business Associate shall not use or disclose PHI or other confidential information other than as permitted or required by this Agreement or as required by law.

9.2 Safeguards and Security

9.2.1 Business Associate shall use safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of PHI and other confidential data and comply, where applicable, with subpart C of 45 CFR Part 164 with respect to electronic protected health information, to prevent use or disclosure of the information other than as provided for by this Agreement. Such safeguards shall be based on applicable Federal Information Processing Standards (FIPS) Publication 199 protection levels.

9.2.2 Business Associate shall, at a minimum, utilize a National Institute of Standards and Technology Special Publication (NIST SP) 800-53 compliant security framework when selecting and implementing its security controls and shall maintain continuous compliance with NIST SP 800-53 as it may be updated from time to time. The current version of NIST SP 800-53, Revision 5, is available online at; updates will be available online through the Computer Security Resource Center website.

9.2.3 Business Associate shall 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 through the Cryptographic Module Validation Program Search, with information about the Cryptographic Module Validation Program under FIPS 140-2. In addition, Business Associate shall maintain, at a minimum, the most current industry standards for transmission and storage of PHI and other confidential information.

9.2.4 Business Associate shall apply security patches and upgrades, and keep virus software up-to-date, on all systems on which PHI and other confidential information may be used.

9.2.5 Business Associate shall ensure that all members of its workforce with access to PHI and/or other confidential information sign a confidentiality statement prior to access to such data. The statement must be renewed annually.

9.2.6 Business Associate shall identify the security official who is responsible for the development and implementation of the policies and procedures required by 45 CFR Part 164, Subpart C.

9.3 Business Associate's Agent

Business Associate shall ensure that any agents, subcontractors, subawardees, vendors or others (collectively, "agents") that use or disclose PHI and/or confidential information on behalf of Business Associate agree to the same restrictions and conditions that apply to Business Associate with respect to such PHI and/or confidential information.

10. Mitigation of Harmful Effects

Business Associate shall mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI and other confidential information in violation of the requirements of this Agreement.

11. Access to PHI

Business Associate shall make PHI available in accordance with 45 CFR section 164.524.

12. Amendment of PHI

Business Associate shall make PHI available for amendment and incorporate any amendments to protected health information in accordance with 45 CFR section 164.526.

13. Accounting for Disclosures

Business Associate shall make available the information required to provide an accounting of disclosures in accordance with 45 CFR section 164.528.

14. Compliance with DHCS Obligations

To the extent Business Associate is to carry out an obligation of DHCS under 45 CFR Part 164, Subpart E, comply with the requirements of the subpart that apply to DHCS in the performance of such obligation.

15. Access to Practices, Books and Records

Business Associate shall make its internal practices, books, and records relating to the use and disclosure of PHI on behalf of DHCS available to DHCS upon reasonable request, and to the federal Secretary of Health and Human Services for purposes of determining DHCS' compliance with 45 CFR Part 164, Subpart E.

16. Return or Destroy PHI on Termination; Survival

At termination of this Agreement, if feasible, Business Associate shall return or destroy all PHI and other confidential information received from, or created or received by Business Associate on behalf of, DHCS that Business Associate still maintains in any form and retain no copies of such information. If return or destruction is not feasible, Business Associate shall notify DHCS of the conditions that make the return or destruction infeasible, and DHCS and Business Associate shall determine the terms and conditions under which Business Associate may retain the PHI. If such return or destruction is not feasible, Business Associate shall extend the protections of this Agreement to the information and limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

17. Special Provision for SSA Data

If Business Associate receives data from or on behalf of DHCS that was verified by or provided by the Social Security Administration (SSA data) and is subject to an agreement between DHCS and SSA, Business Associate shall provide, upon request by DHCS, a list of all employees and agents and employees who have access to such data, including employees and agents of its agents, to DHCS.

18. Breaches and Security Incidents

Business Associate shall implement reasonable systems for the discovery and prompt reporting of any breach or security incident, and take the following steps:

18.1 Notice to DHCS

18.1.1 Business Associate shall notify DHCS immediately upon the discovery of a suspected breach or security incident that involves SSA data. This notification will be provided by email upon discovery of the breach. If Business Associate is unable to provide notification by email, then Business Associate shall provide notice by telephone to DHCS.

18.1.2 Business Associate shall notify DHCS within 24 hours by email (or by telephone if Business Associate is unable to email DHCS) of the discovery of 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 shall be provided to the DHCS Program Contract Manager (as applicable), the DHCS Privacy Office, and the DHCS Information Security Office (collectively, "DHCS Contacts") using the DHCS Contact Information in Section 18.6.

Notice shall be made using the current DHCS "Privacy Incident Reporting Form" ("PIR Form"; the initial notice of a security incident or breach that is submitted is referred to as an "Initial PIR Form") and shall include all information known at the time the incident is reported. The form is available online at the DHCS Data Privacy webpage.

Upon discovery of a breach or suspected security incident, intrusion or unauthorized access, use or disclosure of PHI, Business Associate shall take:

18.1.3.1 Prompt action to mitigate any risks or damages involved with the security incident or breach; and

18.1.3.2 Any action pertaining to such unauthorized disclosure required by applicable Federal and State law.

18.2 Investigation

Business Associate shall immediately investigate such security incident or breach.

18.3 Complete Report

To provide a complete report of the investigation to the DHCS contacts within ten (10) working days of the discovery of the security incident or breach. This “Final PIR” must include any applicable additional information not included in the Initial Form. The Final PIR Form shall include an assessment of all known factors relevant to a determination of whether a breach occurred under HIPAA and other applicable federal and state laws. The report shall also include a full, detailed corrective action plan, including its implementation date and information on mitigation measures taken to halt and/or contain the improper use or disclosure. If DHCS requests information in addition to that requested through the PIR form, Business Associate shall make reasonable efforts to provide DHCS with such information. A “Supplemental PIR” may be used to submit revised or additional information after the Final PIR is submitted. DHCS will review and approve or disapprove Business Associate’s determination of whether a breach occurred, whether the security incident or breach is reportable to the appropriate entities, if individual notifications are required, and Business Associate’s corrective action plan.

18.3.1 If Business Associate does not complete a Final PIR within the ten (10) working day timeframe, Business Associate shall request approval from DHCS within the ten (10) working day timeframe of a new submission timeframe for the Final PIR.

18.4 Notification of Individuals

If the cause of a breach is attributable to Business Associate or its agents, other than when attributable to a treatment provider that is not acting as a business associate of Business Associate, Business Associate shall notify individuals accordingly and shall pay all costs of such notifications, as well as all costs associated with the breach. The notifications shall comply with applicable federal and state law. DHCS shall approve the time, manner and content of any such notifications and their review and approval must be obtained before the notifications are made.

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 shall initiate contact as indicated here. DHCS reserves the right to make changes to the contact information below by giving written notice to Business Associate. These changes shall not require an amendment to this Agreement.

18.6.1 DHCS Program Contract Manager

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.

18.6.2 DHCS Privacy Office

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

18.6.3 DHCS Information Security Office

Information Security Office
DHCS Information Security Office
P.O. Box 997413, MS 6400
Sacramento, CA 95899-7413

Email: incidents@dhcs.ca.gov

19. Responsibility of DHCS

DHCS agrees to not request the Business Associate to use or disclose PHI in any manner that would not be permissible under HIPAA and/or other applicable federal and/or state law.

20. Audits, Inspection and Enforcement

20.1 From time to time, DHCS may inspect the facilities, systems, books and records of Business Associate to monitor compliance with this Agreement. Business Associate shall promptly remedy any violation of this Agreement and shall certify the same to the DHCS Privacy Officer in writing. Whether or how DHCS exercises this provision shall not in any respect relieve Business Associate of its responsibility to comply with this Agreement.

20.2 If Business Associate is the subject of an audit, compliance review, investigation or any proceeding that is related to the performance of its obligations pursuant to this Agreement, or is the subject of any judicial or administrative proceeding alleging a violation of HIPAA, Business Associate shall promptly notify DHCS unless it is legally prohibited from doing so.

21. Termination

21.1 Termination for Cause

Upon DHCS' knowledge of a violation of this Agreement by Business Associate, DHCS may in its discretion:

21.1.1 Provide an opportunity for Business Associate to cure the violation and terminate this Agreement if Business Associate does not do so within the time specified by DHCS; or

21.1.2 Terminate this Agreement if Business Associate has violated a material term of this Agreement.

21.2 Judicial or Administrative Proceedings

DHCS may terminate this Agreement if Business Associate is found to have violated HIPAA, or stipulates or consents to any such conclusion, in any judicial or administrative proceeding.

22. Miscellaneous Provisions

22.1 Disclaimer

DHCS makes no warranty or representation that compliance by Business Associate with this Agreement will satisfy Business Associate's business needs or compliance obligations. Business Associate is solely responsible for all decisions made by Business Associate regarding the safeguarding of PHI and other confidential information.

22.2 Amendment

22.2.1 Any provision of this Agreement which is in conflict with current or future applicable Federal or State laws is hereby amended to conform to the provisions of those laws. Such amendment of this Agreement shall be effective on the effective date of the laws necessitating it, and shall be binding on the parties even though such amendment may not have been reduced to writing and formally agreed upon and executed by the parties.

22.2.2 Failure by Business Associate to take necessary actions required by amendments to this Agreement under Section 22.2.1 shall constitute a material violation of this Agreement.

22.3 Assistance in Litigation or Administrative Proceedings

Business Associate shall make itself and its employees and agents available to DHCS at no cost to DHCS to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against DHCS, its directors, officers and/or employees based upon claimed violation of HIPAA, which involve inactions or actions by the Business Associate.

22.4 No Third-Party Beneficiaries

Nothing in this Agreement is intended to or shall confer, upon any third person any rights or remedies whatsoever.

22.5 Interpretation

The terms and conditions in this Agreement shall be interpreted as broadly as necessary to implement and comply with HIPAA and other applicable laws.

22.6 No Waiver of Obligations

No change, waiver or discharge of any liability or obligation hereunder on any one or more occasions shall be deemed a waiver of performance of any continuing or other obligation, or shall prohibit enforcement of any obligation, on any other occasion.

EXHIBIT A, Attachment 1
General Information

1. The Contractor agrees to provide to the California Department of Aging (CDA) the services described herein Agreement number MS-2223-41.

2. The number of client slots per month shall be 568.

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

4. The services shall be provided as needed.

5. The project representatives during the term of this agreement will be:

State Agency: California Department of Aging	Contractor: ORANGE COUNTY HEALTH AUTHORITY, DBA CALOPTIMA
Name: MSSP Operations Manager	Name: Evelyn Rounds
Section/Unit: MSSP	Section/Unit: Multipurpose Senior Services Program
Address: 2880 Gateway Oaks Dr., Ste 200 Sacramento, CA 95834	Address: 505 City Parkway West Orange, CA 92868
Phone: (916) 419-7561	Phone: (714) 246-8773
Email: MSSPservice@aging.ca.gov	Email: erounds@caloptima.org

Direct all contract document inquiries to:

State Agency: California Department of Aging	Contractor: ORANGE COUNTY HEALTH AUTHORITY, DBA CALOPTIMA
Section/Unit: Procurement & Contract Services Business Management Bureau	Section/Unit: Multipurpose Senior Services Program
Attention: Grace Parker	Attention: Evelyn Rounds, Site Director
Address: 2880 Gateway Oaks Dr., Ste 200 Sacramento, CA 95834	Address: 505 City Parkway West Orange, CA 92868
Phone: (916) 931-1929	Phone: (714) 246-8773
Email: BMBContractAnalyst@aging.ca.gov	Email: erounds@caloptima.org

The parties may change their representatives upon providing ten days written notice to the other party. Said changes do not require an amendment to this agreement.

Site Name	41 - Orange County Health Authority (dba CalOptima)		Funded Slots	568	Date Submitted to CDA-MSSP	2-Mar-22

Fiscal Year 2022-23

A. Care Management

Line #	Position Title	Last Name	Base Salary	Salary Adjustment	FTE	Adjusted Salary
1	Nurse Care Manager	Baylis	$118,025	0.000%	1.000	$118,025
2	Nurse Care Manager	Flinn	$116,174	0.000%	1.000	$116,174
3	Nurse Care Manager	Nguyen V.	$112,270	0.000%	1.000	$112,270
4	Nurse Care Manager	TBH	$93,000	0.000%	1.000	$93,000
5	Nurse Care Manager	TBH	$93,000	0.000%	1.000	$93,000
6	Nurse Care Manager	TBH	$93,000	0.000%	1.000	$93,000
7	Social Work Care Manager	Dinh	$83,065	0.000%	1.000	$83,065
8	Social Work Care Manager	Fierro	$82,798	0.000%	1.000	$82,798
9	Social Work Care Manager	Nguyen F.	$69,288	0.000%	1.000	$69,288
10	Social Work Care Manager	Nguyen Se.	$82,703	0.000%	1.000	$82,703
11	Social Work Care Manager	Osorio	$82,824	0.000%	1.000	$82,824
12	Social Work Care Manager	Pratt	$75,276	0.000%	1.000	$75,276
13	Social Work Care Manager	Rakowski	$81,154	0.000%	1.000	$81,154
14	Social Work Care Manager	Vacant	$82,000	0.000%	1.000	$82,000
15	Social Work Care Manager	Vacant	$82,000	0.000%	1.000	$82,000
16			$0	0.000%	0.000	$0
17			$0	0.000%	0.000	$0
18			$0	0.000%	0.000	$0
19			$0	0.000%	0.000	$0
20			$0	0.000%	0.000	$0
21			$0	0.000%	0.000	$0
22			$0	0.000%	0.000	$0
23			$0	0.000%	0.000	$0
24			$0	0.000%	0.000	$0
25			$0	0.000%	0.000	$0
26					Subtotal Care Management Salaries	$1,346,578
27	Total Care Management (CM) FTE	15.00			Care Management Benefits	$257,870
28	Ratio	37.9				
29	**Total Care Management**			% Budget	53%	**$1,604,448**

B. Care Management Support/Administration

Salaries

Line #	Position Title	Last Name	Base Salary	Salary Adjustment	FTE	Adjusted Salary
30	Accounting Specialist	Hoang A.	$80,619	0.000%	0.750	$60,464
31	Medical Authorization Assistant	Castaneda	$51,467	0.000%	1.000	$51,467
32	Medical Authorization Assistant	Diaz De Leon	$49,251	0.000%	1.000	$49,251
33	Medical Authorization Assistant	Esparza	$50,121	0.000%	1.000	$50,121
34	Medical Authorization Assistant	TBH	$47,000	0.000%	1.000	$47,000
35	Site Director	Rounds	$140,546	0.000%	1.000	$140,546
36	Supervising Care Manager	Rivera	$106,092	0.000%	1.000	$106,092
37	Supervising Care Manager	Young (Bitterman)	$103,564	0.000%	1.000	$103,564
38	Supervising Care Manager	TBH	$103,000	0.000%	1.000	$103,000
39			$0	0.000%	0.000	$0
40			$0	0.000%	0.000	$0
41			$0	0.000%	0.000	$0
42			$0	0.000%	0.000	$0
43			$0	0.000%	0.000	$0
44			$0	0.000%	0.000	$0
45			$0	0.000%	0.000	$0
46			$0	0.000%	0.000	$0
47			$0	0.000%	0.000	$0
48					Subtotal CMS/Administration Salaries	$711,504
49					CMS/Administration Benefits	$136,253
50	Total CMS/Administration FTE	8.75				
51					Total CMS/Administration Salaries	**$847,757**

Operating Costs

52	Consultation, Professional Services			$66,000
53	Facility, Rent & Operations			$0
54	Equipment Cost equal to or greater than $5,000 per Unit (Any Computing Equipment regardless of Cost)			$0
55	Equipment, Maintenance & Rental Costs; Supplies			$40,000
56	Travel (In & Out of State)			$10,000
57	Training without Associated Travel Costs			$2,000
58	Subscriptions, Membership Dues			$6,000
59	Insurance			$0
60	Communication, Postage, Internet			$20,000
61				$0
62				$0
63	Indirect Costs (Indirect Costs/Base) - 15% maximum		2%	$50,516
64	Base = Salaries & Benefits	$2,452,205		
65				$0
66				$0
67			Total CMS/Administration Operating Costs	$194,516
68	**Total CMS/Admin**	% Budget	34%	**$1,042,273**

C. Waived Services

69	**Total Waived Services**	% Budget	13%	**$395,487**

D. Total Budget Amounts

70	**Fiscal Year Total Allocation**		**$3,042,208**

By completing Part I, I understand that this is an electronic signature and by checking the box I certify that all the provided information is believed to be accurate, reliable and complete to the best of my knowledge and ability to confirm it.

Full Name	Title	Date	Check box to indicate agreement with information provided in report.
Evelyn Rounds	Site Director	March 02, 2022	☑

For CDA Use Only.	Approved by:	
	Sarah Hinkson	3/2/2022
	Analyst Signature	Date

Orange County Health Authority, dba CalOptima

Aliso Viejo	92653, 92656, 92698
Anaheim	92801- 92809, 92812, 92814 - 92817, 92825, 92850, 92899
Anaheim Hills	92807, 92808, 92809, 92817
Atwood	92811
Balboa	92661
Balboa Island	92662
Brea	92821, 92822, 92823
Buena Park	90620, 90621, 90622, 90623, 90624
Capistrano Beach	92624
Corona del Mar	92625
Costa Mesa	92626, 92627, 92628
Coto de Caza	92679
Cowan Heights	92705
Cypress	90630
Dana Point	92624, 92629
Dove Canyon	92679
East Lake	92686
East Tustin	92780
El Modena	92869
El Toro	92609, 92610, 92630
Emerald Bay	92718
Foothill Ranch	92610
Fountain Valley	92708, 92728
Fullerton	92831, 92832, 92833, 92834, 92835, 92836, 92837, 92838
Garden Grove	92840, 92841, 92842, 92843, 92844, 92845, 92846
Huntington Beach	92605, 92615, 92646, 92647, 92648, 92649
Irvine	92602 - 92604, 92606, 92612, 92614, 92616, 92618 - 92620, 92623, 92650, 92697, 92709, 92710
Ladera	92692
Ladera Ranch	92694
Laguna Beach	92607, 92637, 92651, 92652, 92653, 92654, 92656, 92677, 92698
Laguna Hills	92637, 92653, 92654, 92656
Laguna Niguel	92607, 92677, 92653, 92654
La Habra	90631, 90632, 90633
La Habra Heights	90631
Lake Forest	92609, 92630
La Plama	90623
Las Flores	92688
Lemon Heights	92705
Lido Isle	92663
Los Alamitos	90720, 90721
Midway City	92655
Mission Viejo	92675, 92690, 92691, 92692, 92694
Modjeska	92676
Monarch Beach	92629

Orange County Health Authority, dba CalOptima

Newport Beach	92657, 92658, 92659, 92660, 92661, 92662, 92663
Newport Center	92660
Newport Coast	92657
Northwood	92629
Olinda	92621
Olive	92665
Orange	92856, 92857, 92859, 92861- 92869
Orange Park Acres	92869
Placentia	92870, 92871
Portola Hills	92679
Rancho Santa Margarita	92688
Red Hill	92705
Rossmoor	90720
San Clemente	92672, 92673, 92674
Santa Ana	92701- 92708, 92711, 92712, 92725, 92728, 92735, 92799
Santa Ana Heights	92707
San Juan Capistrano	92675, 92690, 92691, 92692, 92693, 92694
San Juan Hot Springs	92675
Seal Beach	90740
Silverado	92676
South Laguna	92651
Stanton	90680
Sunset Beach	90742
Surfside	90743
Three Acres Bay	92677
Trabuco Canyon	92678, 92679, 92688
Turtle Rock	92612
Tustin	92780, 92781, 92782
Villa Park	92861, 92867
Westminster	92683, 92684, 92685
Woodbridge	92714
Yorba Linda	92885, 92886, 92887

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 4, 2022
Regular Meeting of the CalOptima Board of Directors

Consent Calendar
10. Approve Action Related to the Student Behavioral Health Incentive Program

Contact
Carmen Katsarov LPCC, CCM, Executive Director, Behavioral Health Integration, (714) 796-6168

Recommended Actions
1. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to execute Memorandums of Understanding (MOUs) and contracts with School Behavioral Health Incentive Program (SBHIP) grantee(s) upon selection and approval by the Department of Health Care Services (DHCS).

Background
The fiscal year 2021–22 enacted state budget includes $4.4 billion dollars to support Children and Youth Behavioral Health Initiative (CYBHI) investments over a five-year period with the aim of improving the behavioral health system for youth (ages 0 to 25).

One component of the CYBHI is the School Behavioral Health Incentive Program (SBHIP) through which DHCS will allocate $400 million dollars of incentive payments to Medi-Cal managed care plans (MCPs) statewide.

The intent of SBHIP is to establish and build infrastructure, partnerships, and capacity for school-based behavioral health services in collaboration with Local Education Agencies (LEAs) and County Mental Health Plans. Please refer to Attachment 1 for additional information that was presented to the Board in December 2021.

Updates

- On March 15, 2022, CalOptima submitted to DHCS the SBHIP partners form with the Orange County Department of Education (OCDE) superintendent, Dr. Al Mijares, identifying the three school districts (Santa Ana Unified, Garden Grove Unified, and Anaheim Unified) that initially confirmed interest in participating in SBHIP.
- CalOptima collaborated with Orange County Health Care Agency (OC HCA) for increased collaboration with Orange County superintendents for SBHIP. CalOptima's Executive Director, Behavioral Health Integration, is now attending the weekly superintendent mental health work group. This increased collaboration effort resulted in 17 school districts confirming interest in participating in SBHIP as of June 2022. *See* Attachment 2.
- CalOptima received 50% of the allotted needs assessment funds in the amount of $217,500 from DHCS on June 14, 2022.

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Discussion
CalOptima is currently working on the DHCS deliverables below with OCDE, LEAs' school superintendents, and OC HCA. The MOU is an important part of the implementation plan for SBHIP. *See* Attachment 3.

DHCS SBHIP Timeline and Deliverables	DHCS Due Date	Status/ Start Date
Board Approval for Letter of Intent (LOI)	12/20/21	Completed
Submit LOI to DHCS	1/31/22	Completed
Partners Form Due to DHCS (Milestone One)	3/15/22	Completed
Medi-Cal MCPs and selected partners conduct assessment	2nd/3rd Quarter 2022	In Progress
Select targeted intervention(s) and submit project plan (Milestone One) to DHCS	12/31/22	August 2022

Once CalOptima collects more data and receives additional guidance from DHCS, staff will return to the Board with a plan for distributing funds to the school districts.

Fiscal Impact
Staff anticipates funding for the new SBHIP program to be sufficient to fully cover expenses associated with the additional behavioral health interventions. CalOptima will monitor utilization and expenses closely to ensure SBHIP funding is sufficient to support this new program.

Rationale for Recommendation
Staff recommends that the Board approve the recommended action so CalOptima can continue to meet all regulatory timelines and DHCS deliverables related to SBHIP. Participation in SBHIP will contribute toward CalOptima's overall goal, in partnership with the OC HCA, of creating a comprehensive and sustainable continuous system of care for all students to access the entire scope of available mental health benefits and services in Orange County.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. December 15, 2021, previous COBAR for approval of LOI with AB 133 (Committee on Budget) Student Behavioral Health Incentive Program Provisions
2. List of participating LEAs
3. SBHIP MOU Template Draft

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Board Action

Board Meeting Dates	Action	Term	Not to Exceed Amount
12/20/2021	Approved	N/A	N/A

/s/ Michael Hunn *07/28/2022*
Authorized Signature **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 20, 2021
Special Meeting of the CalOptima Board of Directors

Consent Calendar
20. Consider Approval of Action Related to the Student Behavioral Health Incentive Program

Contacts
Emily Fonda, MD, MMM, CHCQM, Chief Medical Officer, (714) 246-8887
Natalie Zavala, Interim Director, Behavioral Health Integration, (657) 900-1339

Recommended Action
Authorize the Chief Executive Officer to send a Letter of Intent (LOI) by January 31, 2022, to notify the California Department of Health Care Services (DHCS) of CalOptima's intent to participate in the three -year Student Behavioral Health Incentive Program (SBHIP).

Background/Discussion
The Fiscal Year 2021–22 Enacted State Budget includes $4.4 billion dollars to support Children and Youth Behavioral Health Initiative (CYBHI) investments over a five-year period with the aim to improve the behavioral health system for youth (ages 0 to 25). One component of the CYBHI is the SBHIP, through which DHCS will allocate $400 million dollars of incentive payments to Medi-Cal managed care plans (MCPs) statewide. As defined in Assembly Bill (AB) 133, the intent is to establish and build infrastructure, partnerships and capacity for school-based behavioral health services in collaboration with Local Education Agencies (LEAs) and County Mental Health Plans. Incentive payments are not intended to pay for behavioral health treatment services but rather to increase access to services and the number of children receiving services. The current behavioral health Medi-Cal delivery system already allows for reimbursement of such services.

The State recognizes the behavioral health crisis our youth are facing across the nation. Mental health hospitalizations, suicide rates and overdose deaths have increased in our youth over the past decade. The public health emergency stay-at-home orders and school closures have caused further impact. Youth and adolescents have suffered from isolation and chronic stress which are correlated with higher rates of mental illness and substance use disorders. Schools are considered critical points of access for prevention and early intervention services and provide an opportunity to address disparities. This program aims to address potential gaps in access and increase the number of youth receiving behavioral health services.

In order to participate in the SBHIP, CalOptima is required to notify DHCS of its intent to participate in the program no later than January 31, 2022. As such, staff is seeking authorization for the CEO to submit an LOI to DHCS. The provisions of AB 133 related to the Medi-Cal MCP incentive payments are attached. As additional details from DHCS on participation and implementation become available, staff will provide them to the Board and shall return to the Board for further action as necessary, such as amendment to the State Contract to include the incentive program.

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Fiscal Impact

The recommended action to provide DHCS with a commitment letter has no fiscal impact. Staff anticipates funding for the new SBHIP program will be sufficient to fully cover the expenses associated with the additional behavioral health interventions. CalOptima will monitor utilization and expenses closely to ensure SBHIP funding is sufficient to support this new program.

Rationale for Recommendation

Providing the recommended LOI notifies DHCS of CalOptima's intent to participate in the SBHIP.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. AB 133 (Committee on Budget) Student Behavioral Health Incentive Program Provisions

/s/ Michael Hunn *12/15/2021*
Authorized Signature **Date**

AB 133 (Committee on Budget) Student Behavioral Health Incentive Program Provisions

5961.3.

(a) As a component of the initiative, the State Department of Health Care Services shall make incentive payments to qualifying Medi-Cal managed care plans that meet predefined goals and metrics developed pursuant to subdivision (b) associated with targeted interventions that increase access to preventive, early intervention and behavioral health services by school-affiliated behavioral health providers for K-12 children in schools.

(b) The department, in consultation with the State Department of Education, Medi-Cal managed care plans, county behavioral health departments, local educational agencies, and other affected stakeholders, shall develop the interventions, goals, and metrics used to determine a Medi-Cal managed care plan's eligibility to receive the incentive payments described in this section. Higher incentive payments may be made for activities that increase Medi-Cal reimbursable services provided to children and youth, to reduce health equity gaps, and for services provided to children and youth living in transition, are homeless, or are involved in the child welfare system. Interventions, goals, and metrics include, but are not limited to, the following:

(1) Local planning efforts to review existing plans and documents that articulate children and youth needs in the area; compile data; map existing behavioral health providers and resources; identify gaps, disparities, and inequities; and convene stakeholders and develop a framework for a robust and coordinated system of social, emotional, and behavioral health supports for children and youth.

(2) Providing technical assistance to increase coordination and partnerships between schools and health care plans to build an integrated continuum of behavioral health services using contracts, a memorandum of understanding, or other agreements.

(3) Developing or piloting behavioral health wellness programs to expand greater prevention and early intervention practices in school settings, such as Mental Health First Aid and Social and Emotional Learning.

(4) Expanding the workforce by using community health workers or peers to expand the surveillance and early intervention of behavioral health issues in school-age children 0 to 25 years of age, inclusive.

(5) Increasing telehealth in schools and ensure students have access to technological equipment.

(6) Implementing school-based suicide prevention strategies.

(7) Improving performance and outcomes-based accountability for behavioral health access and quality measures through local student behavioral health dashboards or public reporting.

(8) Increasing access to substance use disorder prevention, early intervention, and treatment.

(c) (1) For each Medi-Cal managed care rating period, as defined in paragraph (3) of subdivision (a) of Section 14105.945, that the department implements this section, the department shall determine the amount of incentive payment earned by each qualifying Medi-Cal managed care plan.

(2) Any incentive payments that are eligible for federal financial participation pursuant to subdivision (e) shall be made in accordance with the requirements for incentive arrangements in Section 438.6(b)(2) of Title 42 of the Code of Federal Regulations and any associated federal guidance.

(d) Incentive payments made pursuant to this section shall be used to supplement and not supplant existing payments to Medi-Cal managed care plans. In addition to developing new collaborative initiatives, incentive payments shall be used to build on existing school-based partnerships between schools and applicable Medi-Cal plans, including Medi-Cal behavioral health delivery systems.

(e) The department shall seek any necessary federal approvals to claim federal financial participation for the incentive payments to qualifying Medi-Cal managed care plans described in this section. If federal approval is obtained for one or more Medi-Cal managed care rating periods, the department shall implement this section only to the extent that federal financial participation is available in that applicable rating period. If federal approval is not obtained for one or more Medi-Cal managed care rating periods, the department may make incentive payments to qualifying Medi-Cal managed care plans as described in this section on a state-only funding basis during the applicable rating period, but only to the extent sufficient funds are appropriated to the department for this purpose and the department determines that federal financial participation for the Medi-Cal program is not otherwise jeopardized as a result.

(f) (1) The department may modify any requirement specified in this section to the extent that it deems the modification necessary to meet the requirements of federal law or regulations, to obtain or maintain federal approval, or to ensure that federal financial participation is available or not otherwise jeopardized. The department shall not propose any modification pursuant to this subdivision until the Department of Finance has reviewed and approved a fiscal impact statement.

(2) If the department, after consulting with the State Department of Education, Medi-Cal managed care plans, county behavioral health departments, local educational agencies, and other affected stakeholder entities, determines that the potential modification would be consistent with the goals of this section, the modification may be made in consultation with the Department of Finance and the department shall execute a declaration stating that this determination has been made. The department shall post the declaration on its internet website.

(3) The department shall notify entities consulted in paragraph (2), the Joint Legislative Budget Committee, the Senate Committees on Appropriations, Budget and Fiscal Review, and Health, and the Assembly Committees on Appropriations, Budget, and Health, within 10 business days of that modification or adjustment.

(4) The department shall work with the affected entities and the Legislature to make the necessary statutory changes.

(g) For purposes of this section, the following definitions apply:

(1) "Comprehensive risk contract" has the same meaning as set forth in Section 438.2 of Title 42 of the Code of Federal Regulations.

(2) "Local educational agency" means a school district, county office of education, charter school, the California Schools for the Deaf, and the California School for the Blind.

(3) "Medi-Cal managed care plan" means an individual, organization, or entity that enters into a comprehensive risk contract with the department to provide covered full-scope health care services to enrolled Medi-Cal beneficiaries pursuant to any provision of Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9.

(4) "Medi-Cal behavioral health delivery system" has the meaning described in subdivision (i) of Section 14184.101.

K-12 School Districts	Partner with CalOptima for SBHIP	School Contact
1. Anaheim Elementary	Yes	Shirley Diaz
2. Anaheim Union High	Yes	Dr. Adela Cruz, LCSW
3. Brea Olinda Unified	Yes	Cherry Lee, NCSP. BCBA
4. Buena Park	Yes	Elsie Briseño Simonovski, Ph.D
5. Centralia Elementary	Yes	Michelle Castillo/ Stacy Chang
6. Cypress	Yes	Tandy Taylor
7. Fullerton Joint Union High	Yes	Carlos Alcántara, LCSW, PPSC
8. Garden Grove Unified	Yes	Jeffrey Layland, Ed.D.
9. Huntington Beach City	Yes	Megan Kempner
10. Laguna Beach Unified	Yes	Michael Keller
11. Los Alamitos Unified	Yes	Grace Delk
12. Lowell Joint	Yes	Sheri McDonald, Ed.D.
13. Magnolia	Yes	Wendy Castillo
14. Orange Unified	Yes	Kristen Nelson, M.A.
15. Santa Ana Unified	Yes	Sonia Llamas, Ed.D
16. Savanna	Yes	Hipolito Murillo
17. Tustin Unified	Yes	Monique Yessian

MEMORANDUM OF UNDERSTANDING
BETWEEN

_____

AND
ORANGE COUNTY HEALTH AUTHORITY DBA CALOPTIMA
FOR STUDENT BEHAVIORAL HEALTH INCENTIVE PROGRAM

This Memorandum of Understanding ("**MOU**") is made and entered into as of this ___ day of ____, 2023 ("**Effective Date**"), by and between [insert legal name here] ("**School District**") and Orange County Health Authority dba CalOptima ("**CalOptima**") in order to facilitate successful implementation of School District's Student Behavioral Health Incentive Program ("**SBHIP**"). School District and CalOptima may each be referred to herein as a "**Party**" and collectively as the "**Parties**".

RECITALS

A. In accordance with California Welfare & Institutions Code Section 5961.3, the California Department of Health Care Services ("DHCS") designed and implemented the SBHIP to increase access to preventive, early intervention and behavioral health services by school-affiliated behavioral health providers for K-12 children in public schools;

B. DHCS established a process, in partnership with Medi-Cal managed care plans ("MCPs") and eligible Orange County school districts, for MCPs to oversee and administer payment for approved SBHIP intervention implementation plan(s);

C. CalOptima, as an MCP participating in the SBHIP, has selected School District's intervention implementation plan(s) ("**Plan**") for the SBHIP; and

D. CalOptima is responsible for oversight and administration of payments to School District consistent with the terms of the SBHIP, the Plan, any terms imposed as a condition of federal approval of the SBHIP, and any DHCS guidance related to the SBHIP.

AGREEMENT

Therefore, CalOptima and School District agree as follows:

1. **Term**. The Term of this MOU shall begin on the Effective Date and shall terminate on [insert termination date], unless earlier terminated under Section 2.

2. **Termination**. The terms of this MOU are contingent upon the approval of School District's SBHIP intervention implementation plan(s), the availability of sufficient state and federal Medicaid funding, and all necessary federal approvals to be obtained by DHCS. Should sufficient funds not be allocated, federal financial participation be unavailable, or DHCS not obtain the necessary approvals, CalOptima may modify the services under the MOU accordingly upon written notice to School District or terminate this MOU after giving School District thirty (30) days' prior written notice. CalOptima

may also terminate this MOU with thirty (30) days' prior written notice to School District and DHCS if School District (i) breaches a material term of the MOU and fails to correct the breach within the thirty (30)-day notice period, or (ii) fails to meet terms of a corrective action plan ("**CAP**"), as set forth in Section 5.

3. **Scope of Project.** School District is responsible for the implementation of and compliance with the SBHIP, as set forth in Plan, which is attached to this MOU as Exhibit 1 and incorporated into the MOU by this reference. School District's compliance includes reporting to CalOptima on the achievement of milestones and objectives consistent with the terms of the SBHIP and the Plan. School District shall promptly notify CalOptima of any material change in information submitted in support of the SBHIP or the Plan, including changes in organizational leadership, business operations, and financial standing. CalOptima is responsible for overseeing the SBHIP as it relates to School District, including monitoring and verifying milestone achievements and administering payments consistent with the terms of the SBHIP, the Plan, any terms imposed as a condition of federal approval of the SBHIP, and any subsequent DHCS guidance related to the SBHIP.

4. **Confidentiality.** CalOptima and School District's performance under this MOU may require the exchange of confidential and/or proprietary information ("**Confidential Information**") as may be identified by either Party. Confidential Information includes but is not limited to computer programs and codes, business plans, customer/member lists and information, financial records, partnership arrangements, projections, methodologies, data, reports, agreements, intellectual property, trade secrets, licensing plans, and proprietary or other information, materials, records, writings, or data that is marked confidential or that due to its character and nature, a reasonable person under like circumstances would treat as confidential. Each Party agrees to protect the other Party's Confidential Information at all times and in the same manner as each protects the confidentiality of its own confidential materials, but in no event with less than a reasonable standard of care. The Parties also shall comply with the processes, standards, and other requirements applicable to the exchange of either Party's respective Confidential Information, in accordance with applicable state and federal law.

5. **Corrective Action**. Upon written notice to School District, CalOptima may implement a CAP for School District or other DHCS-required mechanism (i) to modify the MOU requirements, (ii) to facilitate School District's compliance with the MOU and SBHIP terms, or (iii) to adjust SBHIP/Plan goals and objectives and related payments, as necessary. Such modifications are subject to DHCS review and approval. School District's noncompliance with modifications under this Section 5 may result in CalOptima's termination of this MOU under Section 2. In the event of MOU termination under Section 2, School District shall return funds distributed to School District under this MOU as directed by CalOptima.

6. **School District Responsibilities**.

   A. Use of Funding.

i. School District shall only expend funds provided to School District by CalOptima under this MOU for the purposes of carrying out activities and achieving milestones set forth in this MOU and the Plan.

ii. School District shall document to CalOptima, in a form and manner determined by CalOptima, that Plan activities have been carried out and milestones have been achieved under this MOU.

iii. If School District does not carry out Plan activities and achieve Plan milestones, School District shall promptly notify CalOptima and return any funds that School District received related to those unperformed activities or unachieved milestones under the Plan.

B. Practice Redesign and Infrastructure Development Reporting.

i. School District shall timely implement the practice redesign and infrastructure development components set forth in and in accordance with the terms of the Plan.

ii. School District shall regularly report to CalOptima on the progress of the practice redesign and infrastructure development on a schedule in a format and process specified in the Plan or as otherwise agreed in writing between the Parties.

C. Milestone Achievement.

i. School District shall perform all tasks necessary to meet milestones required by the Plan. School District shall provide CalOptima with the information necessary for CalOptima to determine School District's progress in achieving the milestones set forth in the Plan.

D. Measure Reporting.

i. School District will report to CalOptima on target population measures on a schedule in a format and process required by SBHIP, the Plan, or as otherwise agreed in writing between the Parties.

ii. School District will regularly report performance measures to CalOptima consistent with the specifications required in the Plan and by the SBHIP.

7. **CalOptima Responsibilities.**

A. Monitoring Project Milestones and Measures. CalOptima will evaluate all information provided by School District related to implementation of the Plan(s) to ensure School District's compliance with the Plan and track School District's goals

and milestones under the Plan.

B. Reporting to DHCS. CalOptima will report to DHCS on the Plan status as specified in the terms of the Plan(s), the terms of federal approval for the SBHIP, and any applicable DHCS-issued guidance.

C. Administration of Project Funds.

i. *Initial Payment*. Within [XX] days of CalOptima's selection and acceptance of the Plan, CalOptima will provide initial payment to School District, as set forth in the terms of the Plan and SBHIP.

ii. *Milestone Payments*. Subsequent to the initial payment, all ongoing payments to School District will be tied to achieving practice redesign components, milestones, or defined progress toward goals required by terms of SBHIP and the Plan. CalOptima will remit milestone payments to School District within [XX] days of School District's successful demonstration to CalOptima of each milestone achievement per the terms of SBHIP and the Plan. CalOptima may adjust milestone measurement and related payments consistent with the terms of a CAP. CalOptima will not make any milestone payments to School District until all of School District's past due reporting is completed to CalOptima's satisfaction.

8. **Liaison.** CalOptima and School District will each designate a liaison(s) to serve as a point of contact for activities performed related to this MOU.

9. **MOU Monitoring.** CalOptima and School District will meet on a mutually agreed upon frequency, or upon request a Party's to monitor the performance of parties' responsibilities related to this MOU.

10. **Dispute Resolution.** If there is a dispute that cannot be resolved by the Parties under Section 9, either Party may submit a request for resolution to DHCS. A Party shall give the other Party five (5) business days' notice of its intent to submit a request for resolution.

11. **Notice and Correspondence.** All notices and correspondence concerning this MOU shall be in writing and sent to:

SCHOOL DISTRICT
Attn:
Address:

CALOPTIMA
Attn:
Address:

12. **No Liability of County of Orange.** As required under Ordinance No. 3896, as amended, of the County of Orange, State of California, CalOptima and School District acknowledge and agree that the obligations of CalOptima under this MOU are solely the obligations of CalOptima, and the County of Orange, State of California, shall have no obligation or liability under this MOU.

13. **Independent Contractor**. The Parties intend to establish an independent contractual relationship under this MOU rather than an employer/employee relationship. School District agrees that neither it nor its employees or agents are employees, agents, or legal representatives of CalOptima for any purpose, and nothing in this MOU shall be construed to create a partnership, joint venture, or employment contract between the Parties.

14. **Amendments**. Except as otherwise provide herein, the Parties may amend this MOU only in writing and signed by both Parties; provided, however, that if any law, rule, or regulation applicable to this MOU, or any interpretation thereof by any court, is modified or implemented during the term of the MOU in a way that materially changes the terms of the MOU ("**Regulatory Change**"), CalOptima may, upon written notice to School District, amend the MOU to the minimum degree necessary to comply with the Regulatory Change.

15. **Assignment**. School District may not assign or delegate any obligations or rights under this MOU without the prior written consent of CalOptima.

16. **Counterparts**. This MOU may be executed in multiple counterparts, each of which shall be deemed an original and all of which together shall be deemed one and the same instrument.

17. **Waiver**. Any failure of CalOptima to insist upon strict compliance with any provision of this MOU shall not be deemed a waiver of such provision or any other provision of this MOU. To be effective, a CalOptima waiver must be in a writing that is signed and dated by CalOptima.

18. **Governing Law**. This MOU shall be governed by the laws of the State of California, and the Parties consent to venue and personal jurisdiction over them in Superior Court in Orange, California, and in U.S. District Court for the Central District of California, as applicable, for purposes of construction and enforcement of this MOU.

19. **Authorizations**. Each Party warrants that it has the full right, power, and authority to enter into and fully perform its obligations under this MOU and the execution, delivery, and performance of this MOU by that Party does not conflict with any other agreement to which it is a party or by which it is bound.

20. **Interpretation**. Each Party has had the opportunity to have counsel of its choice examine the provisions of this MOU, and no implication shall be drawn against any Party by virtue of the drafting of this MOU.

21. **Recitals and Exhibits**. The recitals and exhibits set forth in this MOU are made a part of the MOU by this reference.

WHEREFORE, School District and CalOptima have executed the MOU in the County of Orange, California.

School District:

Signature: _____

Name: _____

Title: _____

Date: _____

CalOptima

Signature: _____

Name: _____

Title: _____

Date: _____

EXHIBIT 1
SBHIP Targeted Implementation Plan

[insert Targeted Intervention Implementation Plan Proposal document]

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 4, 2022
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

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

Contacts

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

Recommended Actions

The CalOptima Member Advisory Committee (MAC) recommends:

1. Reappointment of the following individuals to serve two-year terms on the MAC, effective July 1, 2022:
    a. Lee Lombardo as the Children Representative for a term ending June 30, 2024;
    b. Katrina Polezhaev as the Consumer Representative for a term ending June 30, 2024; and
    c. Christine Tolbert as the Persons with Special Needs Representative for a term ending June 30, 2024.

2. Appointment of the following individuals to serve two-year terms on the MAC, effective July 1, 2022:
    a. Iliana Soto Welty as the Behavioral/Mental Health Representative for a term ending June 30, 2024;
    b. Alyssa Vandenberg as the Foster Children Representative for a term ending June 30, 2024; and
    c. Sara Lee as the Long-Term Services and Supports Representative for a term ending June 30, 2024.

Background

The CalOptima Board of Directors established the MAC by resolution on February 14, 1995, to provide input to the Board. The MAC is comprised of fifteen voting members. Pursuant to the resolution, MAC members serve two-year terms, except for the two standing seats, which are representatives from the County of Orange Social Services Agency (SSA) and the Orange County Health Care Agency (HCA). The CalOptima Board is responsible for the appointment of all MAC members.

With the fiscal year ending on June 30, 2022, seven MAC seats will expire: Behavioral/Mental Health, Children, Consumer, Foster Children, Long-Term Services and Supports, Medical Safety Net, and Persons with Special Needs.

Discussion

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

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The MAC Nominations Ad Hoc Subcommittee, composed of MAC committee members Vice Chair Maura Byron and Members Hai Hoang and Steve Thronson evaluated each of the applicants for the impending openings and forwarded the proposed slate of candidates for the seven vacancies to the MAC. At the May 12, 2022, MAC meeting, MAC members approved the recommended slate of candidates as proposed by the MAC Nominations Ad Hoc Subcommittee and requested that the proposed slate of candidates be forwarded to the CalOptima Board for consideration

The candidates for six of the seven open seats are as presented below. Recruitment will continue for the remaining open seat and the candidate will be brought to the Board for appointment when identified.

Behavioral/Mental Health Candidate

Illiana Soto Welty

Illiana Soto Welty is currently the community partnerships consultant at Mind OC, where she works with government agencies, nonprofits, and community groups to help create community transformation initiatives. Prior to working at Mind OC, Ms. Soto Welty was the executive director of the Multi-Ethnic Collaborative of Community Agencies (MECCA), where she helped to advance health equity, eliminate racial and ethnic disparities, and improve the lives of the underserved communities in Orange County. She is also the community co-chair of the HCA Behavioral Health Equity Collaborative, where she participates as a representative for Mind OC in the Equity in OC initiative.

Children Candidate

Lee Lombardo

Lee Lombardo is a licensed clinical social worker and the current associate executive director of YMCA community services at the YMCA of Orange County. Ms. Lombardo has worked in the mental health field with children, teens, families, and adults, including those with co-occurring mental health and developmental disabilities. She also works with Orange County and state agencies on the Developmental Screening Cohort through Help Me Grow OC, the Orange County Child Care and Development Planning Council and its Inclusion Subcommittee, and the Be Well OC Prevent and Act Early Workgroup.

Consumer Representative

Katerina Polezhaev

Katerina Polezhaev is a current CalOptima Medi-Cal member and a full-time student at California State University, Fullerton. She is a certified clinical medical assistant and is an active volunteer in the Anaheim community. She has served on the MAC since October 2020.

Foster Children Candidate

Alyssa Vandenberg

Alyssa Vandenberg is an intake and dependency investigations senior social worker with the Orange County Children and Family Services Social Services Agency. Ms. Vandenberg's experience includes working with foster children who receive Medi-Cal benefits through CalOptima. Ms. Vandenberg investigates allegations of abuse and neglect of children, including effectively planning and conducting investigations with children, family members, and collateral contacts in collaboration with law enforcement agencies and health care providers.

Long-Term Services and Supports Candidate

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Sara Lee
Sara Lee is an attorney at Community Legal Aid SoCal, a partner of the statewide Health Consumer Alliance, where she is the supervising attorney of the Health Consumer Action Center unit. Ms. Lee is a current member of CalOptima's OneCare Connect Member Advisory Committee (OCC MAC), serving as the Ethnic and Cultural Community Representative and advocating on behalf of CalOptima's OCC members. She also serves as the OCC MAC's Ombudsman.

Persons with Special Needs Candidate
Christine Tolbert
Christine Tolbert's current work for the State Council on Developmental Disabilities has allowed her to advocate for thousands of people dealing with an expansive number of medical and/or special needs conditions. She has helped transition people from the state hospital into the community, helping them access health care services through managed care. Ms. Tolbert currently holds the Persons with Special Needs seat and has served as the MAC Chair since 2019.

Fiscal Impact
There is no fiscal impact.

Rationale for Recommendation
As stated in policy AA.1219a, the MAC established a Nominations Ad Hoc Subcommittee to review potential candidates for vacancies on the committee. The MAC met to discuss the Nominations Ad Hoc Subcommittee's recommended slate of candidates and concurred with the Subcommittee's recommendations. The MAC then forwards the recommended slate of candidates to the Board of Directors for consideration.

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

Attachments
None

/s/ Michael Hunn *07/28/2022*
Authorized Signature **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 4, 2022
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

12. Authorize Expenditures in Support of CalOptima's Participation in a Community Event

Contacts

Michael Hunn, Chief Executive Officer, (657) 900-1481
Deanne Thompson, Executive Director, Marketing and Communications, (714) 954-2141

Recommended Actions

1. Authorize expenditures for CalOptima's participation in the following community event:
    - Up to $10,000 for Viet America Society's 2022 Mid-Autumn Moon Festival on Saturday, September 10, 2022, in Fountain Valley.
2. Make a finding that such expenditures are for a public purpose and in furtherance of CalOptima's mission and statutory purpose.
3. Authorize the Chief Executive Officer to execute agreements as necessary for the event and expenditures.

Background

CalOptima has a long history of participating in community events, health and resource fairs, and other public activities in furtherance of the organization's statutory purpose. CalOptima has offered financial participation from time to time when participation is in the public good, in furtherance of CalOptima's mission and statutory purpose, and encourages broader participation in CalOptima's programs and services or promotes health and wellness. As a result, CalOptima has developed a strong reputation with Orange County's community partners, providers, and key stakeholders.

Requests for participation are considered based on the following factors: the number of people that will be reached; the outreach and education benefits accrued to CalOptima; the strength of the partnership or level of involvement with the requesting entity; past participation; staff availability; and available budget.

Discussion

The Mid-Autumn Festival, also known as Moon Festival, is a cultural event that celebrates three (3) fundamental concepts: gathering, thanksgiving, and praying. Part of this tradition includes children lighting lanterns and participating in a parade and enjoying moon cake.

The event will provide opportunities to conduct outreach and education to current and potential members who identify as Vietnamese, increase access to health care services, and strengthen relationships with CalOptima's community partners. As of July 2022, CalOptima's members who identify as Vietnamese represent approximately 12% of CalOptima's total membership.

Staff recommends the authorization of expenditures for participation in Viet America Society's 2022 Mid-Autumn Moon Festival. CalOptima has participated in this event for seven (7) years. Staff recommends CalOptima's continued support for this event with a $10,000 financial commitment, which includes: CalOptima's Chief Executive Officer's participation in the program, one (1) 20' x 20'

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booth in a prime location, three (3) 3' x 8' banner displays, twenty (20) mentions on stage, twenty-five (25) radio impressions, fifteen (15) television impressions, full advertising size 5.5 x 8 inches (the other side will be Moon Festival announcement) on ten thousand (10,000) flyers distributed throughout Orange County prior to the event and two (2) 8' x8' back drop on Moon Festival Stage.

This is an educational event that will allow staff to provide outreach and education to the Vietnamese community and serve members speaking one or more of CalOptima's threshold languages. Employee time will be used to participate in this event.

CalOptima staff reviewed the request, and it meets the requirements for participation as established in CalOptima Policy AA. 1223: Participation in Community Events Involving External Entities, including the following:

1. The number of people the activity/event will reach
2. The marketing benefits accrued to CalOptima
3. The strength of the partnership or level of involvement with the requesting entity
4. Past participation
5. Staff availability
6. Available budget

As part of its consideration of the recommended actions, approval of this item is based on the Board making a finding that proposed activities and expenditures are in the public interest and in furtherance of CalOptima's statutory purpose.

Fiscal Impact

Funding for the recommended action of up to $10,000 is included as part of the Community Events budget under the CalOptima Fiscal Year 2022-23 Operating Budget approved by the Board on June 2, 2022.

Rationale for Recommendation

Staff recommends approval of the recommended actions as an opportunity to educate the community, specifically CalOptima's Vietnamese-speaking members, potential members, and community about CalOptima and Medi-Cal programs and services, as well as in response COVID-19 pandemic.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Entity Covered by this Recommended Board Action
2. Sponsorship Request from Viet America Society

/s/ Michael Hunn *07/28/2022*
Authorized Signature **Date**

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Attachment to the August 4, 2022 Board of Directors Meeting – Agenda Item 12

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip Code
Viet America Society	17801 Santa Anita Circle	Fountain Valley	CA	92708

VIET AMERICA SOCIETY

8907 Warner Ave. Suite 135
Huntington Beach, CA 92647
Email: vietamericasociety@gmail.com
Tel: 714-390-5591

July 21, 2022

Mr. Michael Hunn
Chief Executive Officer CalOptima
505 City Parkway West
Orange, CA 92868

Re: Sponsorship for the 2022 Mid-Autumn Festival — Saturday, September 10, 2022

Dear Mr. Hunn,

On behalf of the non-profit organization, Viet America Society, we would like to thank you for CalOptima's support and invite you to participate in the upcoming Mid-Autumn Festival, also known as "Moon Festival."

This year, the Moon Festival will return to Mile Square Park in Fountain Valley, to celebrate three fundamental concepts: Gathering, Thanksgiving, and Praying. As the "children's Festival," the tradition of brightly lit lanterns lends to the legend that Chu Cuoi and Hang Nga floated to the moon on a banyan free and were stranded. Children light lanterns and participate in the procession to show them the way back to Earth. The celebration is complete with children enjoying the delicious Moon Cake.

The event will take place on Saturday, September 10, 2022, from 6:00 PM to 9:00 PM, and we anticipate over 3,000 in attendance. We ask for CalOptima's participation and sponsorship in the amount of $10,000.00, which will provide the following:

> 20' x 20' booth in a prime location
>Three (3) 3' x 8' banner displays
> Twenty (20) mentions on stage
> Twenty-five (25) radio impressions
> Fifteen (15) television impressions
> Full ad size 5.5 x 8 inches (the other side will be Moon Festival announcement) on ten thousand (10,000) flyers distributed throughout Orange County prior to the event
> Two (2) 8' x8 'back drop on Moon Festival Stage

I look forward to seeing you be a part of program event on stage. Should you have any questions please contact me at (714) 390-5591 or e-mail at vietamericasociety@gmail.com.

Viet America Society appreciates CalOptima's continued support.

Sincerely,

Peter Pham
CEO
Viet America Society

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CalOptima

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Financial Summary

May 31, 2022

Board of Directors Meeting

August 4, 2022

Nancy Huang, Chief Financial Officer

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Financial Highlights: May 2022

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
911,427	832,944	78,483	9.4%	Member Months	9,606,130	9,245,947	360,183	3.9%
377,329,042	277,170,197	100,158,845	36.1%	Revenues	4,089,408,233	3,380,324,263	709,083,970	21.0%
309,125,866	272,927,378	(36,198,488)	(13.3%)	Medical Expenses	3,704,636,702	3,294,167,436	(410,469,266)	(12.5%)
13,952,629	15,449,974	1,497,345	9.7%	Administrative Expenses	138,917,356	163,944,012	25,026,656	15.3%
54,250,548	**(11,207,155)**	**65,457,703**	**584.1%**	**Operating Margin**	**245,854,175**	**(77,787,185)**	**323,641,360**	**416.1%**
3,584,698	833,333	2,751,365	330.2%	Non Operating Income (Loss)	(14,793,503)	9,166,666	(23,960,169)	(261.4%)
57,835,246	**(10,373,822)**	**68,209,068**	**657.5%**	**Change in Net Assets**	**231,060,671**	**(68,620,519)**	**299,681,190**	**436.7%**
81.9%	98.5%	(16.5%)		Medical Loss Ratio	90.6%	97.5%	(6.9%)	
3.7%	5.6%	1.9%		Administrative Loss Ratio	3.4%	4.8%	1.5%	
14.4%	(4.0%)	18.4%		Operating Margin Ratio	6.0%	(2.3%)	8.3%	
100.0%	100.0%			Total Operating	100.0%	100.0%		
81.9%	98.5%	(16.5%)		*MLR (excluding Directed Payments)	89.9%	97.5%	(7.5%)	
3.7%	5.6%	1.9%		*ALR (excluding Directed Payments)	3.6%	4.8%	1.2%	

*CalOptima updated the category of Directed Payments per Department of Health Care Services instructions

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Consolidated Performance: May 2022 (in millions)

May				July-May		
Actual	Budget	Variance		Actual	Budget	Variance
48.2	(10.3)	58.5	Medi-Cal	232.0	(73.0)	305.0
4.5	(0.8)	5.3	OCC	9.9	(5.0)	14.8
0.4	(0.1)	0.5	OneCare	(1.1)	(1.0)	(0.1)
1.1	(0.0)	1.1	PACE	5.1	1.3	3.8
(0.0)	(0.0)	0.0	MSSP	(0.0)	(0.1)	0.1
54.3	**(11.2)**	**65.5**	**Operating**	**245.9**	**(77.8)**	**323.6**
3.6	0.8	2.8	Inv./Rental Inc, MCO tax	(14.8)	9.2	(24.0)
3.6	**0.8**	**2.8**	**Non-Operating**	**(14.8)**	**9.2**	**(24.0)**
57.8	**(10.4)**	**68.2**	**TOTAL**	**231.1**	**(68.6)**	**299.7**

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FY 2021–22: Management Summary

- Change in Net Assets Surplus or (Deficit)
  - MTD (May 2022): $57.8 million, favorable to budget $68.2 million or 657.5%, primarily due to higher than anticipated Calendar Year (CY) 2022 Medi-Cal rates and deferred and delayed services
  - YTD (Jul 2021 – May 2022): $231.1 million, favorable to budget $299.7 million or 436.7%
- Enrollment
  - MTD: 911,427 members, favorable to budget 78,483 or 9.4%
  - YTD: 9,606,130 members, favorable to budget 360,183 or 3.9%
- Revenue
  - MTD: $377.3 million, favorable to budget $100.2 million or 36.1% driven by Medi-Cal (MC) line of business (LOB):
    - $23.3 million due to favorable enrollment as redetermination is suspended during the Public Health Emergency
    - $35.6 million due to updated Medi-Cal rates and extension of Proposition 56
    - $22.5 million due to CalAIM's Incentive Payment Program (IPP) funding from the Department of Health Care Services (DHCS)
  - YTD: $4.1 billion, favorable to budget $709.1 million or 21.0% driven by MC LOB:
    - $294.1 million of Fiscal Year (FY) 2020 hospital Directed Payments (DP) and Intergovernmental Transfer (IGT) 10
    - $273.4 million due to favorable enrollment and Medi-Cal rates, increase in Long-Term Care (LTC) and pharmacy funding from DHCS, and prior year retroactive eligibility changes
    - $127.5 million increase due to the extension of Proposition 56 and Proposition 56 risk corridor estimates
    - $22.5 million due to CalAIM's IPP funding from DHCS
    - Offset by $32.7 million due to COVID-19 risk corridor

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FY 2021–22: Management Summary (cont.)

- Medical Expenses
  - MTD: $309.1 million, unfavorable to budget $36.2 million or 13.3% driven by MC LOB:
    - Provider Capitation expense unfavorable variance of $25.9 million due primarily to the extension of Proposition 56 and short-term supplemental rate increase due to COVID-19
    - Reinsurance & Other expense unfavorable variance of $11.6 million due to CalAIM IPP payments to Health networks and providers
    - Offset by net favorable variance from all other expenses of $4.9 million
  - YTD: $3.7 billion, unfavorable to budget $410.5 million or 12.5% driven by MC LOB:
    - Reinsurance & Other expense unfavorable variance of $287.7 million due to FY 2020 hospital DP
    - Provider Capitation expense unfavorable variance of $186.8 million due primarily to the extension of Proposition 56 and short-term supplemental rate increase due to COVID-19
    - Professional Claims expense unfavorable variance of $33.8 million due to increase in professional crossover claims
    - Offset by:
      - Facilities Claims expense favorable variance of $86.8 million due to decrease in facilities-related crossover claims and low utilization
      - Net favorable variance from all other expenses of $9.5 million

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FY 2021–22: Management Summary (cont.)

- Administrative Expenses
  - MTD: $14.0 million, favorable to budget $1.5 million or 9.7%
  - YTD: $138.9 million, favorable to budget $25.0 million or 15.3%
- Non-Operating Income (Loss)
  - MTD: $3.6 million, favorable to budget $2.8 million or 330.2%
    - Favorable investment variance due to an increase in bond values as increased rates decreased in the month of May
  - YTD: ($14.8) million, unfavorable to budget $24.0 million or 261.4%
    - Unfavorable variance is primarily due to unrealized losses in treasuries, corporate bonds and municipals from the Federal Reserve's responses to inflation and an overall increases to interest rates for the fiscal year

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FY 2021–22: Key Financial Ratios

- Medical Loss Ratio (MLR)
  - MTD: Actual 81.9%, (81.9% excluding DP),Budget 98.5%
  - YTD: Actual 90.6% (89.9% excluding DP), Budget 97.5%
- Administrative Loss Ratio (ALR)
  - MTD: Actual 3.7%, (3.7% excluding DP), Budget 5.6%
  - YTD: Actual 3.4% (3.6% excluding DP), Budget 4.8%
- Balance Sheet Ratios
  - *Current ratio: 1.72
  - Board-designated reserve funds level: 1.66
  - Net position: $1.5 billion, including required Tangible Net Equity (TNE) of $103.4 million

*Current ratio compares current assets to current liabilities. It measures CalOptima's ability to pay short-term obligations.

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Enrollment Summary: May 2022

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
128,319	117,925	10,394	8.8%	SPD	1,319,644	1,291,512	28,132	2.2%
302,882	291,579	11,303	3.9%	TANF Child	3,311,333	3,251,900	59,433	1.8%
123,337	105,322	18,015	17.1%	TANF Adult	1,262,451	1,171,997	90,454	7.7%
3,223	3,191	32	1.0%	LTC	34,577	35,101	(524)	(1.5%)
324,283	286,418	37,865	13.2%	MCE	3,356,277	3,182,328	173,949	5.5%
11,878	11,159	719	6.4%	WCM	130,065	122,749	7,316	6.0%
893,922	**815,594**	**78,328**	**9.6%**	**Medi-Cal Total**	**9,414,347**	**9,055,587**	**358,760**	**4.0%**
14,465	**15,119**	**(654)**	**(4.3%)**	**OneCare Connect**	**161,774**	**166,264**	**(4,490)**	**(2.7%)**
2,616	**1,797**	**819**	**45.6%**	**OneCare**	**25,439**	**19,583**	**5,856**	**29.9%**
424	**434**	**(10)**	**(2.3%)**	**PACE**	**4,570**	**4,513**	**57**	**1.3%**
460	**625**	**(165)**	**(26.4%)**	**MSSP**	**2,285**	**2,785**	**(500)**	**(18.0%)**
911,427	**832,944**	**78,483**	**9.4%**	**CalOptima Total***	**9,606,130**	**9,245,947**	**360,183**	**3.9%**

*Note: CalOptima Total does not include MSSP

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Consolidated Revenue & Expenses: May 2022 MTD

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	MSSP	Consolidated
MEMBER MONTHS	557,761	324,283	11,878	893,922	14,465	2,616	424	460	911,427
REVENUES									
Capitation Revenue	177,150,655	$ 133,319,238	$ 22,009,750	$ 332,479,642	$ 36,648,589	$ 3,728,124	$ 4,253,663	$ 219,023	$ 377,329,042
Other Income	-	-	-	-	-	-	-	-	-
Total Operating Revenue	177,150,655	133,319,238	22,009,750	332,479,642	36,648,589	3,728,124	4,253,663	219,023	377,329,042
MEDICAL EXPENSES									
Provider Capitation	49,678,860	51,828,703	9,098,083	110,605,646	15,851,955	1,076,839			127,534,440
Facilities	22,720,252	31,319,371	3,965,580	58,005,202	3,973,649	1,003,804	305,734		63,288,389
Professional Claims	22,304,642	13,363,967	1,014,236	36,682,846	1,242,221	100,078	794,367		38,819,512
Prescription Drugs	(91,138)	(11,630)	(281,287)	(384,055)	6,566,541	917,437	349,919		7,449,843
MLTSS	37,982,460	3,959,786	1,769,988	43,712,234	1,615,363	56,925	374,057	24,266	45,782,845
Medical Management	2,577,585	1,747,651	344,521	4,669,757	1,148,833	31,056	968,001	126,596	6,944,243
Quality Incentives	2,290,868	1,529,012	59,974	3,879,854	212,685		(10,473)		4,082,066
Reinsurance & Other	8,710,445	6,035,558	206,292	14,952,295	168,922	575	102,735		15,224,527
Total Medical Expenses	146,173,973	109,772,419	16,177,387	272,123,779	30,780,170	3,186,715	2,884,340	150,861	309,125,866
Medical Loss Ratio	82.5%	82.3%	73.5%	81.8%	84.0%	85.5%	67.8%	68.9%	81.9%
GROSS MARGIN	**30,976,682**	**23,546,818**	**5,832,363**	**60,355,863**	**5,868,420**	**541,409**	**1,369,323**	**68,162**	**68,203,177**
ADMINISTRATIVE EXPENSES									
Salaries & Benefits				7,960,097	666,299	53,830	122,349	61,861	8,864,437
Professional fees				347,173	32,771	29,167		2,207	411,318
Purchased services				1,251,646	52,376	15,162	75,496		1,394,679
Printing & Postage				492,058	30,570	3,453	14,299		540,381
Depreciation & Amortization				333,809			829		334,638
Other expenses				2,041,476	2,170	-	7,893	3,960	2,055,498
Indirect cost allocation & Occupancy				(302,285)	578,216	59,743	11,733	4,273	351,680
Total Administrative Expenses				12,123,974	1,362,402	161,355	232,600	72,300	13,952,629
Admin Loss Ratio				3.6%	3.7%	4.3%	5.5%	33.0%	3.7%
INCOME (LOSS) FROM OPERATIONS				48,231,889	4,506,018	380,054	1,136,723	(4,138)	54,250,548
INVESTMENT INCOME									4,160,997
NET RENTAL INCOME									100,079
TOTAL MCO TAX				(646,118)					(646,118)
TOTAL GRANT INCOME				(30,303)					(30,303)
OTHER INCOME				43					43
CHANGE IN NET ASSETS				**$ 47,555,511**	**$ 4,506,018**	**$ 380,054**	**$ 1,136,723**	**$ (4,138)**	**$ 57,835,245**
BUDGETED CHANGE IN NET ASSETS				(10,272,648)	(825,703)	(89,300)	(12,162)	(7,342)	(10,373,822)
VARIANCE TO BUDGET - FAV (UNFAV)				$ 57,828,159	$ 5,331,721	$ 469,354	$ 1,148,885	$ 3,204	$ 68,209,067

Note:* Total membership does not include MSSP

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Consolidated Revenue & Expenses: May 2022 YTD

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total MC	OneCare Connect	OneCare	PACE	MSSP	Consolidated
MEMBER MONTHS	5,928,005	3,356,277	130,065	9,414,347	161,774	25,439	4,570	2,285	9,606,130
REVENUES									
Capitation Revenue	1,899,556,239	$ 1,534,993,475	$ 271,068,042	3,705,617,756	$ 311,968,623	$ 32,640,970	$ 38,123,590	1,057,293	$ 4,089,408,233
Other Income	-	-	-	-	-	-	-	-	-
Total Operating Revenue	1,899,556,239	1,534,993,475	271,068,042	3,705,617,756	311,968,623	32,640,970	38,123,590	1,057,293	4,089,408,233
MEDICAL EXPENSES									
Provider Capitation	509,816,347	548,433,208	98,216,720	1,156,466,274	125,850,116	9,010,764		-	1,291,327,154
Facilities	275,231,474	284,343,965	61,076,078	620,651,517	45,349,377	9,927,280	7,656,994	-	683,585,168
Professional Claims	237,949,850	125,306,198	14,512,969	377,769,017	12,521,668	1,123,602	8,486,605	-	399,900,893
Prescription Drugs	128,344,389	175,086,125	40,136,051	343,566,566	69,976,597	10,572,749	3,594,520	-	427,710,432
MLTSS	404,334,162	44,089,425	19,416,276	467,839,863	15,959,990	563,502	826,796	144,890	485,335,041
Medical Management	28,022,284	17,329,919	3,637,437	48,989,640	11,734,633	402,033	9,305,493	594,065	71,025,865
Quality Incentives	19,847,689	10,821,653	878,008	31,547,350	2,429,085		(43,007)	-	33,933,429
Reinsurance & Other	181,228,124	117,062,993	10,116,881	308,407,998	2,032,548	33,694	1,344,481	-	311,818,721
Total Medical Expenses	1,784,774,319	1,322,473,486	247,990,419	3,355,238,225	285,854,016	31,633,624	31,171,883	738,955	3,704,636,702
Medical Loss Ratio	94.0%	86.2%	91.5%	90.5%	91.6%	96.9%	81.8%	69.9%	90.6%
GROSS MARGIN	**114,781,920**	**212,519,988**	**23,077,623**	**350,379,531**	**26,114,607**	**1,007,346**	**6,951,708**	**318,338**	**384,771,531**
ADMINISTRATIVE EXPENSES									
Salaries & Benefits				81,513,500	7,620,935	844,255	1,193,776	268,344	91,440,810
Professional fees				3,281,676	202,622	327,599	7,251	9,536	3,828,685
Purchased services				10,829,053	1,168,764	135,420	343,066	-	12,476,303
Printing & Postage				3,747,184	879,039	93,853	149,906	-	4,869,982
Depreciation & Amortization				4,015,589			8,342	-	4,023,931
Other expenses				17,966,161	14,133	1,076	80,409	23,912	18,085,690
Indirect cost allocation & Occupancy				(2,962,031)	6,360,374	657,176	114,152	22,285	4,191,956
Total Administrative Expenses				118,391,133	16,245,867	2,059,378	1,896,900	324,077	138,917,356
Admin Loss Ratio				3.2%	5.2%	6.3%	5.0%	30.7%	3.4%
INCOME (LOSS) FROM OPERATIONS				231,988,398	9,868,740	(1,052,032)	5,054,807	(5,739)	245,854,174
INVESTMENT INCOME									(16,746,200)
NET RENTAL INCOME									100,079
TOTAL MCO TAX				1,934,661					1,934,661
TOTAL GRANT INCOME				(90,909)					(90,909)
OTHER INCOME				8,865					8,865
CHANGE IN NET ASSETS				**$ 233,841,015**	**$ 9,868,740**	**$ (1,052,032)**	**$ 5,054,807**	**$ (5,739)**	**$ 231,060,671**
BUDGETED CHANGE IN NET ASSETS				(73,034,822)	(4,953,802)	(989,720)	1,255,478	(64,319)	(68,620,519)
VARIANCE TO BUDGET - FAV (UNFAV)				$ 306,875,837	$ 14,822,542	$ (62,312)	$ 3,799,329	$ 58,580	$ 299,681,190

Note:* Total membership does not include MSSP

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Balance Sheet: As of May 2022

ASSETS		LIABILITIES & NET POSITION	
Current Assets		**Current Liabilities**	
Operating Cash	$667,051,665	Accounts Payable	$35,456,807
Short-term Investments	1,095,296,507	Medical Claims liability	1,008,253,142
Capitation receivable	348,977,084	Accrued Payroll Liabilities	17,021,057
Receivables - Other	49,401,551	Deferred Revenue	8,017,662
Prepaid expenses	17,879,074	Deferred Lease Obligations	95,165
		Capitation and Withholds	200,149,192
Total Current Assets	**2,178,605,881**	**Total Current Liabilities**	**1,268,993,026**
Capital Assets			
Furniture & Equipment	46,607,580		
Building/Leasehold Improvements	9,819,243		
505 City Parkway West	52,324,639		
500 City Parkway West	22,650,000		
	131,401,462		
Less: accumulated depreciation	(63,650,595)	Other (than pensions) post	
Capital assets, net	67,750,867	employment benefits liability	32,106,034
Other Assets		Net Pension Liabilities	30,684,981
		Bldg 505 Development Rights	-
Restricted Deposit & Other	300,000		
Homeless Health Reserve	40,636,739		
		TOTAL LIABILITIES	**1,331,784,041**
Board-designated assets:		**Deferred Inflows**	
Cash and Cash Equivalents	2,239,312	Excess Earnings	344,198
Investments	571,463,554	OPEB 75 Difference in Experience	536,000
Total Board-designated Assets	573,702,865	Change in Assumptions	2,709,945
		OPEB Changes in Assumptions	773,000
Total Other Assets	614,639,604		
		Net Position	
TOTAL ASSETS		TNE	103,388,764
	2,860,996,352	Funds in Excess of TNE	1,436,452,700
Deferred Outflows		**TOTAL NET POSITION**	1,539,841,464
Contributions	1,508,025		
Difference in Experience	3,236,721		
Excess Earning	2,104,780		
Changes in Assumptions	3,692,771		
OPEB 75 Changes in Assumptions	3,906,000		
Pension Contributions	544,000		
TOTAL ASSETS & DEFERRED OUTFLOWS	**2,875,988,649**	**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION**	**2,875,988,649**

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Board Designated Reserve and TNE Analysis: As of May 2022

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	233,279,080				
	Tier 1 - MetLife	231,935,317				
Board-designated Reserve		465,214,396	380,301,278	587,597,011	84,913,118	(122,382,614)
	Tier 2 - Payden & Rygel	54,361,887				
	Tier 2 - MetLife	54,126,582				
TNE Requirement		108,488,469	103,388,764	103,388,764	5,099,705	5,099,705
	Consolidated:	**573,702,865**	**483,690,042**	**690,985,774**	**90,012,823**	**(117,282,909)**
	Current reserve level	*1.66*	*1.40*	*2.00*		

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Net Assets Analysis: As of May 2022

Category	Item Description	Resource Committed	Amount (millions)	%
	Total Net Position @ 05/31/2022:		**$ 1,539.8**	**100.0%**
Resources Assigned	Board Designated Reserve		**$ 573.7**	**37.3%**
	Capital Assets, net of depreciation		**$ 67.8**	**4.4%**
Resources Allocated, not yet Spent	Homeless Health Initiative*	100.0	26.2	1.7%
	Intergovernmental Transfers (IGT)	80.8	24.0	1.6%
	Mind OC Grant	1.0	-	0.0%
	CalFresh Outreach Strategy	2.0	1.8	0.1%
	Digital Transformation and Workplace Modernization	100.0	100.0	6.5%
	Coalition of Orange County Community Health Centers Grant	50.0	50.0	3.2%
	Subtotal:	**333.8**	**$ 202.0**	**13.1%**
Resources Available for New Initiatives	Homeless Health Initiative		40.6	
	Intergovernmental Transfers (IGT)		30.9	
	Unallocated/Unassigned		624.9	
	Subtotal:		**$ 696.4**	**45.2%**

*See Summary of Homeless Health Initiatives and Allocated Funds for list of Board approved initiatives

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Homeless Health Initiative and Allocated Funds: As of May 2022

		Amount
Program Commitment	**$**	**100,000,000**
Funds Allocation, approved initiatives:		
Enhanced Medi-Cal Services at the Be Well OC Regional Mental Health and Wellness Campus	11,400,000	
Recuperative Care	8,250,000	
Medical Respite	250,000	
Day Habilitation (County for HomeKey)	2,500,000	
Clinical Field Team Start-up & Federal Qualified Health Center (FQHC)	1,600,000	
CalOptima Homeless Response Team	6,000,000	
Homeless Coordination at Hospitals	10,000,000	
CalOptima Days & QI Program - Homeless Clinic Access Program or HCAP	1,693,261	
FQHC (Community Health Center) Expansion and HHI Support	570,000	
HCAP Expansion for Telehealth and CFT On Call Days	1,700,000	
Vaccination Intervention and Member Incentive Strategy	400,000	
Street Medicine	8,000,000	
Outreach and Engagement Team	7,000,000	
Funds Allocation Total	**$**	**59,363,261**
Program Commitment Balance, available for new initiatives*	**$**	**40,636,739**

On June 27, 2019 at a Special Board meeting, the Board approved four funding categories.

This report only lists Board approved projects.

* Funding sources of the remaining balance are IGT8 and CalOptima's operating income, which must be used for Medi-Cal covered services for the Medi-Cal population

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Our Mission

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

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UNAUDITED FINANCIAL STATEMENTS

May 2022

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CalOptima - Consolidated
Financial Highlights
For the Eleven Months Ended May 31, 2022

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
911,427	832,944	78,483	9.4%	Member Months	9,606,130	9,245,947	360,183	3.9%
377,329,042	277,170,197	100,158,845	36.1%	Revenues	4,089,408,233	3,380,324,263	709,083,970	21.0%
309,125,866	272,927,378	(36,198,488)	(13.3%)	Medical Expenses	3,704,636,702	3,294,167,436	(410,469,266)	(12.5%)
13,952,629	15,449,974	1,497,345	9.7%	Administrative Expenses	138,917,356	163,944,012	25,026,656	15.3%
54,250,548	**(11,207,155)**	**65,457,703**	**584.1%**	**Operating Margin**	**245,854,175**	**(77,787,185)**	**323,641,360**	**416.1%**
3,584,698	833,333	2,751,365	330.2%	Non Operating Income (Loss)	(14,793,503)	9,166,666	(23,960,169)	(261.4%)
57,835,246	**(10,373,822)**	**68,209,068**	**657.5%**	**Change in Net Assets**	**231,060,671**	**(68,620,519)**	**299,681,190**	**436.7%**
81.9%	98.5%	(16.5%)		Medical Loss Ratio	90.6%	97.5%	(6.9%)	
3.7%	5.6%	1.9%		Administrative Loss Ratio	3.4%	4.8%	1.5%	
14.4%	(4.0%)	18.4%		Operating Margin Ratio	6.0%	(2.3%)	8.3%	
100.0%	100.0%			Total Operating	100.0%	100.0%		
81.9%	98.5%	(16.5%)		*MLR (excluding Directed Payments)	89.9%	97.5%	(7.5%)	
3.7%	5.6%	1.9%		*ALR (excluding Directed Payments)	3.6%	4.8%	1.2%	

*CalOptima updated the category of Directed Payments per Department of Health Care Services instructions

CalOptima
Financial Dashboard
For the Eleven Months Ended May 31, 2022

MONTH - TO - DATE

Enrollment	Actual	Budget	Fav / (Unfav)	
Medi-Cal	893,922	815,594	78,328	9.6%
OneCare Connect	14,465	15,119	(654)	(4.3%)
OneCare	2,616	1,797	819	45.6%
PACE	424	434	(10)	(2.3%)
MSSP	460	625	(165)	(26.4%)
Total*	911,427	832,944	78,483	9.4%

Change in Net Assets (000)	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 47,556	$ (10,273)	$ 57,829	562.9%
OneCare Connect	4,506	(826)	5,332	645.5%
OneCare	380	(89)	469	527.0%
PACE	1,137	(12)	1,149	9575.0%
MSSP	(4)	(7)	3	42.9%
500 and 505 Bldgs.	100	-	100	0.0%
Investment Income	4,161	833	3,328	399.5%
Total	$ 57,836	$ (10,374)	$ 68,210	657.5%

MLR	Actual	Budget	% Point Var
Medi-Cal	81.8%	98.8%	(17.0)
OneCare Connect	84.0%	96.4%	(12.5)
OneCare	85.5%	96.0%	(10.5)

Administrative Cost (000)	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 12,124	$ 13,073	$ 949	7.3%
OneCare Connect	1,362	1,851	489	26.4%
OneCare	161	178	17	9.5%
PACE	233	257	25	9.6%
MSSP	72	90	17	19.3%
Total	$ 13,953	$ 15,450	$ 1,497	9.7%

Total FTE's Month	Actual	Budget	Fav / (Unfav)
Medi-Cal	1,103	1,205	102
OneCare Connect	173	210	37
OneCare	8	9	2
PACE	92	117	24
MSSP	16	18	2
Total	1,392	1,558	167

MM per FTE	Actual	Budget	Fav / (Unfav)
Medi-Cal	810	677	(133)
OneCare Connect	84	72	(11)
OneCare	337	193	(144)
PACE	5	4	(1)
MSSP	29	35	6
Consolidated	655	535	(120)

YEAR - TO - DATE

Year To Date Enrollment	Actual	Budget	Fav / (Unfav)	
Medi-Cal	9,414,347	9,055,587	358,760	4.0%
OneCare Connect	161,774	166,264	(4,490)	(2.7%)
OneCare	25,439	19,583	5,856	29.9%
PACE	4,570	4,513	57	1.3%
MSSP	2,285	2,785	(500)	(18.0%)
Total*	9,606,130	9,245,947	360,183	3.9%

Change in Net Assets (000)	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 233,841	$ (73,035)	$ 306,876	420.2%
OneCare Connect	9,869	(4,954)	14,823	299.2%
OneCare	(1,052)	(990)	(62)	(6.3%)
PACE	5,055	1,255	3,800	302.8%
MSSP	(6)	(64)	58	90.6%
500 and 505 Bldgs.	100	-	100	0.0%
Investment Income	(16,746)	9,167	(25,913)	(282.7%)
Total	$ 231,061	$ (68,621)	$ 299,682	436.7%

MLR	Actual	Budget	% Point Var
Medi-Cal	90.5%	97.8%	(7.3)
OneCare Connect	91.6%	94.9%	(3.3)
OneCare	96.9%	95.8%	1.2

Administrative Cost (000)	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 118,391	$ 138,266	$ 19,875	14.4%
OneCare Connect	16,246	20,684	4,438	21.5%
OneCare	2,059	1,974	(85)	(4.3%)
PACE	1,897	2,603	706	27.1%
MSSP	324	416	92	22.1%
Total	$ 138,917	$ 163,943	$ 25,026	15.3%

Total FTE's YTD	Actual	Budget	Fav / (Unfav)
Medi-Cal	11,903	13,330	1,426
OneCare Connect	2,012	2,305	294
OneCare	106	102	(4)
PACE	1,007	1,261	253
MSSP	81	90	9
Total	15,109	17,088	1,979

MM per FTE	Actual	Budget	Fav / (Unfav)
Medi-Cal	791	679	(112)
OneCare Connect	80	72	(8)
OneCare	239	191	(48)
PACE	5	4	(1)
MSSP	28	31	3
Consolidated	636	541	(95)

Note:* Total membership does not include MSSP

CalOptima - Consolidated
Statement of Revenues and Expenses
For the One Month Ended May 31, 2022

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	911,427		832,944		78,483	
REVENUE						
Medi-Cal	$ 332,479,642	$ 371.93	$ 242,328,018	$ 297.12	$ 90,151,624	$ 74.81
OneCare Connect	36,648,589	2,533.60	28,818,735	1,906.13	7,829,854	627.47
OneCare	3,728,124	1,425.12	2,203,852	1,226.41	1,524,272	198.71
PACE	4,253,663	10,032.22	3,540,861	8,158.67	712,802	1,873.55
MSSP	219,023	476.14	278,731	445.97	(59,708)	30.17
Total Operating Revenue	377,329,042	414.00	277,170,197	332.76	100,158,845	81.24
MEDICAL EXPENSES						
Medi-Cal	272,123,779	304.42	239,527,219	293.68	(32,596,560)	(10.74)
OneCare Connect	30,780,170	2,127.91	27,793,119	1,838.29	(2,987,051)	(289.62)
OneCare	3,186,715	1,218.16	2,114,776	1,176.84	(1,071,939)	(41.32)
PACE	2,884,340	6,802.69	3,295,757	7,593.91	411,417	791.22
MSSP	150,861	327.96	196,507	314.41	45,646	(13.55)
Total Medical Expenses	309,125,866	339.17	272,927,378	327.67	(36,198,488)	(11.50)
GROSS MARGIN	68,203,177	74.83	4,242,819	5.09	63,960,358	69.74
ADMINISTRATIVE EXPENSES						
Salaries and benefits	8,864,437	9.73	9,491,531	11.40	627,094	1.67
Professional fees	411,318	0.45	831,646	1.00	420,328	0.55
Purchased services	1,394,679	1.53	1,215,789	1.46	(178,890)	(0.07)
Printing & Postage	540,381	0.59	639,498	0.77	99,117	0.18
Depreciation & Amortization	334,638	0.37	492,900	0.59	158,262	0.22
Other expenses	2,055,498	2.26	2,308,426	2.77	252,928	0.51
Indirect cost allocation & Occupancy expense	351,680	0.39	470,184	0.56	118,504	0.17
Total Administrative Expenses	13,952,629	15.31	15,449,974	18.55	1,497,345	3.24
INCOME (LOSS) FROM OPERATIONS	54,250,548	59.52	(11,207,155)	(13.45)	65,457,703	72.97
INVESTMENT INCOME						
Interest income	1,535,202	1.68	833,333	1.00	701,869	0.68
Realized gain/(loss) on investments	(556,612)	(0.61)	-	-	(556,612)	(0.61)
Unrealized gain/(loss) on investments	3,182,408	3.49	-	-	3,182,408	3.49
Total Investment Income	4,160,997	4.57	833,333	1.00	3,327,664	3.57
NET RENTAL INCOME	100,079	0.11	-	-	100,079	0.11
TOTAL MCO TAX	(646,118)	(0.71)	-	-	(646,118)	(0.71)
TOTAL GRANT INCOME	(30,303)	(0.03)	-	-	(30,303)	(0.03)
OTHER INCOME	43	-	-	-	43	-
CHANGE IN NET ASSETS	**57,835,245**	**63.46**	**(10,373,822)**	**(12.45)**	**68,209,067**	**75.91**
MEDICAL LOSS RATIO	**81.9%**		**98.5%**		**(16.5%)**	
ADMINISTRATIVE LOSS RATIO	**3.7%**		**5.6%**		**1.9%**	

CalOptima - Consolidated
Statement of Revenues and Expenses
For the Eleven Months Ended May 31, 2022

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	9,606,130		9,245,947		360,183	
REVENUE						
Medi-Cal	$ 3,705,617,756	$ 393.61	$ 3,008,528,429	$ 332.23	$ 697,089,327	$ 61.38
OneCare Connect	311,968,623	1,928.42	310,662,624	1,868.49	1,305,999	59.93
OneCare	32,640,970	1,283.11	23,203,856	1,184.90	9,437,114	98.21
PACE	38,123,590	8,342.14	36,686,981	8,129.18	1,436,609	212.96
MSSP	1,057,293	462.71	1,242,373	446.09	(185,080)	16.62
Total Operating Revenue	4,089,408,233	425.71	3,380,324,263	365.60	709,083,970	60.11
MEDICAL EXPENSES						
Medi-Cal	3,355,238,225	356.40	2,943,296,912	325.03	(411,941,313)	(31.37)
OneCare Connect	285,854,016	1,767.00	294,932,186	1,773.88	9,078,170	6.88
OneCare	31,633,624	1,243.51	22,219,524	1,134.63	(9,414,100)	(108.88)
PACE	31,171,883	6,820.98	32,828,593	7,274.23	1,656,710	453.25
MSSP	738,955	323.39	890,221	319.65	151,266	(3.75)
Total Medical Expenses	3,704,636,702	385.65	3,294,167,436	356.28	(410,469,266)	(29.37)
GROSS MARGIN	384,771,531	40.06	86,156,827	9.32	298,614,704	30.74
ADMINISTRATIVE EXPENSES						
Salaries and benefits	91,440,810	9.52	103,503,617	11.19	12,062,807	1.67
Professional fees	3,828,685	0.40	8,144,618	0.88	4,315,933	0.48
Purchased services	12,476,303	1.30	13,862,214	1.50	1,385,911	0.20
Printing & Postage	4,869,982	0.51	6,374,478	0.69	1,504,496	0.18
Depreciation & Amortization	4,023,931	0.42	5,421,900	0.59	1,397,969	0.17
Other expenses	18,085,690	1.88	21,715,161	2.35	3,629,471	0.47
Indirect cost allocation & Occupancy expense	4,191,956	0.44	4,922,024	0.53	730,068	0.09
Total Administrative Expenses	138,917,356	14.46	163,944,012	17.73	25,026,656	3.27
INCOME (LOSS) FROM OPERATIONS	245,854,174	25.59	(77,787,185)	(8.41)	323,641,359	34.00
INVESTMENT INCOME						
Interest income	8,380,617	0.87	9,166,666	0.99	(786,049)	(0.12)
Realized gain/(loss) on investments	(1,789,634)	(0.19)	-	-	(1,789,634)	(0.19)
Unrealized gain/(loss) on investments	(23,337,184)	(2.43)	-	-	(23,337,184)	(2.43)
Total Investment Income	(16,746,200)	(1.74)	9,166,666	0.99	(25,912,866)	(2.73)
NET RENTAL INCOME	100,079	0.01	-	-	100,079	0.01
TOTAL MCO TAX	1,934,661	0.20	-	-	1,934,661	0.20
TOTAL GRANT INCOME	(90,909)	(0.01)	-	-	(90,909)	(0.01)
OTHER INCOME	8,865	-	-	-	8,865	-
CHANGE IN NET ASSETS	**231,060,671**	**24.05**	**(68,620,519)**	**(7.42)**	**299,681,190**	**31.47**
MEDICAL LOSS RATIO	**90.6%**		**97.5%**		**(6.9%)**	
ADMINISTRATIVE LOSS RATIO	**3.4%**		**4.8%**		**1.5%**	

CalOptima - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the One Month Ended May 31, 2022

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	MSSP	Consolidated
MEMBER MONTHS	557,761	324,283	11,878	893,922	14,465	2,616	424	460	911,427
REVENUES									
Capitation Revenue	177,150,655	$ 133,319,238	$ 22,009,750	$ 332,479,642	$ 36,648,589	$ 3,728,124	$ 4,253,663	$ 219,023	$ 377,329,042
Other Income	-	-	-	-	-	-	-	-	-
Total Operating Revenue	177,150,655	133,319,238	22,009,750	332,479,642	36,648,589	3,728,124	4,253,663	219,023	377,329,042
MEDICAL EXPENSES									
Provider Capitation	49,678,860	51,828,703	9,098,083	110,605,646	15,851,955	1,076,839			127,534,440
Facilities	22,720,252	31,319,371	3,965,580	58,005,202	3,973,649	1,003,804	305,734		63,288,389
Professional Claims	22,304,642	13,363,967	1,014,236	36,682,846	1,242,221	100,078	794,367		38,819,512
Prescription Drugs	(91,138)	(11,630)	(281,287)	(384,055)	6,566,541	917,437	349,919		7,449,843
MLTSS	37,982,460	3,959,786	1,769,988	43,712,234	1,615,363	56,925	374,057	24,266	45,782,845
Medical Management	2,577,585	1,747,651	344,521	4,669,757	1,148,833	31,056	968,001	126,596	6,944,243
Quality Incentives	2,290,868	1,529,012	59,974	3,879,854	212,685		(10,473)		4,082,066
Reinsurance & Other	8,710,445	6,035,558	206,292	14,952,295	168,922	575	102,735		15,224,527
Total Medical Expenses	146,173,973	109,772,419	16,177,387	272,123,779	30,780,170	3,186,715	2,884,340	150,861	309,125,866
Medical Loss Ratio	82.5%	82.3%	73.5%	81.8%	84.0%	85.5%	67.8%	68.9%	81.9%
GROSS MARGIN	**30,976,682**	**23,546,818**	**5,832,363**	**60,355,863**	**5,868,420**	**541,409**	**1,369,323**	**68,162**	**68,203,177**
ADMINISTRATIVE EXPENSES									
Salaries & Benefits	7,960,097	666,299	53,830	122,349	61,861	8,864,437			
Professional fees	347,173	32,771	29,167		2,207	411,318			
Purchased services	1,251,646	52,376	15,162	75,496		1,394,679			
Printing & Postage	492,058	30,570	3,453	14,299		540,381			
Depreciation & Amortization	333,809			829		334,638			
Other expenses	2,041,476	2,170	-	7,893	3,960	2,055,498			
Indirect cost allocation & Occupancy	(302,285)	578,216	59,743	11,733	4,273	351,680			
Total Administrative Expenses	12,123,974	1,362,402	161,355	232,600	72,300	13,952,629			
Admin Loss Ratio	3.6%	3.7%	4.3%	5.5%	33.0%	3.7%			
INCOME (LOSS) FROM OPERATIONS	48,231,889	4,506,018	380,054	1,136,723	(4,138)	54,250,548			
INVESTMENT INCOME						4,160,997			
NET RENTAL INCOME						100,079			
TOTAL MCO TAX	(646,118)					(646,118)			
TOTAL GRANT INCOME	(30,303)					(30,303)			
OTHER INCOME	43					43			
CHANGE IN NET ASSETS	**$ 47,555,511**	**$ 4,506,018**	**$ 380,054**	**$ 1,136,723**	**$ (4,138)**	**$ 57,835,245**			
BUDGETED CHANGE IN NET ASSETS	(10,272,648)	(825,703)	(89,300)	(12,162)	(7,342)	(10,373,822)			
VARIANCE TO BUDGET - FAV (UNFAV)	$ 57,828,159	$ 5,331,721	$ 469,354	$ 1,148,885	$ 3,204	$ 68,209,067			

Note:* Total membership does not include MSSP

CalOptima - Consolidated - Year to Date
Statement of Revenues and Expenses by LOB
For the Eleven Months Ended May 31, 2022

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total MC	OneCare Connect	OneCare	PACE	MSSP	Consolidated
MEMBER MONTHS	5,928,005	3,356,277	130,065	9,414,347	161,774	25,439	4,570	2,285	9,606,130
REVENUES									
Capitation Revenue	1,899,556,239	$ 1,534,993,475	$ 271,068,042	3,705,617,756	$ 311,968,623	$ 32,640,970	$ 38,123,590	1,057,293	$ 4,089,408,233
Other Income	-	-	-	-	-	-	-	-	-
Total Operating Revenue	1,899,556,239	1,534,993,475	271,068,042	3,705,617,756	311,968,623	32,640,970	38,123,590	1,057,293	4,089,408,233
MEDICAL EXPENSES									
Provider Capitation	509,816,347	548,433,208	98,216,720	1,156,466,274	125,850,116	9,010,764		-	1,291,327,154
Facilities	275,231,474	284,343,965	61,076,078	620,651,517	45,349,377	9,927,280	7,656,994	-	683,585,168
Professional Claims	237,949,850	125,306,198	14,512,969	377,769,017	12,521,668	1,123,602	8,486,605	-	399,900,893
Prescription Drugs	128,344,389	175,086,125	40,136,051	343,566,566	69,976,597	10,572,749	3,594,520	-	427,710,432
MLTSS	404,334,162	44,089,425	19,416,276	467,839,863	15,959,990	563,502	826,796	144,890	485,335,041
Medical Management	28,022,284	17,329,919	3,637,437	48,989,640	11,734,633	402,033	9,305,493	594,065	71,025,865
Quality Incentives	19,847,689	10,821,653	878,008	31,547,350	2,429,085		(43,007)	-	33,933,429
Reinsurance & Other	181,228,124	117,062,993	10,116,881	308,407,998	2,032,548	33,694	1,344,481	-	311,818,721
Total Medical Expenses	1,784,774,319	1,322,473,486	247,990,419	3,355,238,225	285,854,016	31,633,624	31,171,883	738,955	3,704,636,702
Medical Loss Ratio	94.0%	86.2%	91.5%	90.5%	91.6%	96.9%	81.8%	69.9%	90.6%
GROSS MARGIN	**114,781,920**	**212,519,988**	**23,077,623**	**350,379,531**	**26,114,607**	**1,007,346**	**6,951,708**	**318,338**	**384,771,531**
ADMINISTRATIVE EXPENSES									
Salaries & Benefits	81,513,500	7,620,935	844,255	1,193,776	268,344	91,440,810			
Professional fees	3,281,676	202,622	327,599	7,251	9,536	3,828,685			
Purchased services	10,829,053	1,168,764	135,420	343,066	-	12,476,303			
Printing & Postage	3,747,184	879,039	93,853	149,906	-	4,869,982			
Depreciation & Amortization	4,015,589			8,342	-	4,023,931			
Other expenses	17,966,161	14,133	1,076	80,409	23,912	18,085,690			
Indirect cost allocation & Occupancy	(2,962,031)	6,360,374	657,176	114,152	22,285	4,191,956			
Total Administrative Expenses	118,391,133	16,245,867	2,059,378	1,896,900	324,077	138,917,356			
Admin Loss Ratio	3.2%	5.2%	6.3%	5.0%	30.7%	3.4%			
INCOME (LOSS) FROM OPERATIONS	231,988,398	9,868,740	(1,052,032)	5,054,807	(5,739)	245,854,174			
INVESTMENT INCOME						(16,746,200)			
NET RENTAL INCOME						100,079			
TOTAL MCO TAX	1,934,661					1,934,661			
TOTAL GRANT INCOME	(90,909)					(90,909)			
OTHER INCOME	8,865					8,865			
CHANGE IN NET ASSETS	**$ 233,841,015**	**$ 9,868,740**	**$ (1,052,032)**	**$ 5,054,807**	**$ (5,739)**	**$ 231,060,671**			
BUDGETED CHANGE IN NET ASSETS	(73,034,822)	(4,953,802)	(989,720)	1,255,478	(64,319)	(68,620,519)			
VARIANCE TO BUDGET - FAV (UNFAV)	$ 306,875,837	$ 14,822,542	$ (62,312)	$ 3,799,329	$ 58,580	$ 299,681,190			

Note:* Total membership does not include MSSP

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May 31, 2022 Unaudited Financial Statements

SUMMARY MONTHLY RESULTS:

- Change in Net Assets is $57.8 million, $68.2 million favorable to budget
- Operating surplus is $54.3 million, with a surplus in non-operating income of $3.6 million

YEAR TO DATE RESULTS:

- Change in Net Assets is $231.1 million, $299.7 million favorable to budget
- Operating surplus is $245.9 million, with a deficit in non-operating income of $14.8 million

Change in Net Assets by Line of Business (LOB) ($ millions):

May				July-May		
Actual	Budget	Variance		Actual	Budget	Variance
48.2	(10.3)	58.5	Medi-Cal	232.0	(73.0)	305.0
4.5	(0.8)	5.3	OCC	9.9	(5.0)	14.8
0.4	(0.1)	0.5	OneCare	(1.1)	(1.0)	(0.1)
1.1	(0.0)	1.1	PACE	5.1	1.3	3.8
(0.0)	(0.0)	0.0	MSSP	(0.0)	(0.1)	0.1
54.3	**(11.2)**	**65.5**	**Operating**	**245.9**	**(77.8)**	**323.6**
3.6	0.8	2.8	Inv./Rental Inc, MCO tax	(14.8)	9.2	(24.0)
3.6	**0.8**	**2.8**	**Non-Operating**	**(14.8)**	**9.2**	**(24.0)**
57.8	**(10.4)**	**68.2**	**TOTAL**	**231.1**	**(68.6)**	**299.7**

CalOptima - Consolidated
Enrollment Summary
For the Eleven Months Ended May 31, 2022

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
128,319	117,925	10,394	8.8%	SPD	1,319,644	1,291,512	28,132	2.2%
302,882	291,579	11,303	3.9%	TANF Child	3,311,333	3,251,900	59,433	1.8%
123,337	105,322	18,015	17.1%	TANF Adult	1,262,451	1,171,997	90,454	7.7%
3,223	3,191	32	1.0%	LTC	34,577	35,101	(524)	(1.5%)
324,283	286,418	37,865	13.2%	MCE	3,356,277	3,182,328	173,949	5.5%
11,878	11,159	719	6.4%	WCM	130,065	122,749	7,316	6.0%
893,922	**815,594**	**78,328**	**9.6%**	**Medi-Cal Total**	**9,414,347**	**9,055,587**	**358,760**	**4.0%**
14,465	**15,119**	**(654)**	**(4.3%)**	**OneCare Connect**	**161,774**	**166,264**	**(4,490)**	**(2.7%)**
2,616	**1,797**	**819**	**45.6%**	**OneCare**	**25,439**	**19,583**	**5,856**	**29.9%**
424	**434**	**(10)**	**(2.3%)**	**PACE**	**4,570**	**4,513**	**57**	**1.3%**
460	**625**	**(165)**	**(26.4%)**	**MSSP**	**2,285**	**2,785**	**(500)**	**(18.0%)**
911,427	**832,944**	**78,483**	**9.4%**	**CalOptima Total***	**9,606,130**	**9,245,947**	**360,183**	**3.9%**
				Enrollment (by Network)				
205,389	189,268	16,121	8.5%	HMO	2,189,995	2,099,734	90,261	4.3%
234,034	223,944	10,090	4.5%	PHC	2,536,711	2,495,353	41,358	1.7%
216,745	199,505	17,240	8.6%	Shared Risk Group	2,301,152	2,223,111	78,041	3.5%
237,754	202,877	34,877	17.2%	Fee for Service	2,386,489	2,237,389	149,100	6.7%
893,922	**815,594**	**78,328**	**9.6%**	**Medi-Cal Total**	**9,414,347**	**9,055,587**	**358,760**	**4.0%**
14,465	**15,119**	**(654)**	**(4.3%)**	**OneCare Connect**	**161,774**	**166,264**	**(4,490)**	**(2.7%)**
2,616	**1,797**	**819**	**45.6%**	**OneCare**	**25,439**	**19,583**	**5,856**	**29.9%**
424	**434**	**(10)**	**(2.3%)**	**PACE**	**4,570**	**4,513**	**57**	**1.3%**
460	**625**	**(165)**	**-26.4%**	**MSSP**	**2,285**	**2,785**	**(500)**	**-18.0%**
911,427	**832,944**	**78,483**	**9.4%**	**CalOptima Total***	**9,606,130**	**9,245,947**	**360,183**	**3.9%**

*Note: CalOptima Total does not include MSSP

CalOptima
Enrollment Trend by Network
Fiscal Year 2022

	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	June	YTD Actual	YTD Budget	Variance
HMOs															
SPD	10,759	10,772	10,796	10,750	10,821	10,837	10,841	10,887	10,843	10,879	10,858		119,043	118,961	82
TANF Child	57,684	57,453	57,592	57,944	58,108	58,236	58,526	58,795	58,905	59,086	59,080		641,409	624,730	16,679
TANF Adult	33,827	34,099	34,339	34,622	35,046	35,411	35,758	36,052	36,426	36,751	36,959		389,290	363,722	25,568
LTC		1	3	1		1	1		2	2	1		12		12
MCE	88,797	89,334	90,159	91,017	91,516	92,159	93,225	93,841	94,771	95,797	96,408		1,017,024	970,211	46,813
WCM	2,114	2,193	2,177	2,133	2,130	2,143	2,103	1,986	2,147	2,008	2,083		23,217	22,110	1,107
Total	**193,181**	**193,852**	**195,066**	**196,467**	**197,621**	**198,787**	**200,454**	**201,561**	**203,094**	**204,523**	**205,389**		**2,189,995**	**2,099,734**	**90,261**
PHCs															
SPD	6,896	6,819	6,942	6,915	6,953	6,926	6,861	6,880	6,894	6,846	6,916		75,848	78,341	(2,493)
TANF Child	155,214	154,985	155,440	155,771	156,156	156,251	156,692	157,039	156,984	157,528	157,532		1,719,592	1,694,738	24,854
TANF Adult	14,006	14,054	14,197	14,390	14,667	14,851	14,985	15,115	15,270	15,437	15,596		162,568	151,416	11,152
LTC		2	1			1							4		4
MCE	44,256	44,359	44,580	44,754	44,973	45,241	45,668	45,753	46,013	46,253	46,607		498,457	495,266	3,191
WCM	7,304	7,368	7,236	7,322	7,178	7,262	7,246	7,037	7,679	7,227	7,383		80,242	75,592	4,650
Total	**227,676**	**227,587**	**228,396**	**229,152**	**229,927**	**230,532**	**231,452**	**231,824**	**232,840**	**233,291**	**234,034**		**2,536,711**	**2,495,353**	**41,358**
Shared Risk Groups															
SPD	10,063	10,104	10,074	10,003	10,122	10,095	10,096	10,086	10,077	10,099	10,756		111,575	113,651	(2,076)
TANF Child	59,085	58,837	58,641	58,541	58,523	58,347	58,363	58,200	58,279	58,269	57,989		643,074	652,520	(9,446)
TANF Adult	33,013	33,123	33,374	33,745	34,109	34,482	34,824	35,120	35,551	35,818	36,744		379,903	363,474	16,429
LTC	1	1	1		1			1		3	1		9		9
MCE	99,994	100,643	101,666	102,780	103,620	104,418	105,563	106,367	107,480	108,934	109,914		1,151,379	1,077,890	73,489
WCM	1,373	1,368	1,394	1,400	1,395	1,394	1,423	1,363	1,393	1,368	1,341		15,212	15,576	(364)
Total	**203,529**	**204,076**	**205,150**	**206,469**	**207,770**	**208,736**	**210,269**	**211,137**	**212,780**	**214,491**	**216,745**		**2,301,152**	**2,223,111**	**78,041**
Fee for Service (Dual)															
SPD	79,829	80,117	80,139	80,438	80,738	80,494	81,326	81,148	81,219	81,291	81,397		888,136	866,214	21,922
TANF Child	1	1	1	1	1	1	1	1	1	1	1		11		11
TANF Adult	1,318	1,351	1,392	1,408	1,435	1,465	1,529	1,568	1,563	1,582	1,615		16,226	12,728	3,498
LTC	2,788	2,778	2,806	2,847	2,864	2,870	2,914	2,624	2,846	2,819	2,891		31,047	31,757	(710)
MCE	3,612	3,813	4,013	4,268	4,489	4,889	4,982	5,145	5,468	5,693	5,908		52,280	28,604	23,676
WCM	16	16	18	20	15	18	16	16	19	18	18		190	165	25
Total	**87,564**	**88,076**	**88,369**	**88,982**	**89,542**	**89,737**	**90,768**	**90,502**	**91,116**	**91,404**	**91,830**		**987,890**	**939,468**	**48,422**
Fee for Service (Non-Dual - Total)															
SPD	10,163	10,047	10,616	10,358	10,832	10,708	10,937	10,763	11,022	11,204	18,392		125,042	114,345	10,697
TANF Child	26,720	26,952	27,715	28,188	27,730	27,774	28,746	28,788	28,055	28,299	28,280		307,247	279,912	27,335
TANF Adult	26,224	26,653	27,382	27,916	28,150	28,339	29,265	29,129	29,267	29,716	32,423		314,464	280,657	33,807
LTC	309	314	305	316	321	332	292	332	324	330	330		3,505	3,344	161
MCE	53,947	54,384	55,449	56,467	56,714	56,885	58,967	59,675	59,349	59,854	65,446		637,137	610,357	26,780
WCM	993	962	999	1,030	1,009	975	1,053	898	1,172	1,060	1,053		11,204	9,306	1,898
Total	**118,356**	**119,312**	**122,466**	**124,275**	**124,756**	**125,013**	**129,260**	**129,585**	**129,189**	**130,463**	**145,924**		**1,398,599**	**1,297,921**	**100,678**
SPD	117,710	117,859	118,567	118,464	119,466	119,060	120,061	119,764	120,055	120,319	128,319		1,319,644	1,291,512	28,132
TANF Child	298,704	298,228	299,389	300,445	300,518	300,609	302,328	302,823	302,224	303,183	302,882		3,311,333	3,251,900	59,433
TANF Adult	108,388	109,280	110,684	112,081	113,407	114,548	116,361	116,984	118,077	119,304	123,337		1,262,451	1,171,997	90,454
LTC	3,098	3,096	3,116	3,164	3,186	3,204	3,207	2,957	3,172	3,154	3,223		34,577	35,101	(524)
MCE	290,606	292,533	295,867	299,286	301,312	303,592	308,405	310,781	313,081	316,531	324,283		3,356,277	3,182,328	173,949
WCM	11,800	11,907	11,824	11,905	11,727	11,792	11,841	11,300	12,410	11,681	11,878		130,065	122,749	7,316
Total Medi-Cal MM	**830,306**	**832,903**	**839,447**	**845,345**	**849,616**	**852,805**	**862,203**	**864,609**	**869,019**	**874,172**	**893,922**		**9,414,347**	**9,055,587**	**358,760**
OneCare Connect	**14,688**	**14,819**	**14,817**	**14,833**	**14,877**	**14,933**	**14,686**	**14,579**	**14,587**	**14,490**	**14,465**		**161,774**	**166,264**	**(4,490)**
OneCare	**2,019**	**2,110**	**2,152**	**2,232**	**2,274**	**2,330**	**2,319**	**2,395**	**2,461**	**2,531**	**2,616**		**25,439**	**19,583**	**5,856**
PACE	**401**	**407**	**409**	**418**	**415**	**421**	**427**	**418**	**413**	**417**	**424**		**4,570**	**4,513**	**57**
MSSP							**452**	**457**	**459**	**457**	**460**		**2,285**	**2,785**	**(500)**
Grand Total*	**847,414**	**850,239**	**856,825**	**862,828**	**867,182**	**870,489**	**879,635**	**882,001**	**886,480**	**891,610**	**911,427**		**9,606,130**	**9,245,947**	**360,183**

*Note: Grand Total does not include MSSP

ENROLLMENT:

Overall, May enrollment was 911,427

- Favorable to budget 78,483 or 9.4%
- Increased 19,817 or 2.2% from Prior Month (PM) (April 2022)
- Increased 72,397 or 8.6% from Prior Year (PY) (May 2021)

Medi-Cal enrollment was 893,922

- Favorable to budget 78,328 or 9.6% due to pause in redetermination due to the Public Health Emergency
  - Medi-Cal Expansion (MCE) favorable 37,865
  - Temporary Assistance for Needy Families (TANF) favorable 29,318
  - Seniors and Persons with Disabilities (SPD) favorable 10,394
  - Whole Child Model (WCM) favorable 719
  - Long-Term Care (LTC) favorable 32
- Increased 19,750 from PM

OneCare Connect enrollment was 14,465

- Unfavorable to budget 654 or 4.3%
- Decreased 25 from PM

OneCare enrollment was 2,616

- Favorable to budget 819 or 45.6%
- Increased 85 from PM

PACE enrollment was 424

- Unfavorable to budget 10 or 2.3%
- Increased 7 from PM

MSSP enrollment was 460

- Unfavorable to budget 165 or 26.4% due to MSSP currently being under-staffed. There is a staff to member ratio that must be met
- Increased 3 from PM

CalOptima
Medi-Cal Total
Statement of Revenues and Expenses
For the Eleven Months Ending May 31, 2022

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
893,922	**815,594**	**78,328**	**9.6%**	**Member Months**	**9,414,347**	**9,055,587**	**358,760**	**4.0%**
				Revenues				
332,479,642	242,328,018	90,151,624	37.2%	Capitation Revenue	3,705,617,756	3,008,528,429	697,089,327	23.2%
-	-	-	0.0%	Other Income	-	-	-	0.0%
332,479,642	**242,328,018**	**90,151,624**	**37.2%**	**Total Operating Revenue**	**3,705,617,756**	**3,008,528,429**	**697,089,327**	**23.2%**
				Medical Expenses				
114,485,500	88,627,943	(25,857,557)	(29.2%)	Provider Capitation	1,188,013,625	1,001,199,120	(186,814,505)	(18.7%)
58,005,202	66,606,223	8,601,021	12.9%	Facilities Claims	620,651,517	707,427,522	86,776,005	12.3%
36,682,846	31,985,982	(4,696,864)	(14.7%)	Professional Claims	377,769,017	343,989,545	(33,779,472)	(9.8%)
(384,055)	-	384,055	0.0%	Prescription Drugs	343,566,566	345,521,586	1,955,020	0.6%
43,712,234	43,416,556	(295,678)	(0.7%)	MLTSS	467,839,863	464,824,103	(3,015,760)	(0.6%)
4,669,757	5,563,995	894,238	16.1%	Medical Management	48,989,640	59,599,153	10,609,513	17.8%
14,952,295	3,326,520	(11,625,775)	(349.5%)	Reinsurance & Other	308,407,998	20,735,883	(287,672,115)	(1387.3%)
272,123,779	**239,527,219**	**(32,596,560)**	**(13.6%)**	**Total Medical Expenses**	**3,355,238,225**	**2,943,296,912**	**(411,941,313)**	**(14.0%)**
60,355,863	**2,800,799**	**57,555,064**	**2055.0%**	**Gross Margin**	**350,379,531**	**65,231,517**	**285,148,014**	**437.1%**
				Administrative Expenses				
7,960,097	8,325,580	365,483	4.4%	Salaries, Wages & Employee Benefits	81,513,500	90,994,522	9,481,022	10.4%
347,173	771,868	424,695	55.0%	Professional Fees	3,281,676	7,281,660	3,999,984	54.9%
1,251,646	1,045,945	(205,701)	(19.7%)	Purchased Services	10,829,053	12,049,645	1,220,592	10.1%
492,058	466,328	(25,730)	(5.5%)	Printing and Postage	3,747,184	4,469,608	722,424	16.2%
333,809	492,500	158,691	32.2%	Depreciation & Amortization	4,015,589	5,417,500	1,401,911	25.9%
2,041,476	2,241,847	200,371	8.9%	Other Operating Expenses	17,966,161	21,250,931	3,284,770	15.5%
(302,285)	(270,621)	31,664	11.7%	Indirect Cost Allocation, Occupancy Expense	(2,962,031)	(3,197,527)	(235,496)	(7.4%)
12,123,974	**13,073,447**	**949,473**	**7.3%**	**Total Administrative Expenses**	**118,391,133**	**138,266,339**	**19,875,206**	**14.4%**
				Operating Tax				
7,304,352	13,734,607	(6,430,255)	(46.8%)	Tax Revenue	154,330,495	152,496,085	1,834,410	1.2%
7,950,470	13,734,607	5,784,137	42.1%	Premium Tax Expense	152,395,833	152,496,085	100,252	0.1%
(646,118)	-	(646,118)	**0.0%**	**Total Net Operating Tax**	1,934,661	-	1,934,661	**0.0%**
				Grant Income				
-	-	-	0.0%	Grant Revenue	-	-	-	0.0%
30,303	-	(30,303)	0.0%	Grant Expense	90,909	-	(90,909)	0.0%
(30,303)	-	(30,303)	**0.0%**	**Total Grant Income**	(90,909)	-	(90,909)	**0.0%**
43	**-**	**43**	**0.0%**	**Other income**	**8,865**	**-**	**8,865**	**0.0%**
47,555,511	**(10,272,648)**	**57,828,159**	**562.9%**	**Change in Net Assets**	**233,841,015**	**(73,034,822)**	**306,875,837**	**420.2%**
81.8%	***98.8%***	***(17.0%)***		***Medical Loss Ratio***	***90.5%***	***97.8%***	***(7.3%)***	
3.6%	***5.4%***	***1.7%***		***Admin Loss Ratio***	***3.2%***	***4.6%***	***1.4%***	

MEDI-CAL INCOME STATEMENT– MAY MONTH:

REVENUES of $332.5 million are favorable to budget $90.2 million driven by:

- Favorable volume related variance of $23.3 million
- Favorable price related variance of $66.9 million
  - $35.6 million due to favorable revenue rates and Proposition 56 risk corridor estimates
  - $22.5 million due to CalAIM's Incentive Payment Program (IPP) funding from the Department of Health Care Services (DHCS)

MEDICAL EXPENSES of $272.1 million are unfavorable to budget $32.6 million driven by:

- Unfavorable volume related variance of $23.0 million
- Unfavorable price related variance of $9.6 million
  - Provider Capitation expense unfavorable variance of $17.3 million due primarily to the extension of Proposition 56 and short-term supplemental rate increase due to COVID-19
  - Reinsurance & Other expense unfavorable variance of $11.3 million due to CalAIM IPP payments to Health Networks and providers
  - Offset by:
  - Facilities Claims expense favorable variance of $15.0 million due to decrease facilities-related crossover claims and low utilization
  - Managed Long-Term Services and Supports (MLTSS) expense favorable variance of $3.9 million due to Incurred But Not Reported (IBNR) claims

ADMINISTRATIVE EXPENSES of $12.1 million are favorable to budget $0.9 million driven by:

- Other Non-Salary expense favorable to budget $0.6 million
- Salaries & Benefit expense favorable to budget $0.4 million

CHANGE IN NET ASSETS is $47.6 million, favorable to budget $57.8 million

CalOptima
OneCare Connect Total
Statement of Revenue and Expenses
For the Eleven Months Ending May 31, 2022

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
14,465	**15,119**	**(654)**	**(4.3%)**	**Member Months**	**161,774**	**166,264**	**(4,490)**	**(2.7%)**
				Revenues				
2,689,102	2,783,196	(94,094)	(3.4%)	Medi-Cal Capitation Revenue	29,747,518	30,825,483	(1,077,965)	(3.5%)
27,262,364	20,246,279	7,016,085	34.7%	Medicare Capitation Revenue Part C	215,511,884	216,520,066	(1,008,182)	(0.5%)
6,697,123	5,789,260	907,863	15.7%	Medicare Capitation Revenue Part D	66,709,221	63,317,075	3,392,146	5.4%
-	-	-	0.0%	Other Income	-	-	-	0.0%
36,648,589	**28,818,735**	**7,829,854**	**27.2%**	**Total Operating Revenue**	**311,968,623**	**310,662,624**	**1,305,999**	**0.4%**
				Medical Expenses				
16,064,640	12,404,459	(3,660,181)	(29.5%)	Provider Capitation	128,279,201	131,329,576	3,050,375	2.3%
3,973,649	4,549,020	575,371	12.6%	Facilities Claims	45,349,377	48,315,163	2,965,786	6.1%
1,242,221	1,085,474	(156,747)	(14.4%)	Ancillary	12,521,668	11,534,529	(987,139)	(8.6%)
1,615,363	1,409,172	(206,191)	(14.6%)	MLTSS	15,959,990	15,622,004	(337,986)	(2.2%)
6,566,541	6,925,617	359,076	5.2%	Prescription Drugs	69,976,597	72,634,242	2,657,645	3.7%
1,148,833	1,235,095	86,262	7.0%	Medical Management	11,734,633	13,539,376	1,804,743	13.3%
168,922	184,282	15,360	8.3%	Other Medical Expenses	2,032,548	1,957,296	(75,252)	(3.8%)
30,780,170	**27,793,119**	**(2,987,051)**	**(10.7%)**	**Total Medical Expenses**	**285,854,016**	**294,932,186**	**9,078,170**	**3.1%**
5,868,420	**1,025,616**	**4,842,804**	**472.2%**	**Gross Margin**	**26,114,607**	**15,730,438**	**10,384,169**	**66.0%**
				Administrative Expenses				
666,299	863,010	196,711	22.8%	Salaries, Wages & Employee Benefits	7,620,935	9,656,406	2,035,471	21.1%
32,771	29,320	(3,451)	(11.8%)	Professional Fees	202,622	534,670	332,048	62.1%
52,376	119,752	67,376	56.3%	Purchased Services	1,168,764	1,261,557	92,793	7.4%
30,570	138,109	107,539	77.9%	Printing and Postage	879,039	1,519,199	640,160	42.1%
2,170	21,075	18,905	89.7%	Other Operating Expenses	14,133	231,825	217,692	93.9%
578,216	680,053	101,837	15.0%	Indirect Cost Allocation	6,360,374	7,480,583	1,120,209	15.0%
1,362,402	**1,851,319**	**488,917**	**26.4%**	**Total Administrative Expenses**	**16,245,867**	**20,684,240**	**4,438,373**	**21.5%**
4,506,018	**(825,703)**	**5,331,721**	**645.7%**	**Change in Net Assets**	**9,868,740**	**(4,953,802)**	**14,822,542**	**299.2%**
84.0%	***96.4%***	***(12.5%)***		***Medical Loss Ratio***	***91.6%***	***94.9%***	***(3.3%)***	
3.7%	***6.4%***	***2.7%***		***Admin Loss Ratio***	***5.2%***	***6.7%***	***1.5%***	

ONECARE CONNECT INCOME STATEMENT– MAY MONTH:

REVENUES of $36.6 million are favorable to budget $7.8 million driven by:

- Unfavorable volume related variance of $1.2 million
- Favorable price related variance of $9.1 million

MEDICAL EXPENSES of $30.8 million are unfavorable to budget $3.0 million driven by:

- Favorable volume related variance of $1.2 million
- Unfavorable price related variance of $4.2 million
  - Provider Capitation expense unfavorable variance of $4.2 million

ADMINISTRATIVE EXPENSES of $1.4 million are favorable to budget $0.5 million

CHANGE IN NET ASSETS is $4.5 million, favorable to budget 5.3 million

CalOptima
OneCare
Statement of Revenues and Expenses
For the Eleven Months Ending May 31, 2022

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
2,616	**1,797**	**819**	**45.6%**	**Member Months**	**25,439**	**19,583**	**5,856**	**29.9%**
				Revenues				
2,712,388	1,483,398	1,228,990	82.8%	Medicare Part C revenue	22,322,316	15,788,909	6,533,407	41.4%
1,015,736	720,454	295,282	41.0%	Medicare Part D revenue	10,318,654	7,414,947	2,903,707	39.2%
3,728,124	**2,203,852**	**1,524,272**	**69.2%**	**Total Operating Revenue**	**32,640,970**	**23,203,856**	**9,437,114**	**40.7%**
				Medical Expenses				
1,076,839	587,731	(489,108)	(83.2%)	Provider Capitation	9,010,764	6,189,894	(2,820,870)	(45.6%)
1,003,804	648,737	(355,067)	(54.7%)	Inpatient	9,927,280	6,796,591	(3,130,689)	(46.1%)
100,078	77,460	(22,618)	(29.2%)	Ancillary	1,123,602	806,234	(317,368)	(39.4%)
56,925	29,669	(27,256)	(91.9%)	Skilled Nursing Facilities	563,502	321,831	(241,671)	(75.1%)
917,437	718,872	(198,565)	(27.6%)	Prescription Drugs	10,572,749	7,528,049	(3,044,700)	(40.4%)
31,056	50,977	19,921	39.1%	Medical Management	402,033	562,434	160,401	28.5%
575	1,330	755	56.8%	Other Medical Expenses	33,694	14,491	(19,203)	(132.5%)
3,186,715	**2,114,776**	**(1,071,939)**	**(50.7%)**	**Total Medical Expenses**	**31,633,624**	**22,219,524**	**(9,414,100)**	**(42.4%)**
541,409	**89,076**	**452,333**	**507.8%**	**Gross Margin**	**1,007,346**	**984,332**	**23,014**	**2.3%**
				Administrative Expenses				
53,830	72,267	18,437	25.5%	Salaries, wages & employee benefits	844,255	806,853	(37,402)	(4.6%)
29,167	29,166	(1)	(0.0%)	Professional fees	327,599	320,826	(6,773)	(2.1%)
15,162	9,167	(5,995)	(65.4%)	Purchased services	135,420	100,837	(34,583)	(34.3%)
3,453	15,823	12,370	78.2%	Printing and postage	93,853	174,053	80,200	46.1%
-	1,029	1,029	100.0%	Other operating expenses	1,076	11,319	10,243	90.5%
59,743	50,924	(8,819)	(17.3%)	Indirect cost allocation, occupancy expense	657,176	560,164	(97,012)	(17.3%)
161,355	**178,376**	**17,021**	**9.5%**	**Total Administrative Expenses**	**2,059,378**	**1,974,052**	**(85,326)**	**(4.3%)**
380,054	**(89,300)**	**469,354**	**525.6%**	**Change in Net Assets**	**(1,052,032)**	**(989,720)**	**(62,312)**	**(6.3%)**
85.5%	***96.0%***	***(10.5%)***		***Medical Loss Ratio***	***96.9%***	***95.8%***	***1.2%***	
4.3%	***8.1%***	***3.8%***		***Admin Loss Ratio***	***6.3%***	***8.5%***	***2.2%***	

CalOptima
PACE
Statement of Revenues and Expenses
For the Eleven Months Ending May 31, 2022

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
424	**434**	**(10)**	**(2.3%)**	**Member Months**	**4,570**	**4,513**	**57**	**1.3%**
				Revenues				
2,729,602	2,677,176	52,426	2.0%	Medi-Cal Capitation Revenue	28,480,544	27,955,409	525,135	1.9%
1,265,841	706,924	558,917	79.1%	Medicare Part C Revenue	7,417,986	7,094,394	323,592	4.6%
258,220	156,761	101,459	64.7%	Medicare Part D Revenue	2,225,060	1,637,178	587,882	35.9%
4,253,663	**3,540,861**	**712,802**	**20.1%**	**Total Operating Revenue**	**38,123,590**	**36,686,981**	**1,436,609**	**3.9%**
				Medical Expenses				
968,001	1,075,443	107,442	10.0%	Medical Management	9,305,493	11,183,123	1,877,630	16.8%
305,734	804,376	498,642	62.0%	Facilities Claims	7,656,994	8,154,861	497,867	6.1%
794,367	747,811	(46,556)	(6.2%)	Professional Claims	8,486,605	7,452,784	(1,033,821)	(13.9%)
102,735	230,535	127,800	55.4%	Patient Transportation	1,344,481	1,831,889	487,408	26.6%
349,919	367,393	17,474	4.8%	Prescription Drugs	3,594,520	3,631,799	37,279	1.0%
374,057	64,730	(309,327)	(477.9%)	MLTSS	826,796	518,279	(308,517)	(59.5%)
(10,473)	5,469	15,942	291.5%	Other Expenses	(43,007)	55,858	98,865	177.0%
2,884,340	**3,295,757**	**411,417**	**12.5%**	**Total Medical Expenses**	**31,171,883**	**32,828,593**	**1,656,710**	**5.0%**
1,369,323	**245,104**	**1,124,219**	**458.7%**	**Gross Margin**	**6,951,708**	**3,858,388**	**3,093,320**	**80.2%**
				Administrative Expenses				
122,349	154,426	32,077	20.8%	Salaries, wages & employee benefits	1,193,776	1,695,955	502,179	29.6%
-	167	167	100.0%	Professional fees	7,251	1,837	(5,414)	(294.7%)
75,496	40,925	(34,571)	(84.5%)	Purchased services	343,066	450,175	107,109	23.8%
14,299	19,238	4,939	25.7%	Printing and postage	149,906	211,618	61,712	29.2%
829	400	(429)	(107.2%)	Depreciation & amortization	8,342	4,400	(3,942)	(89.6%)
7,893	37,166	29,273	78.8%	Other operating expenses	80,409	184,541	104,132	56.4%
11,733	4,944	(6,789)	(137.3%)	Indirect Cost Allocation, Occupancy Expense	114,152	54,384	(59,768)	(109.9%)
232,600	**257,266**	**24,666**	**9.6%**	**Total Administrative Expenses**	**1,896,900**	**2,602,910**	**706,010**	**27.1%**
				Operating Tax				
(166,193)	-	(166,193)	0.0%	Tax Revenue	(104,667)	-	(104,667)	0.0%
(166,193)	-	166,193	0.0%	Premium Tax Expense	(104,667)	-	104,667	0.0%
-	**-**	**-**	**0.0%**	**Total Net Operating Tax**	**-**	**-**	**-**	**0.0%**
1,136,723	**(12,162)**	**1,148,885**	**9446.5%**	**Change in Net Assets**	**5,054,807**	**1,255,478**	**3,799,329**	**302.6%**
67.8%	***93.1%***	***(25.3%)***		***Medical Loss Ratio***	***81.8%***	***89.5%***	***(7.7%)***	
5.5%	***7.3%***	***1.8%***		***Admin Loss Ratio***	***5.0%***	***7.1%***	***2.1%***	

CalOptima
Multipurpose Senior Services Program
Statement of Revenues and Expenses
For the Eleven Months Ending May 31, 2022

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
460	**625**	**(165)**	**(26.4%)**	**Member Months**	**2,285**	**2,785**	**(500)**	**(18.0%)**
				Revenues				
219,023	278,731	(59,708)	(21.4%)	Capitation Revenue	1,057,293	1,242,373	(185,080)	(14.9%)
219,023	**278,731**	**(59,708)**	**(21.4%)**	**Total Operating Revenue**	**1,057,293**	**1,242,373**	**(185,080)**	**(14.9%)**
				Medical Expenses				
126,596	160,270	33,674	21.0%	Medical Management	594,065	728,705	134,640	18.5%
				Waived Services				
75	165	90	54.5%	Minor home repairs	532	735	203	27.6%
5,817	10,300	4,483	43.5%	Non-medical home equipment	32,837	45,911	13,074	28.5%
117	4,189	4,072	97.2%	Chores	17,557	18,670	1,113	6.0%
2,876	3,589	713	19.9%	Personal care	17,136	15,998	(1,138)	(7.1%)
597	549	(48)	(8.8%)	In-home respite	1,894	2,447	553	22.6%
345	884	539	61.0%	Transportation	2,118	3,940	1,822	46.2%
950	1,319	369	28.0%	Home delivered meals	3,149	5,879	2,730	46.4%
290	209	(81)	(38.7%)	Food	384	931	547	58.8%
10,459	13,887	3,428	24.7%	Communications	48,346	61,897	13,551	21.9%
9	1,146	1,137	99.2%	Non-Covered Services	147	5,108	4,961	97.1%
2,730	-	(2,730)	0.0%	Protective Services	20,790	-	(20,790)	0.0%
126,596	160,270	33,674	21.0%	Total Medical Management	594,065	728,705	134,640	18.5%
24,266	36,237	11,971	33.0%	Other Medical Expenses	144,890	161,516	16,626	10.3%
150,861	**196,507**	**45,646**	**23.2%**	**Total Program Expenses**	**738,955**	**890,221**	**151,266**	**17.0%**
68,162	**82,224**	**(14,062)**	**(17.1%)**	**Gross Margin**	**318,338**	**352,152**	**(33,814)**	**(9.6%)**
				Administrative Expenses				
61,861	76,248	14,387	18.9%	Salaries, wages & employee benefits	268,344	349,881	81,537	23.3%
2,207	1,125	(1,082)	(96.2%)	Professional fees	9,536	5,625	(3,911)	(69.5%)
3,960	7,309	3,349	45.8%	Other operating expenses	23,912	36,545	12,633	34.6%
4,273	4,884	611	12.5%	Indirect Cost Allocation	22,285	24,420	2,135	8.7%
72,300	**89,566**	**17,266**	**19.3%**	**Total Administrative Expenses**	**324,077**	**416,471**	**92,394**	**22.2%**
(4,138)	**(7,342)**	**3,204**	**43.6%**	**Change in Net Assets**	**(5,739)**	**(64,319)**	**58,580**	**91.1%**
68.9%	***70.5%***	***(1.6%)***		***Medical Loss Ratio***	***69.9%***	***71.7%***	***(1.8%)***	
33.0%	***32.1%***	***(0.9%)***		***Admin Loss Ratio***	***30.7%***	***33.5%***	***2.9%***	

CalOptima
Building 505 - City Parkway West
Statement of Revenues and Expenses
For the Eleven Months Ending May 31, 2022

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
-	-	-	0.0%	Rental Income	-	-	-	0.0%
-	-	-	**0.0%**	**Total Operating Revenue**	-	-	-	**0.0%**
				Administrative Expenses				
38,661	54,250	15,589	28.7%	Purchase services	415,816	596,750	180,934	30.3%
179,147	206,000	26,853	13.0%	Depreciation & amortization	1,914,078	2,266,000	351,922	15.5%
20,875	19,750	(1,125)	(5.7%)	Insurance expense	217,833	217,250	(583)	(0.3%)
109,245	162,833	53,588	32.9%	Repair and maintenance	1,281,987	1,541,163	259,176	16.8%
37,948	43,000	5,052	11.7%	Other Operating Expense	522,516	473,000	(49,516)	(10.5%)
(385,877)	(485,833)	(99,956)	(20.6%)	Indirect allocation, Occupancy	(4,352,230)	(5,094,163)	(741,933)	(14.6%)
-	-	-	**0.0%**	**Total Administrative Expenses**	-	-	-	**0.0%**
-	-	-	**0.0%**	**Change in Net Assets**	-	-	-	**0.0%**

CalOptima
Building 500 - City Parkway
Statement of Revenues and Expenses
For the Eleven Months Ending May 31, 2022

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
112,410	-	112,410	0.0%	Rental Income	112,410	-	112,410	0.0%
112,410	**-**	**112,410**	**0.0%**	**Total Operating Revenue**	**112,410**	**-**	**112,410**	**0.0%**
				Administrative Expenses				
3,100	-	(3,100)	0.0%	Professional Fees	3,100	-	(3,100)	0.0%
3,700	-	(3,700)	0.0%	Purchased Services	3,700	-	(3,700)	0.0%
-	-	-	0.0%	Depreciation & amortization	-	-	-	0.0%
5,530	-	(5,530)	0.0%	Insurance expense	5,530	-	(5,530)	0.0%
-	-	-	0.0%	Repair & Maintenance	-	-	-	0.0%
-	-	-	0.0%	Other Operating Expense	-	-	-	0.0%
-	-	-	0.0%	Indirect allocation, Occupancy	-	-	-	0.0%
12,330	**-**	**(12,330)**	**0.0%**	**Total Administrative Expenses**	**12,330**	**-**	**(12,330)**	**0.0%**
100,079	**-**	**100,079**	**0.0%**	**Change in Net Assets**	**100,079**	**-**	**100,079**	**0.0%**

OTHER INCOME STATEMENTS – MAY MONTH:

ONECARE INCOME STATEMENT

CHANGE IN NET ASSETS is $0.4 million, favorable to budget $0.5 million

PACE INCOME STATEMENT

CHANGE IN NET ASSETS is $1.1 million, favorable to budget $1.1 million

MSSP INCOME STATEMENT

CHANGE IN NET ASSETS is ($4,138), favorable to budget $3,204

- Carved out of Medi-Cal effective January 1, 2022

BUILDING 500 INCOME STATEMENT

CHANGE IN NET ASSETS is $0.1 million, favorable to budget $0.1 million

- Rental Income for ½ month of $0.1 million booked in May

NET INVESTMENT INCOME

- Favorable variance of $3.3 million is due primarily to unrealized gains in investments from increased value bonds as interest rates decreased in the month of May

CalOptima
Balance Sheet
May 31, 2022

ASSETS		LIABILITIES & NET POSITION	
Current Assets		Current Liabilities	
Operating Cash	$667,051,665	Accounts Payable	$35,456,807
Short-term Investments	1,095,296,507	Medical Claims liability	1,008,253,142
Capitation receivable	348,977,084	Accrued Payroll Liabilities	17,021,057
Receivables - Other	49,401,551	Deferred Revenue	8,017,662
Prepaid expenses	17,879,074	Deferred Lease Obligations	95,165
		Capitation and Withholds	200,149,192
Total Current Assets	**2,178,605,881**	**Total Current Liabilities**	**1,268,993,026**
Capital Assets			
Furniture & Equipment	46,607,580		
Building/Leasehold Improvements	9,819,243		
505 City Parkway West	52,324,639		
500 City Parkway West	22,650,000		
	131,401,462		
Less: accumulated depreciation	(63,650,595)	Other (than pensions) post	
Capital assets, net	67,750,867	employment benefits liability	32,106,034
Other Assets		Net Pension Liabilities	30,684,981
Restricted Deposit & Other	300,000	Bldg 505 Development Rights	-
Homeless Health Reserve	40,636,739		
Board-designated assets:		**TOTAL LIABILITIES**	**1,331,784,041**
Cash and Cash Equivalents	2,239,312	Deferred Inflows	
Investments	571,463,554	Excess Earnings	344,198
Total Board-designated Assets	573,702,865	OPEB 75 Difference in Experience	536,000
		Change in Assumptions	2,709,945
Total Other Assets	614,639,604	OPEB Changes in Assumptions	773,000
TOTAL ASSETS		Net Position	
	2,860,996,352	TNE	103,388,764
Deferred Outflows		Funds in Excess of TNE	1,436,452,700
		TOTAL NET POSITION	1,539,841,464
Contributions	1,508,025		
Difference in Experience	3,236,721		
Excess Earning	2,104,780		
Changes in Assumptions	3,692,771		
OPEB 75 Changes in Assumptions	3,906,000		
Pension Contributions	544,000		
TOTAL ASSETS & DEFERRED OUTFLOWS	**2,875,988,649**	**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION**	**2,875,988,649**

Back to Agenda

CalOptima
Board Designated Reserve and TNE Analysis
as of May 31, 2022

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	233,279,080				
	Tier 1 - MetLife	231,935,317				
Board-designated Reserve		465,214,396	380,301,278	587,597,011	84,913,118	(122,382,614)
	Tier 2 - Payden & Rygel	54,361,887				
	Tier 2 - MetLife	54,126,582				
TNE Requirement		108,488,469	103,388,764	103,388,764	5,099,705	5,099,705
	Consolidated:	**573,702,865**	**483,690,042**	**690,985,774**	**90,012,823**	**(117,282,909)**
	Current reserve level	*1.66*	*1.40*	*2.00*		

CalOptima
Statement of Cash Flows
May 31, 2022

	Month Ended	Year-To-Date
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	57,835,245	231,060,671
Adjustments to reconcile change in net assets		
to net cash provided by operating activities		
Depreciation and amortization	513,785	5,938,009
Changes in assets and liabilities:		
Prepaid expenses and other	(4,633,662)	(5,900,463)
Catastrophic reserves		
Capitation receivable	(200,544,591)	76,517,383
Medical claims liability	190,340,351	63,934,194
Deferred revenue	(26,188,055)	(5,569,163)
Payable to health networks	20,407,740	55,369,403
Accounts payable	8,442,341	(10,957,613)
Accrued payroll	1,170,848	1,365,148
Other accrued liabilities	(2,982)	(32,163)
Net cash provided by/(used in) operating activities	47,341,020	411,725,406
GASB 68 CalPERS Adjustments	-	-
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES:		
Net Asset transfer from Foundation	-	-
Net cash provided by (used in) in capital and related financing activities	-	-
CASH FLOWS FROM INVESTING ACTIVITIES		
Change in Investments	(70,360,257)	(29,886,700)
Change in Property and Equipment	(23,471,973)	(27,961,000)
Change in Board designated reserves	(2,827,797)	15,177,287
Change in Homeless Health Reserve	700,000	16,162,174
Net cash provided by/(used in) investing activities	(95,960,027)	(26,508,239)
NET INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS	(48,619,007)	385,217,167
CASH AND CASH EQUIVALENTS, beginning of period	$715,670,672	281,834,499
CASH AND CASH EQUIVALENTS, end of period	**667,051,665**	**667,051,665**

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BALANCE SHEET – MAY MONTH:

ASSETS of $2.9 billion increased $252.0 million from April or 9.6%

- Capitation Receivables increased $199.0 million due to reclassification DHCS overpayments to claims liabilities, and timing of receipts
- Capital Assets increased $23.0 million due to purchase of building located at 500 City Parkway West
- Operating Cash and Short-term Investments net increase of $21.7 million due primarily to
  - Operating cash decreased $48.6 million
  - Short-term Investments increased $70.4 million

LIABILITIES of $1.3 billion increased $194.2 million from April or 17.1%

- Claims Liabilities increased $190.3 million due to reclassification of overpayments from capitation receivables, timing of claim payments and changes in IBNR
- Capitation and Withholds increased $20.4 million due to increase in payables for Proposition 56 and timing of capitation payments
- Deferred Revenue decreased $26.2 million due to timing of capitation payments from Centers for Medicare & Medicaid Services (CMS)

NET ASSETS of $1.5 billion, increased $57.8 million from April or 3.9%

CalOptima - Consolidated
Net Assets Analysis
For the Eleven Months Ended May 31, 2022

Category	Item Description	Resource Committed	Amount (millions)	%
	Total Net Position @ 05/31/2022:		**$ 1,539.8**	**100.0%**
Resources Assigned	Board Designated Reserve		**$ 573.7**	**37.3%**
	Capital Assets, net of depreciation		**$ 67.8**	**4.4%**
Resources Allocated, not yet Spent	Homeless Health Initiative*	100.0	26.2	1.7%
	Intergovernmental Transfers (IGT)	80.8	24.0	1.6%
	Mind OC Grant	1.0	-	0.0%
	CalFresh Outreach Strategy	2.0	1.8	0.1%
	Digital Transformation and Workplace Modernization	100.0	100.0	6.5%
	Coalition of Orange County Community Health Centers Grant	50.0	50.0	3.2%
	Subtotal:	**333.8**	**$ 202.0**	**13.1%**
Resources Available for New Initiatives	Homeless Health Initiative		40.6	
	Intergovernmental Transfers (IGT)		30.9	
	Unallocated/Unassigned		624.9	
	Subtotal:		**$ 696.4**	**45.2%**

*See Summary of Homeless Health Initiatives and Allocated Funds for list of Board approved initiatives

Summary of Homeless Health Initiatives and Allocated Funds
As of May 31, 2022

			Amount
Program Commitment		**$**	**100,000,000**
Funds Allocation, approved initiatives:			
Enhanced Medi-Cal Services at the Be Well OC Regional Mental Health and Wellness Campus	11,400,000		
Recuperative Care	8,250,000		
Medical Respite	250,000		
Day Habilitation (County for HomeKey)	2,500,000		
Clinical Field Team Start-up & Federal Qualified Health Center (FQHC)	1,600,000		
CalOptima Homeless Response Team	6,000,000		
Homeless Coordination at Hospitals	10,000,000		
CalOptima Days & QI Program - Homeless Clinic Access Program or HCAP	1,693,261		
FQHC (Community Health Center) Expansion and HHI Support	570,000		
HCAP Expansion for Telehealth and CFT On Call Days	1,700,000		
Vaccination Intervention and Member Incentive Strategy	400,000		
Street Medicine	8,000,000		
Outreach and Engagement Team	7,000,000		
Funds Allocation Total		**$**	**59,363,261**
Program Commitment Balance, available for new initiatives*		**$**	**40,636,739**

On June 27, 2019 at a Special Board meeting, the Board approved four funding categories.

This report only lists Board approved projects.

* Funding sources of the remaining balance are IGT8 and CalOptima's operating income, which must be used for Medi-Cal covered services for the Medi-Cal population

Budget Allocation Changes
Reporting Changes for May 2022

Transfer Month	Line of Business	From	To	Amount	Expense Description	Fiscal Year
August	Medi-Cal	Ground Floor Corridor Heating and Cooling Boxes Replacement	Multiple Bathroom Upgrades (Original Bathrooms on 2nd and 4th Floors)	$25,800	To transfer funds from capital project Ground Floor Corridor Heating and Cooling Boxes Replacement to capital project Multiple Bathroom Upgrades (Original Bathrooms on the 2nd and 4th Floors) to fund the final bathroom change order.	2020-21
November	Medi-Cal	Upgrade the System Backup Application Disk Storage - Hardware	Upgrade the Citrix Virtual Servers to Support Version - Hardware	$24,000	To transfer funds from capital project Upgrade the System Backup Application Disk Storage to capital project Upgrade the Citrix Virtual Servers to Support Version to provide additional funds for hardware purchases.	2021-22
November	Medi-Cal	Upgrade the System Backup Application Disk Storage - Hardware	Upgrade the Database Disk Storage Equipment - Hardware	$51,000	To transfer funds from capital project Upgrade the System Backup Application Disk Storage to capital project Upgrade the Database Disk Storage Equipment to provide additional funds for hardware purchases.	2021-22
December	Medi-Cal	Maintenance HW/SW - BMC	Maintenance HW/SW – SolarWinds	$10,500	To repurpose funds from BMC to SolarWinds to provide additional funds for maintenance contract renewal.	2021-22
December	Medi-Cal	Upgrade the Citrix Virtual Servers to Support Version - Hardware	Upgrade the Database Disk Storage Equipment - Hardware	$13,500	To transfer funds from capital project Upgrade the Citrix Virtual Servers to Support Version to capital project Upgrade the Database Disk Storage Equipment to provide additional funds for hardware purchases.	2021-22
December	Medi-Cal	Maintenance HW/SW – Optum/Ingenix ICD 10	Maintenance HW/SW – Smart Communications	$14,000	To repurpose funds from Optum/Ingenix ICD10 to Smart Communications to provide additional funds for maintenance contract renewal.	2021-22
December	Medi-Cal	Maintenance HW/SW – Microsoft True-Up	Maintenance HW/SW – Extreme Networks	$24,000	To repurpose funds from Microsoft True-UP to Extreme Networks to provide additional funds for maintenance contract renewal.	2021-22
January	Medi-Cal	Professional Fees – Citrix Pro Fees	Professional Fees – HIPPA Compliance (Risk Assessment & Network Penetration)	$10,500	To repurpose funds from Citrix professional fees to HIPPAA Compliance professional fees to provide additional funds.	2021-22
January	Medi-Cal	Maintenance HW/SW – Microsoft True-Up	Maintenance HW/SW – SSL Certs for Production Applications	$12,000	To repurpose funds from Microsoft True-UP to SSL Certs for Production Applications to provide additional funds for maintenance contract renewal.	2021-22
January	Medi-Cal	Purchased Services – Executive Coaching	Purchased Services – Concentra	$18,000	To reallocate funding from Executive Coaching to Concentra for additional funds needed.	2021-22
February	Medi-Cal	Purchased Services – Disaster Recovery Technology Services	Purchased Services – Offsite Backup Tape Storage and Services	$25,000	To repurpose funds from Purchased Services - Disaster Recovery Technology Services to Purchased Services - Offsite Backup Tape Storage and Services to provide additional funds.	2021-22
March	Medi-Cal	Cert/Cont. Education - Leadership Series Quarterly	Training & Seminar	$28,000	To reallocate funding from Cert/Cont. Education Leadership Series to Training & Seminar for the funding of company-wide training from Dale Carnegie	2021-22
April	Medi-Cal	Purchased Services - Executive Coaching	Purchased Services - Concentra	$15,000	To reallocate funding from Executive Coaching to Concentra for additional funds needed.	2021-22
May	Medi-Cal	Infrastructure – Professional Fees	Government Affairs – Professional Fees	$15,000	To reallocate funds from Infrastructure Professional Fees Budget to Government Affairs for funds needed on the state lobbyist.	2021-22

This report summarizes budget transfers between general ledger classes that are greater than $10,000 and less than $100,000.
This is the result of Board Resolution No. 12-0301-01 which permits the CEO to make budget allocation changes within certain parameters.

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Financial Summary

Preliminary Unaudited Financials

June 30, 2022

Board of Directors Meeting

August 4, 2022

Nancy Huang, Chief Financial Officer

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Financial Highlights: June 2022

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
914,646	828,220	86,426	10.4%	Member Months	10,520,776	10,074,167	446,609	4.4%
135,913,944	276,091,762	(140,177,818)	(50.8%)	Revenues	4,225,322,176	3,656,416,025	568,906,151	15.6%
241,209,505	267,284,576	26,075,071	9.8%	Medical Expenses	3,945,846,206	3,561,452,012	(384,394,194)	(10.8%)
(7,860,095)	16,187,339	24,047,434	148.6%	Administrative Expenses	131,057,261	180,131,351	49,074,090	27.2%
(97,435,465)	**(7,380,153)**	**(90,055,312)**	**(1220.2%)**	**Operating Margin**	**148,418,709**	**(85,167,338)**	**233,586,047**	**274.3%**
(3,550,394)	833,334	(4,383,728)	(526.0%)	Non Operating Income (Loss)	(18,343,897)	10,000,000	(28,343,897)	(283.4%)
(100,985,859)	**(6,546,819)**	**(94,439,040)**	**(1442.5%)**	**Change in Net Assets**	**130,074,812**	**(75,167,338)**	**205,242,150**	**273.0%**
177.5%	96.8%	80.7%		Medical Loss Ratio	93.4%	97.4%	(4.0%)	
(5.8%)	5.9%	11.6%		Administrative Loss Ratio	3.1%	4.9%	1.8%	
(71.7%)	(2.7%)	(69.0%)		Operating Margin Ratio	3.5%	(2.3%)	5.8%	
100.0%	100.0%			Total Operating	100.0%	100.0%		
177.5%	96.8%	80.7%		*MLR (excluding Directed Payments)	92.9%	97.4%	(4.5%)	
(5.8%)	5.9%	11.6%		*ALR (excluding Directed Payments)	3.3%	4.9%	1.6%	

*CalOptima updated the category of Directed Payments per Department of Health Care Services instructions

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Consolidated Performance: June 2022 (in millions)

June				July-June		
Actual	Budget	Variance		Actual	Budget	Variance
(99.8)	(6.9)	(92.9)	Medi-Cal	132.2	(79.9)	212.1
0.8	(0.5)	1.3	OCC	10.7	(5.5)	16.1
1.4	(0.0)	1.5	OneCare	0.4	(1.0)	1.4
0.1	0.1	0.1	PACE	5.2	1.3	3.9
(0.0)	(0.0)	0.0	MSSP	(0.0)	(0.1)	0.1
(97.4)	**(7.4)**	**(90.1)**	**Operating**	**148.4**	**(85.2)**	**233.6**
(3.6)	0.8	(4.4)	Inv./Rental Inc, MCO tax	(18.3)	10.0	(28.3)
(3.6)	**0.8**	**(4.4)**	**Non-Operating**	**(18.3)**	**10.0**	**(28.3)**
(101.0)	**(6.5)**	**(94.4)**	**TOTAL**	**130.1**	**(75.2)**	**205.2**

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FY 2021–22: Management Summary

- Change in Net Assets Surplus or (Deficit)
  - MTD (June 2022): ($101.0) million, unfavorable to budget $94.4 million or 1,442.5%, primarily due to estimates relating to the Department of Health Care Services (DHCS) COVID-19 Risk Corridor settlement amount for period January 2021 through June 2022
  - YTD (July 2021 – June 2022): $130.1 million, favorable to budget $205.2 million or 273.0%
- Enrollment
  - MTD: 914,646 members, favorable to budget 86,426 or 10.4%
  - YTD: 10,520,776 members, favorable to budget 446,609 or 4.4%

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FY 2021–22: Management Summary (cont.)

- Revenue
  - MTD: $135.9 million, unfavorable to budget $140.2 million or 50.8% driven by Medi-Cal (MC) line of business (LOB):
    - $206.8 million due to DHCS' COVID-19 risk corridor for January 2021 through June 2020 and Enhanced Care Management (ECM) risk corridor estimates
    - Offset by:
    - $35.7 million due to updated Medi-Cal rates and extension of Proposition 56
    - $23.3 million due to favorable enrollment as redetermination is suspended during the Public Health Emergency
  - YTD: $4.2 billion, favorable to budget $568.9 million or 15.6% driven by MC LOB:
    - $294.1 million of Fiscal Year (FY) 2020 hospital Directed Payments (DP) and Intergovernmental Transfer (IGT) 10
    - $318.4 million due to favorable enrollment and Medi-Cal rates, increase in Long-Term Care (LTC) and pharmacy funding from DHCS, and Prior Year (PY) retroactive eligibility changes
    - $141.1 million net increase due to the extension of Proposition 56 and Proposition 56 risk corridor
    - $22.5 million due to CalAIM's Incentive Payment Program (IPP) funding from DHCS
    - Offset by $239.5 million due to COVID-19 and ECM risk corridors

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FY 2021–22: Management Summary (cont.)

- Medical Expenses
  - MTD: $241.2 million, favorable to budget $26.1 million or 9.8% driven by MC LOB:
    - Facilities Claims expense favorable variance of $19.7 million due to decrease in facilities-related crossover claims and release of PY hospital shared risk pool
    - Provider Capitation expense favorable variance of $14.8 million due primarily to Whole Child Model (WCM) risk corridor estimates of $35.4 million offset by the extension of Proposition 56 and short-term supplemental rate increase due to COVID-19
    - Offset by net unfavorable variance from all other expenses of $5.5 million
  - YTD: $3.9 billion, unfavorable to budget $384.4 million or 10.8% driven by MC LOB:
    - Reinsurance & Other expense unfavorable variance of $284.9 million due to FY 2020 hospital DP
    - Provider Capitation expense unfavorable variance of $172.0 million due primarily to the extension of Proposition 56 and short-term supplemental rate increase due to COVID-19 offset by WCM risk corridor
    - Professional Claims expense unfavorable variance of $43.1 million due to increase in professional-related crossover and Proposition 56 claims
    - Offset by:
      - Facilities Claims expense favorable variance of $106.5 million due to decrease in facilities-related crossover claims and low utilization
      - Net favorable variance from all other expenses of $10.6 million

FY 2021–22: Management Summary (cont.)

- Administrative Expenses
  - MTD: ($7.9) million, favorable to budget $24.0 million or 148.6% primarily due to true up of pension liabilities in accordance with GASB 68
  - YTD: $131.1 million, favorable to budget $49.1 million or 27.2%
- Non-Operating Income (Loss)
  - MTD: ($3.6) million, unfavorable to budget $4.4 million or 526.0%
  - YTD: ($18.3) million, unfavorable to budget $28.3 million or 283.4%
    - Unfavorable variance is primarily due to unrealized losses in treasuries, corporate bonds and municipals from the Federal Reserve's responses to inflation and an overall increase to interest rates for the fiscal year

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FY 2021–22: Key Financial Ratios

- Medical Loss Ratio (MLR)
  - MTD: Actual 177.5%, (177.5% excluding DP), Budget 96.8%
  - YTD: Actual 93.4% (92.9% excluding DP), Budget 97.4%
- Administrative Loss Ratio (ALR)
  - MTD: Actual -5.8%, (-5.8% excluding DP), Budget 5.9%
  - YTD: Actual 3.1% (3.3% excluding DP), Budget 4.9%
- Balance Sheet Ratios
  - *Current ratio: 1.51
  - Board-designated reserve funds level: 1.77
  - Net position: $1.4 billion, including required Tangible Net Equity (TNE) of $107.3 million

*Current ratio compares current assets to current liabilities. It measures CalOptima's ability to pay short-term obligations.

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Enrollment Summary: June 2022

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
116,502	118,028	(1,526)	(1.3%)	SPD	1,436,146	1,409,540	26,606	1.9%
303,275	289,533	13,742	4.7%	TANF Child	3,614,608	3,541,433	73,175	2.1%
135,450	104,585	30,865	29.5%	TANF Adult	1,397,901	1,276,582	121,319	9.5%
3,212	3,191	21	0.7%	LTC	37,789	38,292	(503)	(1.3%)
326,646	284,408	42,238	14.9%	MCE	3,682,923	3,466,736	216,187	6.2%
12,049	11,159	890	8.0%	WCM	142,114	133,908	8,206	6.1%
897,134	**810,904**	**86,230**	**10.6%**	**Medi-Cal Total**	**10,311,481**	**9,866,491**	**444,990**	**4.5%**
14,415	**15,077**	**(662)**	**(4.4%)**	**OneCare Connect**	**176,189**	**181,341**	**(5,152)**	**(2.8%)**
2,668	**1,799**	**869**	**48.3%**	**OneCare**	**28,107**	**21,382**	**6,725**	**31.5%**
429	**440**	**(11)**	**(2.5%)**	**PACE**	**4,999**	**4,953**	**46**	**0.9%**
466	**623**	**(157)**	**(25.2%)**	**MSSP**	**2,751**	**3,408**	**(657)**	**(19.3%)**
914,646	**828,220**	**86,426**	**10.4%**	**CalOptima Total**	**10,520,776**	**10,074,167**	**446,609**	**4.4%**

*Note: CalOptima Total does not include MSSP

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Consolidated Revenue & Expenses: June 2022 MTD

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	MSSP	Consolidated
MEMBER MONTHS	558,439	326,646	12,049	897,134	14,415	2,668	429	466	914,646
REVENUES									
Capitation Revenue	46,957,088	$ 46,305,862	$ 664,385	$ 93,927,335	$ 32,433,876	$ 5,420,345	$ 3,868,397	$ 263,991	$ 135,913,944
Other Income	-	-	-	-	-	-	-	-	-
Total Operating Revenue	46,957,088	46,305,862	664,385	93,927,335	32,433,876	5,420,345	3,868,397	263,991	135,913,944
MEDICAL EXPENSES									
Provider Capitation	46,893,950	50,426,931	(27,614,268)	69,706,613	13,205,196	983,857			83,895,666
Facilities	23,717,969	16,927,044	4,022,670	44,667,683	3,999,979	1,027,295	560,056		50,255,012
Professional Claims	24,411,678	14,368,009	1,416,908	40,196,596	1,229,316	97,960	936,769		42,460,641
Prescription Drugs	(525,669)	(30,782)	0	(556,451)	7,808,792	1,308,863	363,657		8,924,860
MLTSS	34,212,591	3,483,316	1,273,438	38,969,345	1,354,689	62,087	163,543	29,053	40,578,717
Medical Management	4,515,389	3,481,235	269,518	8,266,143	1,367,863	159,079	1,198,603	131,189	11,122,877
Qualtiy Incentives	2,639,234	802,070	218,593	3,659,897	(611,686)		5,363		3,053,574
Reinsurance & Other	321,905	237,778	931	560,614	181,585	850	175,109		918,158
Total Medical Expenses	136,187,048	89,695,602	(20,412,210)	205,470,440	28,535,733	3,639,990	3,403,100	160,242	241,209,505
Medical Loss Ratio	290.0%	193.7%	-3072.3%	218.8%	88.0%	67.2%	88.0%	60.7%	177.5%
GROSS MARGIN	**(89,229,960)**	**(43,389,740)**	**21,076,595**	**(111,543,104)**	**3,898,143**	**1,780,354**	**465,297**	**103,749**	**(105,295,561)**
ADMINISTRATIVE EXPENSES									
Salaries & Benefits				(15,772,224)	676,831	66,577	103,679	86,547	(14,838,591)
Professional fees				919,824	23,499	(18,822)	474	2,207	927,181
Purchased services				1,673,496	247,031	17,825	131,433		2,069,785
Printing & Postage				527,955	228,163	20,970	25,743		802,832
Depreciation & Amortization				460,952			698		461,650
Other expenses				2,246,239	63,837	-	29,707	4,216	2,343,999
Indirect cost allocation & Occupancy				(1,794,579)	1,872,671	252,692	28,569	13,696	373,048
Total Administrative Expenses				**(11,738,337)**	**3,112,031**	**339,242**	**320,302**	**106,666**	**(7,860,095)**
Admin Loss Ratio				(12.5%)	9.6%	6.3%	8.3%	40.4%	(5.8%)
INCOME (LOSS) FROM OPERATIONS				(99,804,768)	786,112	1,441,112	144,995	(2,917)	(97,435,465)
INVESTMENT INCOME									(3,614,469)
NET RENTAL INCOME									93,937
TOTAL MCO TAX				441					441
TOTAL GRANT INCOME				(30,303)					(30,303)
CHANGE IN NET ASSETS				**$ (99,834,629)**	**$ 786,112**	**$ 1,441,112**	**$ 144,995**	**$ (2,917)**	**$ (100,985,859)**
BUDGETED CHANGE IN NET ASSETS				(6,865,534)	(504,852)	(47,921)	50,918	(12,764)	(6,546,819)
VARIANCE TO BUDGET - FAV (UNFAV)				$ (92,969,095)	$ 1,290,964	$ 1,489,033	$ 94,077	$ 9,847	$ (94,439,040)

Note:* Total membership does not include MSSP

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Consolidated Revenue & Expenses: June 2022 YTD

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total MC	OneCare Connect	OneCare	PACE	MSSP	Consolidated
MEMBER MONTHS	6,486,444	3,682,923	142,114	10,311,481	176,189	28,107	4,999	2,751	10,520,776
REVENUES									
Capitation Revenue	1,946,513,327	$ 1,581,299,337	$ 271,732,428	3,799,545,091	$ 344,402,500	$ 38,061,315	$ 41,991,987	1,321,284	$ 4,225,322,176
Other Income	-	-	-	-	-	-	-	-	-
Total Operating Revenue	1,946,513,327	1,581,299,337	271,732,428	3,799,545,091	344,402,500	38,061,315	41,991,987	1,321,284	4,225,322,176
MEDICAL EXPENSES									
Provider Capitation	556,710,297	598,860,139	70,602,451	1,226,172,887	139,055,312	9,994,621		-	1,375,222,820
Facilities	298,949,443	301,271,009	65,098,748	665,319,199	49,349,356	10,954,575	8,217,050	-	733,840,180
Professional Claims	262,361,528	139,674,207	15,929,878	417,965,613	13,750,985	1,221,562	9,423,374	-	442,361,534
Prescription Drugs	127,818,720	175,055,343	40,136,051	343,010,114	77,785,389	11,881,611	3,958,177	-	436,635,292
MLTSS	438,546,753	47,572,741	20,689,714	506,809,208	17,314,679	625,588	990,339	173,943	525,913,757
Medical Management	32,537,672	20,811,155	3,906,955	57,255,782	13,102,496	561,113	10,504,096	725,254	82,148,741
Quality Incentives	22,486,923	11,623,723	1,096,601	35,207,248	1,817,399		(37,644)	-	36,987,003
Reinsurance & Other	181,550,029	117,300,771	10,117,812	308,968,612	2,214,133	34,544	1,519,590	-	312,736,879
Total Medical Expenses	1,920,961,367	1,412,169,088	227,578,209	3,560,708,664	314,389,749	35,273,614	34,574,982	899,197	3,945,846,206
Medical Loss Ratio	98.7%	89.3%	83.8%	93.7%	91.3%	92.7%	82.3%	68.1%	93.4%
GROSS MARGIN	**25,551,960**	**169,130,249**	**44,154,218**	**238,836,427**	**30,012,751**	**2,787,701**	**7,417,005**	**422,087**	**279,475,970**
ADMINISTRATIVE EXPENSES									
Salaries & Benefits				65,741,276	8,297,765	910,832	1,297,454	354,891	76,602,219
Professional fees				4,201,500	226,121	308,777	7,725	11,743	4,755,866
Purchased services				12,502,549	1,415,795	153,244	474,499	-	14,546,087
Printing & Postage				4,275,139	1,107,202	114,823	175,649	-	5,672,814
Depreciation & Amortization				4,476,541			9,040	-	4,485,581
Other expenses				20,212,400	77,970	1,076	110,115	28,128	20,429,689
Indirect cost allocation & Occupancy				(4,756,610)	8,233,046	909,867	142,720	35,981	4,565,004
Total Administrative Expenses				**106,652,797**	**19,357,899**	**2,398,620**	**2,217,202**	**430,743**	**131,057,261**
Admin Loss Ratio				2.8%	5.6%	6.3%	5.3%	32.6%	3.1%
INCOME (LOSS) FROM OPERATIONS				132,183,630	10,654,852	389,081	5,199,802	(8,656)	148,418,709
INVESTMENT INCOME									(20,360,669)
NET RENTAL INCOME									194,016
TOTAL MCO TAX				1,935,103					1,935,103
TOTAL GRANT INCOME				(121,212)					(121,212)
OTHER INCOME				8,865					8,865
CHANGE IN NET ASSETS				**$ 134,006,386**	**$ 10,654,852**	**$ 389,081**	**$ 5,199,802**	**$ (8,656)**	**$ 130,074,812**
BUDGETED CHANGE IN NET ASSETS				(79,900,356)	(5,458,654)	(1,037,641)	1,306,396	(77,083)	(75,167,338)
VARIANCE TO BUDGET - FAV (UNFAV)				$ 213,906,742	$ 16,113,506	$ 1,426,722	$ 3,893,406	$ 68,427	$ 205,242,150

Note:* Total membership does not include MSSP

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Balance Sheet: As of June 2022

ASSETS		LIABILITIES & NET POSITION	
Current Assets		**Current Liabilities**	
Operating Cash	$823,489,434	Accounts Payable	$52,304,518
Short-term Investments	1,014,460,503	Medical Claims liability	1,278,015,349
Capitation receivable	405,190,937	Accrued Payroll Liabilities	19,568,204
Receivables - Other	71,719,307	Deferred Revenue	8,104,044
Prepaid expenses	22,564,000	Deferred Lease Obligations	92,171
		Capitation and Withholds	193,214,628
Total Current Assets	**2,337,424,181**	**Total Current Liabilities**	**1,551,298,916**
Capital Assets			
Furniture & Equipment	47,622,259		
Building/Leasehold Improvements	8,585,827		
505 City Parkway West	52,373,356		
500 City Parkway West	22,631,500		
	131,212,942		
Less: accumulated depreciation	(64,330,363)		
Capital assets, net	66,882,579		
Other Assets		Other (than pensions) post employment benefits liability	32,158,541
Restricted Deposit & Other	300,051	Net Pension Liabilities	577,854
		Bldg 505 Development Rights	-
Homeless Health Reserve	40,636,739	GASB Liability	-
Board-designated assets:			
Cash and Cash Equivalents	4,332,184	**TOTAL LIABILITIES**	**1,584,035,311**
Investments	566,159,456	**Deferred Inflows**	
Total Board-designated Assets	570,491,641	Excess Earnings	686,563
		OPEB 75 Difference in Experience	536,000
Total Other Assets	611,428,430	Change in Assumptions	1,909,305
		OPEB Changes in Assumptions	773,000
TOTAL ASSETS	**3,015,735,190**	**Net Position**	
		TNE	107,345,455
Deferred Outflows		Funds in Excess of TNE	1,331,510,149
Contributions	1,931,845	**TOTAL NET POSITION**	1,438,855,605
Difference in Experience	2,353,671		
Excess Earning	-		
Changes in Assumptions	2,325,077		
OPEB 75 Changes in Assumptions	3,906,000		
Pension Contributions	544,000		
TOTAL ASSETS & DEFERRED OUTFLOWS	**3,026,795,783**	**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION**	**3,026,795,783**

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Board Designated Reserve and TNE Analysis: As of June 2022

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	232,027,155				
	Tier 1 - MetLife	230,643,052				
Board-designated Reserve		462,670,206	343,838,840	537,203,538	118,831,366	(74,533,332)
	Tier 2 - Payden & Rygel	54,010,235				
	Tier 2 - MetLife	53,811,199				
TNE Requirement		107,821,434	107,345,455	107,345,455	475,979	475,979
	Consolidated:	**570,491,640**	**451,184,295**	**644,548,993**	**119,307,345**	**(74,057,353)**
	Current reserve level	*1.77*	*1.40*	*2.00*		

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Net Assets Analysis: As of June 2022

Category	Item Description	Resource Committed	Amount (millions)	%
	Total Net Position @ 06/30/2022:		**$ 1,438.9**	**100.0%**
Resources Assigned	Board Designated Reserve		**$ 570.5**	**39.6%**
	Capital Assets, net of depreciation		**$ 66.9**	**4.6%**
Resources Allocated, not yet Spent	Homeless Health Initiative*	100.0	25.5	1.8%
	Intergovernmental Transfers (IGT)	80.8	20.5	1.4%
	Mind OC Grant	1.0	-	0.0%
	CalFresh Outreach Strategy	2.0	1.6	0.1%
	Digital Transformation and Workplace Modernization	100.0	100.0	6.9%
	Coalition of Orange County Community Health Centers Grant	50.0	40.0	2.8%
	Subtotal:	**333.8**	**$ 187.6**	**13.0%**
Resources Available for New Initiatives	Homeless Health Initiative		40.6	
	Intergovernmental Transfers (IGT)		30.9	
	Unallocated/Unassigned		542.4	
	Subtotal:		**$ 613.9**	**42.7%**

*See Summary of Homeless Health Initiatives and Allocated Funds for list of Board approved initiatives

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Homeless Health Initiative and Allocated Funds: As of June 2022

		Amount
Program Commitment	**$**	**100,000,000**
Funds Allocation, approved initiatives:		
Enhanced Medi-Cal Services at the Be Well OC Regional Mental Health and Wellness Campus	11,400,000	
Recuperative Care	8,250,000	
Medical Respite	250,000	
Day Habilitation (County for HomeKey)	2,500,000	
Clinical Field Team Start-up & Federal Qualified Health Center (FQHC)	1,600,000	
CalOptima Homeless Response Team	6,000,000	
Homeless Coordination at Hospitals	10,000,000	
CalOptima Days & QI Program - Homeless Clinic Access Program or HCAP	1,693,261	
FQHC (Community Health Center) Expansion and HHI Support	570,000	
HCAP Expansion for Telehealth and CFT On Call Days	1,700,000	
Vaccination Intervention and Member Incentive Strategy	400,000	
Street Medicine	8,000,000	
Outreach and Engagement Team	7,000,000	
Funds Allocation Total	**$**	**59,363,261**
Program Commitment Balance, available for new initiatives*	**$**	**40,636,739**

On June 27, 2019 at a Special Board meeting, the Board approved four funding categories.

This report only lists Board approved projects.

* Funding sources of the remaining balance are IGT8 and CalOptima's operating income, which must be used for Medi-Cal covered services for the Medi-Cal population

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Our Mission

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

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UNAUDITED FINANCIAL STATEMENTS

June 2022

Preliminary Reports as of July 18, 2022

Final fiscal year report is subject to change following financial audit

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CalOptima - Consolidated
Financial Highlights
For the Twelve Months Ended June 30, 2022

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
914,646	828,220	86,426	10.4%	Member Months	10,520,776	10,074,167	446,609	4.4%
135,913,944	276,091,762	(140,177,818)	(50.8%)	Revenues	4,225,322,176	3,656,416,025	568,906,151	15.6%
241,209,505	267,284,576	26,075,071	9.8%	Medical Expenses	3,945,846,206	3,561,452,012	(384,394,194)	(10.8%)
(7,860,095)	16,187,339	24,047,434	148.6%	Administrative Expenses	131,057,261	180,131,351	49,074,090	27.2%
(97,435,465)	**(7,380,153)**	**(90,055,312)**	**(1220.2%)**	**Operating Margin**	**148,418,709**	**(85,167,338)**	**233,586,047**	**274.3%**
(3,550,394)	833,334	(4,383,728)	(526.0%)	Non Operating Income (Loss)	(18,343,897)	10,000,000	(28,343,897)	(283.4%)
(100,985,859)	**(6,546,819)**	**(94,439,040)**	**(1442.5%)**	**Change in Net Assets**	**130,074,812**	**(75,167,338)**	**205,242,150**	**273.0%**
177.5%	96.8%	80.7%		Medical Loss Ratio	93.4%	97.4%	(4.0%)	
(5.8%)	5.9%	11.6%		Administrative Loss Ratio	3.1%	4.9%	1.8%	
(71.7%)	(2.7%)	(69.0%)		Operating Margin Ratio	3.5%	(2.3%)	5.8%	
100.0%	100.0%			Total Operating	100.0%	100.0%		
177.5%	96.8%	80.7%		*MLR (excluding Directed Payments)	92.9%	97.4%	(4.5%)	
(5.8%)	5.9%	11.6%		*ALR (excluding Directed Payments)	3.3%	4.9%	1.6%	

*CalOptima updated the category of Directed Payments per Department of Health Care Services instructions

CalOptima
Financial Dashboard
For the Twelve Months Ended June 30, 2022

MONTH - TO - DATE

Enrollment	Actual	Budget	Fav / (Unfav)	
Medi-Cal	897,134	810,904	86,230	10.6%
OneCare Connect	14,415	15,077	(662)	(4.4%)
OneCare	2,668	1,799	869	48.3%
PACE	429	440	(11)	(2.5%)
MSSP	466	623	(157)	(25.2%)
Total*	914,646	828,220	86,426	10.4%

Change in Net Assets (000)	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ (99,835)	$ (6,866)	(92,969)	(1354.0%)
OneCare Connect	786	(505)	1,291	255.6%
OneCare	1,441	(48)	1,489	3102.1%
PACE	145	51	94	184.3%
MSSP	(3)	(13)	10	76.9%
505 Bldg.	94	-	94	0.0%
Investment Income & Other	(3,614)	833	(4,447)	(533.9%)
Total	$ (100,986)	$ (6,548)	(94,438)	(1442.2%)

MLR	Actual	Budget	% Point Var
Medi-Cal	218.8%	97.1%	121.6
OneCare Connect	88.0%	95.2%	(7.2)
OneCare	67.2%	94.0%	(26.9)

Administrative Cost (000)	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ (11,738)	$ 13,778	$ 25,517	185.2%
OneCare Connect	3,112	1,876	(1,236)	(65.9%)
OneCare	339	180	(159)	(88.6%)
PACE	320	262	(58)	(22.2%)
MSSP	107	91	(15)	(17.0%)
Total	$ (7,860)	$ 16,187	$ 24,047	148.6%

Total FTE's Month	Actual	Budget	Fav / (Unfav)
Medi-Cal	1,122	1,206	84
OneCare Connect	171	210	38
OneCare	7	9	2
PACE	95	122	27
MSSP	17	18	1
Total	1,412	1,564	152

MM per FTE	Actual	Budget	Fav / (Unfav)
Medi-Cal	800	673	(127)
OneCare Connect	84	72	(12)
OneCare	388	193	(195)
PACE	5	4	(1)
MSSP	27	35	7
Total	648	529	(118)

YEAR - TO - DATE

Year To Date Enrollment	Actual	Budget	Fav / (Unfav)	
Medi-Cal	10,311,481	9,866,491	444,990	4.5%
OneCare Connect	176,189	181,341	(5,152)	(2.8%)
OneCare	28,107	21,382	6,725	31.5%
PACE	4,999	4,953	46	0.9%
MSSP	2,751	3,408	(657)	(19.3%)
Total*	10,520,776	10,074,167	446,609	4.4%

Change in Net Assets (000)	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 134,006	$ (79,900)	213,906	267.7%
OneCare Connect	10,655	(5,459)	16,114	295.2%
OneCare	389	(1,038)	1,427	137.5%
PACE	5,200	1,306	3,894	298.2%
MSSP	(9)	(77)	68	88.3%
505 Bldg.	194	-	194	0.0%
Investment Income & Other	(20,361)	10,000	(30,361)	(303.6%)
Total	$ 130,074	$ (75,168)	205,242	273.0%

MLR	Actual	Budget	% Point Var
Medi-Cal	93.7%	97.8%	(4.1)
OneCare Connect	91.3%	95.0%	(3.7)
OneCare	92.7%	95.6%	(2.9)

Administrative Cost (000)	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 106,653	$ 152,044	$ 45,392	29.9%
OneCare Connect	19,358	22,560	3,202	14.2%
OneCare	2,399	2,154	(245)	(11.4%)
PACE	2,217	2,865	648	22.6%
MSSP	431	508	77	15.2%
Total	$ 131,057	$ 180,131	$ 49,074	27.2%

Total FTE's YTD	Actual	Budget	Fav / (Unfav)
Medi-Cal	13,025	14,536	1,510
OneCare Connect	2,183	2,515	332
OneCare	113	112	(2)
PACE	1,102	1,382	280
MSSP	98	108	10
Total	16,521	18,652	2,131

MM per FTE	Actual	Budget	Fav / (Unfav)
Medi-Cal	792	679	(113)
OneCare Connect	81	72	(9)
OneCare	248	192	(57)
PACE	5	4	(1)
MSSP	28	32	3
Total	637	540	(97)

Note:* Total membership does not include MSSP

CalOptima - Consolidated
Statement of Revenues and Expenses
For the One Month Ended June 30, 2022

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	914,646		828,220		86,426	
REVENUE						
Medi-Cal	$ 93,927,335	$ 104.70	$ 241,350,231	$ 297.63	$ (147,422,896)	$ (193)
OneCare Connect	32,433,876	2,250.01	28,669,826	1,901.56	3,764,050	348.45
OneCare	5,420,345	2,031.61	2,205,915	1,226.19	3,214,430	805.42
PACE	3,868,397	9,017.24	3,587,058	8,152.40	281,339	864.84
MSSP	263,991	566.50	278,732	447.40	(14,741)	119.10
Total Operating Revenue	135,913,944	148.60	276,091,762	333.36	(140,177,818)	(184.76)
MEDICAL EXPENSES						
Medi-Cal	205,470,440	229.03	234,437,310	289.11	28,966,870	60.08
OneCare Connect	28,535,733	1,979.59	27,298,922	1,810.63	(1,236,811)	(168.96)
OneCare	3,639,990	1,364.31	2,073,968	1,152.84	(1,566,022)	(211.47)
PACE	3,403,100	7,932.63	3,274,082	7,441.10	(129,018)	(491.53)
MSSP	160,242	343.87	200,294	321.50	40,052	(22.37)
Total Medical Expenses	241,209,505	263.72	267,284,576	322.72	26,075,071	59.00
GROSS MARGIN	(105,295,561)	(115.12)	8,807,186	10.64	(114,102,747)	(125.76)
ADMINISTRATIVE EXPENSES						
Salaries and benefits	(14,838,591)	(16.22)	9,829,019	11.87	24,667,610	28.09
Professional fees	927,181	1.01	831,698	1.00	(95,483)	(0.01)
Purchased services	2,069,785	2.26	1,615,788	1.95	(453,997)	(0.31)
Printing & Postage	802,832	0.88	639,511	0.77	(163,321)	(0.11)
Depreciation & Amortization	461,650	0.50	492,900	0.60	31,250	0.10
Other expenses	2,343,999	2.56	2,308,238	2.79	(35,761)	0.23
Indirect cost allocation & Occupancy expense	373,048	0.41	470,185	0.57	97,137	0.16
Total Administrative Expenses	(7,860,095)	(8.59)	16,187,339	19.54	24,047,434	28.13
INCOME (LOSS) FROM OPERATIONS	(97,435,465)	(106.53)	(7,380,153)	(8.91)	(90,055,312)	(97.62)
INVESTMENT INCOME						
Interest income	2,235,048	2.44	833,334	1.01	1,401,714	1.43
Realized gain/(loss) on investments	(525,854)	(0.57)	-	-	(525,854)	(0.57)
Unrealized gain/(loss) on investments	(5,323,662)	(5.82)	-	-	(5,323,662)	(5.82)
Total Investment Income	(3,614,469)	(3.95)	833,334	1.01	(4,447,803)	(4.96)
NET RENTAL INCOME	93,937	0.10	-	-	93,937	0.10
TOTAL MCO TAX	441	-	-	-	441	-
TOTAL GRANT INCOME	(30,303)	(0.03)	-	-	(30,303)	(0.03)
CHANGE IN NET ASSETS	**(100,985,859)**	**(110.41)**	**(6,546,819)**	**(7.90)**	**(94,439,040)**	**(102.51)**
MEDICAL LOSS RATIO	**177.5%**		**96.8%**		**80.7%**	
ADMINISTRATIVE LOSS RATIO	**(5.8%)**		**5.9%**		**11.6%**	

CalOptima - Consolidated
Statement of Revenues and Expenses
For the Twelve Months Ended June 30, 2022

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	10,520,776		10,074,167		446,609	
REVENUE						
Medi-Cal	$ 3,799,545,091	$ 368.48	3,249,878,660	$ 329.39	$ 549,666,431	$ 39.09
OneCare Connect	344,402,500	1,954.73	339,332,450	1,871.24	5,070,050	83.49
OneCare	38,061,315	1,354.16	25,409,771	1,188.37	12,651,544	165.79
PACE	41,991,987	8,400.08	40,274,039	8,131.24	1,717,948	268.84
MSSP	1,321,284	480.29	1,521,105	446.33	(199,821)	33.96
Total Operating Revenue	4,225,322,176	401.62	3,656,416,025	362.95	568,906,151	38.67
MEDICAL EXPENSES						
Medi-Cal	3,560,708,664	345.31	3,177,734,222	322.07	(382,974,442)	(23.24)
OneCare Connect	314,389,749	1,784.39	322,231,108	1,776.93	7,841,359	(7.46)
OneCare	35,273,614	1,254.98	24,293,492	1,136.17	(10,980,122)	(118.81)
PACE	34,574,982	6,916.38	36,102,675	7,289.05	1,527,693	372.67
MSSP	899,197	326.86	1,090,515	319.99	191,318	(6.88)
Total Medical Expenses	3,945,846,206	375.05	3,561,452,012	353.52	(384,394,194)	(21.53)
GROSS MARGIN	279,475,970	26.57	94,964,013	9.43	184,511,957	17.14
ADMINISTRATIVE EXPENSES						
Salaries and benefits	76,602,219	7.28	113,332,636	11.25	36,730,417	3.97
Professional fees	4,755,866	0.45	8,976,316	0.89	4,220,450	0.44
Purchased services	14,546,087	1.38	15,478,002	1.54	931,915	0.16
Printing & Postage	5,672,814	0.54	7,013,989	0.70	1,341,175	0.16
Depreciation & Amortization	4,485,581	0.43	5,914,800	0.59	1,429,219	0.16
Other expenses	20,429,689	1.94	24,023,399	2.38	3,593,710	0.44
Indirect cost allocation & Occupancy expense	4,565,004	0.43	5,392,209	0.54	827,205	0.11
Total Administrative Expenses	131,057,261	12.46	180,131,351	17.88	49,074,090	5.42
INCOME (LOSS) FROM OPERATIONS	148,418,709	14.11	(85,167,338)	(8.45)	233,586,047	22.56
INVESTMENT INCOME						
Interest income	10,615,665	1.01	10,000,000	0.99	615,665	0.02
Realized gain/(loss) on investments	(2,315,488)	(0.22)	-	0.00	(2,315,488)	(0.22)
Unrealized gain/(loss) on investments	(28,660,846)	(2.72)	-	0.00	(28,660,846)	(2.72)
Total Investment Income	(20,360,669)	(1.94)	10,000,000	0.99	(30,360,669)	(2.93)
NET RENTAL INCOME	194,016	0.02	-	0.00	194,016	0.02
TOTAL MCO TAX	1,935,103	0.18	-	0.00	1,935,103	0.18
TOTAL GRANT INCOME	(121,212)	(0.01)	-	0.00	(121,212)	(0.01)
OTHER INCOME	8,865	0.00	-	0.00	8,865	0.00
CHANGE IN NET ASSETS	**130,074,812**	**12.36**	**(75,167,338)**	**(7.46)**	**205,242,150**	**19.82**
MEDICAL LOSS RATIO	**93.4%**		**97.4%**		**(4.0%)**	
ADMINISTRATIVE LOSS RATIO	**3.1%**		**4.9%**		**1.8%**	

CalOptima - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the One Month Ended June 30, 2022

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	MSSP	Consolidated
MEMBER MONTHS	558,439	326,646	12,049	897,134	14,415	2,668	429	466	914,646
REVENUES									
Capitation Revenue	46,957,088	$ 46,305,862	$ 664,385	$ 93,927,335	$ 32,433,876	$ 5,420,345	$ 3,868,397	$ 263,991	$ 135,913,944
Other Income	-	-	-	-	-	-	-	-	-
Total Operating Revenue	46,957,088	46,305,862	664,385	93,927,335	32,433,876	5,420,345	3,868,397	263,991	135,913,944
MEDICAL EXPENSES									
Provider Capitation	46,893,950	50,426,931	(27,614,268)	69,706,613	13,205,196	983,857			83,895,666
Facilities	23,717,969	16,927,044	4,022,670	44,667,683	3,999,979	1,027,295	560,056		50,255,012
Professional Claims	24,411,678	14,368,009	1,416,908	40,196,596	1,229,316	97,960	936,769		42,460,641
Prescription Drugs	(525,669)	(30,782)	0	(556,451)	7,808,792	1,308,863	363,657		8,924,860
MLTSS	34,212,591	3,483,316	1,273,438	38,969,345	1,354,689	62,087	163,543	29,053	40,578,717
Medical Management	4,515,389	3,481,235	269,518	8,266,143	1,367,863	159,079	1,198,603	131,189	11,122,877
Qualtiy Incentives	2,639,234	802,070	218,593	3,659,897	(611,686)		5,363		3,053,574
Reinsurance & Other	321,905	237,778	931	560,614	181,585	850	175,109		918,158
Total Medical Expenses	136,187,048	89,695,602	(20,412,210)	205,470,440	28,535,733	3,639,990	3,403,100	160,242	241,209,505
Medical Loss Ratio	290.0%	193.7%	-3072.3%	218.8%	88.0%	67.2%	88.0%	60.7%	177.5%
GROSS MARGIN	**(89,229,960)**	**(43,389,740)**	**21,076,595**	**(111,543,104)**	**3,898,143**	**1,780,354**	**465,297**	**103,749**	**(105,295,561)**
ADMINISTRATIVE EXPENSES									
Salaries & Benefits	(15,772,224)	676,831	66,577	103,679	86,547	(14,838,591)			
Professional fees	919,824	23,499	(18,822)	474	2,207	927,181			
Purchased services	1,673,496	247,031	17,825	131,433		2,069,785			
Printing & Postage	527,955	228,163	20,970	25,743		802,832			
Depreciation & Amortization	460,952			698		461,650			
Other expenses	2,246,239	63,837	-	29,707	4,216	2,343,999			
Indirect cost allocation & Occupancy	(1,794,579)	1,872,671	252,692	28,569	13,696	373,048			
Total Administrative Expenses	**(11,738,337)**	**3,112,031**	**339,242**	**320,302**	**106,666**	**(7,860,095)**			
Admin Loss Ratio	(12.5%)	9.6%	6.3%	8.3%	40.4%	(5.8%)			
INCOME (LOSS) FROM OPERATIONS	(99,804,768)	786,112	1,441,112	144,995	(2,917)	(97,435,465)			
INVESTMENT INCOME						(3,614,469)			
NET RENTAL INCOME						93,937			
TOTAL MCO TAX	441					441			
TOTAL GRANT INCOME	(30,303)					(30,303)			
CHANGE IN NET ASSETS	**$ (99,834,629)**	**$ 786,112**	**$ 1,441,112**	**$ 144,995**	**$ (2,917)**	**$ (100,985,859)**			
BUDGETED CHANGE IN NET ASSETS	(6,865,534)	(504,852)	(47,921)	50,918	(12,764)	(6,546,819)			
VARIANCE TO BUDGET - FAV (UNFAV)	$ (92,969,095)	$ 1,290,964	$ 1,489,033	$ 94,077	$ 9,847	$ (94,439,040)			

Note:* Total membership does not include MSSP

CalOptima - Consolidated - Year to Date
Statement of Revenues and Expenses by LOB
For the Twelve Months Ended June 30, 2022

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total MC	OneCare Connect	OneCare	PACE	MSSP	Consolidated
MEMBER MONTHS	6,486,444	3,682,923	142,114	10,311,481	176,189	28,107	4,999	2,751	10,520,776
REVENUES									
Capitation Revenue	1,946,513,327	$ 1,581,299,337	$ 271,732,428	3,799,545,091	$ 344,402,500	$ 38,061,315	$ 41,991,987	1,321,284	$ 4,225,322,176
Other Income	-	-	-	-	-	-	-	-	-
Total Operating Revenue	1,946,513,327	1,581,299,337	271,732,428	3,799,545,091	344,402,500	38,061,315	41,991,987	1,321,284	4,225,322,176
MEDICAL EXPENSES									
Provider Capitation	556,710,297	598,860,139	70,602,451	1,226,172,887	139,055,312	9,994,621		-	1,375,222,820
Facilities	298,949,443	301,271,009	65,098,748	665,319,199	49,349,356	10,954,575	8,217,050	-	733,840,180
Professional Claims	262,361,528	139,674,207	15,929,878	417,965,613	13,750,985	1,221,562	9,423,374	-	442,361,534
Prescription Drugs	127,818,720	175,055,343	40,136,051	343,010,114	77,785,389	11,881,611	3,958,177	-	436,635,292
MLTSS	438,546,753	47,572,741	20,689,714	506,809,208	17,314,679	625,588	990,339	173,943	525,913,757
Medical Management	32,537,672	20,811,155	3,906,955	57,255,782	13,102,496	561,113	10,504,096	725,254	82,148,741
Quality Incentives	22,486,923	11,623,723	1,096,601	35,207,248	1,817,399		(37,644)	-	36,987,003
Reinsurance & Other	181,550,029	117,300,771	10,117,812	308,968,612	2,214,133	34,544	1,519,590	-	312,736,879
Total Medical Expenses	1,920,961,367	1,412,169,088	227,578,209	3,560,708,664	314,389,749	35,273,614	34,574,982	899,197	3,945,846,206
Medical Loss Ratio	98.7%	89.3%	83.8%	93.7%	91.3%	92.7%	82.3%	68.1%	93.4%
GROSS MARGIN	**25,551,960**	**169,130,249**	**44,154,218**	**238,836,427**	**30,012,751**	**2,787,701**	**7,417,005**	**422,087**	**279,475,970**
ADMINISTRATIVE EXPENSES									
Salaries & Benefits	65,741,276	8,297,765	910,832	1,297,454	354,891	76,602,219			
Professional fees	4,201,500	226,121	308,777	7,725	11,743	4,755,866			
Purchased services	12,502,549	1,415,795	153,244	474,499	-	14,546,087			
Printing & Postage	4,275,139	1,107,202	114,823	175,649	-	5,672,814			
Depreciation & Amortization	4,476,541			9,040	-	4,485,581			
Other expenses	20,212,400	77,970	1,076	110,115	28,128	20,429,689			
Indirect cost allocation & Occupancy	(4,756,610)	8,233,046	909,867	142,720	35,981	4,565,004			
Total Administrative Expenses	**106,652,797**	**19,357,899**	**2,398,620**	**2,217,202**	**430,743**	**131,057,261**			
Admin Loss Ratio	2.8%	5.6%	6.3%	5.3%	32.6%	3.1%			
INCOME (LOSS) FROM OPERATIONS	132,183,630	10,654,852	389,081	5,199,802	(8,656)	148,418,709			
INVESTMENT INCOME						(20,360,669)			
NET RENTAL INCOME						194,016			
TOTAL MCO TAX	1,935,103					1,935,103			
TOTAL GRANT INCOME	(121,212)					(121,212)			
OTHER INCOME	8,865					8,865			
CHANGE IN NET ASSETS	**$ 134,006,386**	**$ 10,654,852**	**$ 389,081**	**$ 5,199,802**	**$ (8,656)**	**$ 130,074,812**			
BUDGETED CHANGE IN NET ASSETS	(79,900,356)	(5,458,654)	(1,037,641)	1,306,396	(77,083)	(75,167,338)			
VARIANCE TO BUDGET - FAV (UNFAV)	$ 213,906,742	$ 16,113,506	$ 1,426,722	$ 3,893,406	$ 68,427	$ 205,242,150			

Note:* Total membership does not include MSSP

June 30, 2022 Unaudited Financial Statements

SUMMARY MONTHLY RESULTS:

- Change in Net Assets is ($101.0) million, $94.4 million unfavorable to budget
- Operating deficit is $97.4 million, with a deficit in non-operating income of $3.6 million

YEAR TO DATE RESULTS:

- Change in Net Assets is $130.1 million, $205.2 million favorable to budget
- Operating surplus is $148.4 million, with a deficit in non-operating income of $18.3 million

Change in Net Assets by Line of Business (LOB) ($ millions):

June				July-June		
Actual	Budget	Variance		Actual	Budget	Variance
(99.8)	(6.9)	(92.9)	Medi-Cal	132.2	(79.9)	212.1
0.8	(0.5)	1.3	OCC	10.7	(5.5)	16.1
1.4	(0.0)	1.5	OneCare	0.4	(1.0)	1.4
0.1	0.1	0.1	PACE	5.2	1.3	3.9
(0.0)	(0.0)	0.0	MSSP	(0.0)	(0.1)	0.1
(97.4)	**(7.4)**	**(90.1)**	**Operating**	**148.4**	**(85.2)**	**233.6**
(3.6)	0.8	(4.4)	Inv./Rental Inc, MCO tax	(18.3)	10.0	(28.3)
(3.6)	**0.8**	**(4.4)**	**Non-Operating**	**(18.3)**	**10.0**	**(28.3)**
(101.0)	**(6.5)**	**(94.4)**	**TOTAL**	**130.1**	**(75.2)**	**205.2**

CalOptima - Consolidated
Enrollment Summary
For the Twelve Months Ended June 30, 2022

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
116,502	118,028	(1,526)	(1.3%)	SPD	1,436,146	1,409,540	26,606	1.9%
303,275	289,533	13,742	4.7%	TANF Child	3,614,608	3,541,433	73,175	2.1%
135,450	104,585	30,865	29.5%	TANF Adult	1,397,901	1,276,582	121,319	9.5%
3,212	3,191	21	0.7%	LTC	37,789	38,292	(503)	(1.3%)
326,646	284,408	42,238	14.9%	MCE	3,682,923	3,466,736	216,187	6.2%
12,049	11,159	890	8.0%	WCM	142,114	133,908	8,206	6.1%
897,134	**810,904**	**86,230**	**10.6%**	**Medi-Cal Total**	**10,311,481**	**9,866,491**	**444,990**	**4.5%**
14,415	**15,077**	**(662)**	**(4.4%)**	**OneCare Connect**	**176,189**	**181,341**	**(5,152)**	**(2.8%)**
2,668	**1,799**	**869**	**48.3%**	**OneCare**	**28,107**	**21,382**	**6,725**	**31.5%**
429	**440**	**(11)**	**(2.5%)**	**PACE**	**4,999**	**4,953**	**46**	**0.9%**
466	**623**	**(157)**	**(25.2%)**	**MSSP**	**2,751**	**3,408**	**(657)**	**(19.3%)**
914,646	**828,220**	**86,426**	**10.4%**	**CalOptima Total**	**10,520,776**	**10,074,167**	**446,609**	**4.4%**
				Enrollment (by Network)				
206,333	188,039	18,294	9.7%	HMO	2,396,328	2,287,773	108,555	4.7%
234,466	222,474	11,992	5.4%	PHC	2,771,177	2,717,827	53,350	2.0%
217,429	198,190	19,239	9.7%	Shared Risk Group	2,518,581	2,421,301	97,280	4.0%
238,906	202,201	36,705	18.2%	Fee for Service	2,625,395	2,439,590	185,805	7.6%
897,134	**810,904**	**86,230**	**10.6%**	**Medi-Cal Total**	**10,311,481**	**9,866,491**	**444,990**	**4.5%**
14,415	**15,077**	**(662)**	**(4.4%)**	**OneCare Connect**	**176,189**	**181,341**	**(5,152)**	**(2.8%)**
2,668	**1,799**	**869**	**48.3%**	**OneCare**	**28,107**	**21,382**	**6,725**	**31.5%**
429	**440**	**(11)**	**(2.5%)**	**PACE**	**4,999**	**4,953**	**46**	**0.9%**
466	**623**	**(157)**	**(25.2%)**	**MSSP**	**2,751**	**3,408**	**(657)**	**(19.3%)**
914,646	**828,220**	**86,426**	**10.4%**	**CalOptima Total**	**10,520,776**	**10,074,167**	**446,609**	**4.4%**

*Note: CalOptima Total does not include MSSP

CalOptima
Enrollment Trend by Network
Fiscal Year 2022

	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	YTD Actual	YTD Budget	Variance
HMOs															
SPD	10,759	10,772	10,796	10,750	10,821	10,837	10,841	10,887	10,843	10,879	10,858	10,879	129,922	129,821	101
BCCTP													-		0
Disabled													-		0
TANF Child	57,684	57,453	57,592	57,944	58,108	58,236	58,526	58,795	58,905	59,086	59,080	59,139	700,548	680,353	20,195
TANF Adult	33,827	34,099	34,339	34,622	35,046	35,411	35,758	36,052	36,426	36,751	36,959	37,381	426,671	396,177	30,494
LTC		1	3	1		1	1		2	2	1		12		12
MCE	88,797	89,334	90,159	91,017	91,516	92,159	93,225	93,841	94,771	95,797	96,408	96,884	1,113,908	1,057,302	56,606
WCM	2,114	2,193	2,177	2,133	2,130	2,143	2,103	1,986	2,147	2,008	2,083	2,050	25,267	24,120	1,147
Total	**193,181**	**193,852**	**195,066**	**196,467**	**197,621**	**198,787**	**200,454**	**201,561**	**203,094**	**204,523**	**205,389**	**206,333**	**2,396,328**	**2,287,773**	**108,555**
PHCs															
SPD	6,896	6,819	6,942	6,915	6,953	6,926	6,861	6,880	6,894	6,846	6,916	6,605	82,453	85,478	(3,025)
BCCTP													-		0
Disabled													-		0
TANF Child	155,214	154,985	155,440	155,771	156,156	156,251	156,692	157,039	156,984	157,528	157,532	157,692	1,877,284	1,845,629	31,655
TANF Adult	14,006	14,054	14,197	14,390	14,667	14,851	14,985	15,115	15,270	15,437	15,596	15,919	178,487	164,927	13,560
LTC		2	1			1							4		4
MCE	44,256	44,359	44,580	44,754	44,973	45,241	45,668	45,753	46,013	46,253	46,607	46,742	545,199	539,329	5,870
WCM	7,304	7,368	7,236	7,322	7,178	7,262	7,246	7,037	7,679	7,227	7,383	7,508	87,750	82,464	5,286
Total	**227,676**	**227,587**	**228,396**	**229,152**	**229,927**	**230,532**	**231,452**	**231,824**	**232,840**	**233,291**	**234,034**	**234,466**	**2,771,177**	**2,717,827**	**53,350**
Shared Risk Groups															
SPD	10,063	10,104	10,074	10,003	10,122	10,095	10,096	10,086	10,077	10,099	10,756	9,481	121,056	123,997	(2,941)
BCCTP													-		0
Disabled													-		0
TANF Child	59,085	58,837	58,641	58,541	58,523	58,347	58,363	58,200	58,279	58,269	57,989	57,823	700,897	710,617	(9,720)
TANF Adult	33,013	33,123	33,374	33,745	34,109	34,482	34,824	35,120	35,551	35,818	36,744	38,324	418,227	395,907	22,320
LTC	1	1	1		1			1		3	1	7	16		16
MCE	99,994	100,643	101,666	102,780	103,620	104,418	105,563	106,367	107,480	108,934	109,914	110,427	1,261,806	1,173,788	88,018
WCM	1,373	1,368	1,394	1,400	1,395	1,394	1,423	1,363	1,393	1,368	1,341	1,367	16,579	16,992	(413)
Total	**203,529**	**204,076**	**205,150**	**206,469**	**207,770**	**208,736**	**210,269**	**211,137**	**212,780**	**214,491**	**216,745**	**217,429**	**2,518,581**	**2,421,301**	**97,280**
Fee for Service (Dual)															
SPD	79,829	80,117	80,139	80,438	80,738	80,494	81,326	81,148	81,219	81,291	81,397	81,589	969,725	945,433	24,292
BCCTP													-		0
Disabled													-		0
TANF Child	1	1	1	1	1	1	1	1	1	1	1	1	12		12
TANF Adult	1,318	1,351	1,392	1,408	1,435	1,465	1,529	1,568	1,563	1,582	1,615	1,649	17,875	13,861	4,014
LTC	2,788	2,778	2,806	2,847	2,864	2,870	2,914	2,624	2,846	2,819	2,891	2,859	33,906	34,644	(738)
MCE	3,612	3,813	4,013	4,268	4,489	4,889	4,982	5,145	5,468	5,693	5,908	6,197	58,477	31,172	27,305
WCM	16	16	18	20	15	18	16	16	19	18	18	18	208	180	28
Total	**87,564**	**88,076**	**88,369**	**88,982**	**89,542**	**89,737**	**90,768**	**90,502**	**91,116**	**91,404**	**91,830**	**92,313**	**1,080,203**	**1,025,290**	**54,913**
Fee for Service (Non-Dual - Total)															
SPD	10,163	10,047	10,616	10,358	10,832	10,708	10,937	10,763	11,022	11,204	18,392	7,948	132,990	124,811	8,179
BCCTP													-		0
Disabled													-		0
TANF Child	26,720	26,952	27,715	28,188	27,730	27,774	28,746	28,788	28,055	28,299	28,280	28,620	335,867	304,834	31,033
TANF Adult	26,224	26,653	27,382	27,916	28,150	28,339	29,265	29,129	29,267	29,716	32,423	42,177	356,641	305,710	50,931
LTC	309	314	305	316	321	332	292	332	324	330	330	346	3,851	3,648	203
MCE	53,947	54,384	55,449	56,467	56,714	56,885	58,967	59,675	59,349	59,854	65,446	66,396	703,533	665,145	38,388
WCM	993	962	999	1,030	1,009	975	1,053	898	1,172	1,060	1,053	1,106	12,310	10,152	2,158
Total	**118,356**	**119,312**	**122,466**	**124,275**	**124,756**	**125,013**	**129,260**	**129,585**	**129,189**	**130,463**	**145,924**	**146,593**	**1,545,192**	**1,414,300**	**130,892**
Grand Totals															
SPD	117,710	117,859	118,567	118,464	119,466	119,060	120,061	119,764	120,055	120,319	128,319	116,502	1,436,146	1,409,540	26,606
BCCTP													-		0
Disabled													-		0
TANF Child	298,704	298,228	299,389	300,445	300,518	300,609	302,328	302,823	302,224	303,183	302,882	303,275	3,614,608	3,541,433	73,175
TANF Adult	108,388	109,280	110,684	112,081	113,407	114,548	116,361	116,984	118,077	119,304	123,337	135,450	1,397,901	1,276,582	121,319
LTC	3,098	3,096	3,116	3,164	3,186	3,204	3,207	2,957	3,172	3,154	3,223	3,212	37,789	38,292	(503)
MCE	290,606	292,533	295,867	299,286	301,312	303,592	308,405	310,781	313,081	316,531	324,283	326,646	3,682,923	3,466,736	216,187
WCM	11,800	11,907	11,824	11,905	11,727	11,792	11,841	11,300	12,410	11,681	11,878	12,049	142,114	133,908	8,206
Total MediCal MM	**830,306**	**832,903**	**839,447**	**845,345**	**849,616**	**852,805**	**862,203**	**864,609**	**869,019**	**874,172**	**893,922**	**897,134**	**10,311,481**	**9,866,491**	**444,990**
OneCare Connect	**14,688**	**14,819**	**14,817**	**14,833**	**14,877**	**14,933**	**14,686**	**14,579**	**14,587**	**14,490**	**14,465**	**14,415**	**176,189**	**181,341**	**(5,152)**
OneCare	**2,019**	**2,110**	**2,152**	**2,232**	**2,274**	**2,330**	**2,319**	**2,395**	**2,461**	**2,531**	**2,616**	**2,668**	**28,107**	**21,382**	**6,725**
PACE	**401**	**407**	**409**	**418**	**415**	**421**	**427**	**418**	**413**	**417**	**424**	**429**	**4,999**	**4,953**	**46**
MSSP							**452**	**457**	**459**	**457**	**460**	**466**	**2,751**	**3,408**	**(657)**
Grand Total	**847,414**	**850,239**	**856,825**	**862,828**	**867,182**	**870,489**	**879,635**	**882,001**	**886,480**	**891,610**	**911,427**	**914,646**	**10,520,776**	**10,074,167**	**446,609**

*Note: Grand Total does not include MSSP

ENROLLMENT:

Overall, June enrollment was 914,646

- Favorable to budget 86,426 or 10.4%
- Increased 3,219 or 0.4% from Prior Month (PM) (May 2022)
- Increased 72,405 or 8.6% from Prior Year (PY) (June 2021)

Medi-Cal enrollment was 897,134

- Favorable to budget 86,230 or 10.6% due to pause in redetermination due to the Public Health Emergency
  - Temporary Assistance for Needy Families (TANF) favorable 44,607
  - Medi-Cal Expansion (MCE) favorable 42,238
  - Whole Child Model (WCM) favorable 890
  - Long-Term Care (LTC) favorable 21
  - Seniors and Persons with Disabilities (SPD) unfavorable 1,526
- Increased 3,212 from PM

OneCare Connect enrollment was 14,415

- Unfavorable to budget 662 or 4.4%
- Decreased 50 from PM

OneCare enrollment was 2,668

- Favorable to budget 869 or 48.3%
- Increased 52 from PM

PACE enrollment was 429

- Unfavorable to budget 11 or 2.5%
- Increased 5 from PM

MSSP enrollment was 466

- Unfavorable to budget 157 or 25.2% due to MSSP currently being under-staffed. There is a staff to member ratio that must be met
- Increased 6 from PM

CalOptima
Medi-Cal Total
Statement of Revenues and Expenses
For the Twelve Months Ending June 30, 2022

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
897,134	**810,904**	**86,230**	**10.6%**	**Member Months**	**10,311,481**	**9,866,491**	**444,990**	**4.5%**
				Revenues				
93,927,335	241,350,231	(147,422,896)	(61.1%)	Capitation Revenue	3,799,545,091	3,249,878,660	549,666,431	16.9%
-	-	-	0.0%	Other Income	-	-	-	0.0%
93,927,335	**241,350,231**	**(147,422,896)**	**(61.1%)**	**Total Operating Revenue**	**3,799,545,091**	**3,249,878,660**	**549,666,431**	**16.9%**
				Medical Expenses				
73,366,510	88,134,888	14,768,378	16.8%	Provider Capitation	1,261,380,135	1,089,334,008	(172,046,127)	(15.8%)
44,667,683	64,388,152	19,720,469	30.6%	Facilities Claims	665,319,199	771,815,674	106,496,475	13.8%
40,196,596	30,900,391	(9,296,205)	(30.1%)	Professional Claims	417,965,613	374,889,936	(43,075,677)	(11.5%)
(556,451)	-	556,451	0.0%	Prescription Drugs	343,010,114	345,521,586	2,511,472	0.7%
38,969,345	42,032,620	3,063,275	7.3%	MLTSS	506,809,208	506,856,723	47,515	0.0%
8,266,143	5,648,162	(2,617,981)	(46.4%)	Medical Management	57,255,782	65,247,315	7,991,533	12.2%
560,614	3,333,097	2,772,483	83.2%	Reinsurance & Other	308,968,612	24,068,980	(284,899,632)	(1183.7%)
205,470,440	**234,437,310**	**28,966,870**	**12.4%**	**Total Medical Expenses**	**3,560,708,664**	**3,177,734,222**	**(382,974,442)**	**(12.1%)**
(111,543,104)	**6,912,921**	**(118,456,025)**	**(1713.5%)**	**Gross Margin**	**238,836,427**	**72,144,438**	**166,691,989**	**231.1%**
				Administrative Expenses				
(15,772,224)	8,630,671	24,402,895	282.7%	Salaries, Wages & Employee Benefits	65,741,276	99,625,193	33,883,917	34.0%
919,824	771,906	(147,918)	(19.2%)	Professional Fees	4,201,500	8,053,566	3,852,066	47.8%
1,673,496	1,445,975	(227,521)	(15.7%)	Purchased Services	12,502,549	13,495,620	993,071	7.4%
527,955	466,332	(61,623)	(13.2%)	Printing and Postage	4,275,139	4,935,940	660,801	13.4%
460,952	492,500	31,548	6.4%	Depreciation & Amortization	4,476,541	5,910,000	1,433,459	24.3%
2,246,239	2,241,690	(4,549)	(0.2%)	Other Operating Expenses	20,212,400	23,492,621	3,280,221	14.0%
(1,794,579)	(270,619)	1,523,960	563.1%	Indirect Cost Allocation, Occupancy Expense	(4,756,610)	(3,468,146)	1,288,464	37.2%
(11,738,337)	**13,778,455**	**25,516,792**	**185.2%**	**Total Administrative Expenses**	**106,652,797**	**152,044,794**	**45,391,997**	**29.9%**
				Operating Tax				
13,854,608	13,655,623	198,985	1.5%	Tax Revenue	168,185,103	166,151,708	2,033,395	1.2%
13,854,167	13,655,623	(198,544)	(1.5%)	Premium Tax Expense	166,250,000	166,151,708	(98,292)	(0.1%)
441	-	441	**0.0%**	**Total Net Operating Tax**	1,935,103	-	1,935,103	**0.0%**
				Grant Income				
30,303	-	(30,303)	0.0%	Grant Expense	121,212	-	(121,212)	0.0%
(30,303)	-	(30,303)	**0.0%**	**Total Grant Income**	(121,212)	-	(121,212)	**0.0%**
-	**-**	**-**	**0.0%**	**Other income**	**8,865**	**-**	**8,865**	**0.0%**
(99,834,629)	**(6,865,534)**	**(92,969,095)**	**(1354.1%)**	**Change in Net Assets**	**134,006,386**	**(79,900,356)**	**213,906,742**	**267.7%**
218.8%	***97.1%***	***121.6%***		***Medical Loss Ratio***	***93.7%***	***97.8%***	***(4.1%)***	
(12.5%)	***5.7%***	***18.2%***		***Admin Loss Ratio***	***2.8%***	***4.7%***	***1.9%***	

MEDI-CAL INCOME STATEMENT– JUNE MONTH:

REVENUES of $93.9 million are unfavorable to budget $147.4 million driven by:

- Favorable volume related variance of $25.7 million
- Unfavorable price related variance of $173.1 million
  - $198.6 million due to COVID-19 risk corridor estimates
  - $8.2 million due to Enhanced Care Management (ECM) risk corridor estimates
  - Offset by:
  - $35.7 million due to updated Medi-Cal rates and extension of Proposition 56

MEDICAL EXPENSES of $205.5 million are favorable to budget $29.0 million driven by:

- Unfavorable volume related variance of $24.9 million
- Favorable price related variance of $53.9 million
  - Facilities Claims expense favorable variance of $26.6 million primarily due to decrease in facilities-related crossover claims and PY hospital shared risk pool
  - Provider Capitation expense favorable variance of $24.1 million due primarily to WCM risk corridor estimates of $35.4 million offset by the extension of Proposition 56 and short-term supplemental rate increase due to COVID-19
  - Managed Long-Term Services and Supports (MLTSS) expense favorable variance of $7.5 million due to Incurred But Not Reported (IBNR) claims
  - Offset by:
  - Professional Claims expense unfavorable variance of $6.0 million due to increase in professional-related crossover claims

ADMINISTRATIVE EXPENSES of ($11.7) million are favorable to budget $25.5 million driven by:

- Salaries & Benefit expense favorable to budget $24.4 million due primarily to release of pension liabilities in accordance with GASB 68
- Other Non-Salary expense favorable to budget $1.1 million

CHANGE IN NET ASSETS is ($99.8) million, unfavorable to budget $93.0 million

CalOptima
OneCare Connect Total
Statement of Revenue and Expenses
For the Twelve Months Ending June 30, 2022

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
14,415	**15,077**	**(662)**	**(4.4%)**	**Member Months**	**176,189**	**181,341**	**(5,152)**	**(2.8%)**
				Revenues				
2,719,439	2,775,492	(56,053)	(2.0%)	Medi-Cal Capitation Revenue	32,466,957	33,600,975	(1,134,018)	(3.4%)
23,257,833	20,122,395	3,135,438	15.6%	Medicare Capitation Revenue Part C	238,769,717	236,642,461	2,127,256	0.9%
6,456,604	5,771,939	684,665	11.9%	Medicare Capitation Revenue Part D	73,165,825	69,089,014	4,076,811	5.9%
-	-	-	0.0%	Other Income	-	-	-	0.0%
32,433,876	**28,669,826**	**3,764,050**	**13.1%**	**Total Operating Revenue**	**344,402,500**	**339,332,450**	**5,070,050**	**1.5%**
				Medical Expenses				
12,593,510	12,338,702	(254,808)	(2.1%)	Provider Capitation	140,872,711	143,668,278	2,795,567	1.9%
3,999,979	4,438,456	438,477	9.9%	Facilities Claims	49,349,356	52,753,619	3,404,263	6.5%
1,229,316	1,046,950	(182,366)	(17.4%)	Ancillary	13,750,985	12,581,479	(1,169,506)	(9.3%)
1,354,689	1,354,716	27	0.0%	MLTSS	17,314,679	16,976,720	(337,959)	(2.0%)
7,808,792	6,706,562	(1,102,230)	(16.4%)	Prescription Drugs	77,785,389	79,340,804	1,555,415	2.0%
1,367,863	1,235,099	(132,764)	(10.7%)	Medical Management	13,102,496	14,774,475	1,671,979	11.3%
181,585	178,437	(3,148)	(1.8%)	Other Medical Expenses	2,214,133	2,135,733	(78,400)	(3.7%)
28,535,733	**27,298,922**	**(1,236,811)**	**(4.5%)**	**Total Medical Expenses**	**314,389,749**	**322,231,108**	**7,841,359**	**2.4%**
3,898,143	**1,370,904**	**2,527,239**	**184.3%**	**Gross Margin**	**30,012,751**	**17,101,342**	**12,911,409**	**75.5%**
				Administrative Expenses				
676,831	887,492	210,661	23.7%	Salaries, Wages & Employee Benefits	8,297,765	10,543,898	2,246,133	21.3%
23,499	29,330	5,832	19.9%	Professional Fees	226,121	564,000	337,880	59.9%
247,031	119,725	(127,306)	(106.3%)	Purchased Services	1,415,795	1,381,282	(34,513)	(2.5%)
228,163	138,121	(90,042)	(65.2%)	Printing and Postage	1,107,202	1,657,320	550,118	33.2%
-	-	-	0.0%	Depreciation & Amortization	-	-	-	0.0%
63,837	21,040	(42,797)	(203.4%)	Other Operating Expenses	77,970	252,865	174,895	69.2%
1,872,671	680,048	(1,192,623)	(175.4%)	Indirect Cost Allocation	8,233,046	8,160,631	(72,415)	(0.9%)
3,112,031	**1,875,756**	**(1,236,275)**	**(65.9%)**	**Total Administrative Expenses**	**19,357,899**	**22,559,996**	**3,202,097**	**14.2%**
786,112	**(504,852)**	**1,290,964**	**255.7%**	**Change in Net Assets**	**10,654,852**	**(5,458,654)**	**16,113,506**	**295.2%**
88.0%	***95.2%***	***(7.2%)***		***Medical Loss Ratio***	***91.3%***	***95.0%***	***(3.7%)***	
9.6%	***6.5%***	***(3.1%)***		***Admin Loss Ratio***	***5.6%***	***6.6%***	***1.0%***	

ONECARE CONNECT INCOME STATEMENT– JUNE MONTH:

REVENUES of $32.4 million are favorable to budget $3.8 million driven by:

- Unfavorable volume related variance of $1.3 million
- Favorable price related variance of $5.0 million due to mid-year Current Year (CY) 2022 Hierarchical Condition Category (HCC)

MEDICAL EXPENSES of $28.5 million are unfavorable to budget $1.2 million driven by:

- Favorable volume related variance of $1.2 million
- Unfavorable price related variance of $2.4 million
  - Prescription Drugs expense unfavorable variance of $1.4 million
  - Provider Capitation expense unfavorable variance of $0.8 million

ADMINISTRATIVE EXPENSES of $3.1 million are unfavorable to budget $1.2 million driven by:

- Other Non-Salary expense unfavorable to budget $1.4 million
- Salaries & Benefit expense favorable to budget $0.2 million

CHANGE IN NET ASSETS is $0.8 million, favorable to budget $1.3 million

CalOptima
OneCare
Statement of Revenues and Expenses
For the Twelve Months Ending June 30, 2022

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
2,668	**1,799**	**869**	**48.3%**	**Member Months**	**28,107**	**21,382**	**6,725**	**31.5%**
				Revenues				
3,276,279	1,485,098	1,791,181	120.6%	Medicare Part C revenue	25,598,595	17,274,007	8,324,588	48.2%
2,144,065	720,817	1,423,248	197.4%	Medicare Part D revenue	12,462,719	8,135,764	4,326,955	53.2%
5,420,345	**2,205,915**	**3,214,430**	**145.7%**	**Total Operating Revenue**	**38,061,315**	**25,409,771**	**12,651,544**	**49.8%**
				Medical Expenses				
983,857	588,403	(395,454)	(67.2%)	Provider Capitation	9,994,621	6,778,297	(3,216,324)	(47.5%)
1,027,295	641,907	(385,388)	(60.0%)	Inpatient	10,954,575	7,438,498	(3,516,077)	(47.3%)
97,960	75,276	(22,684)	(30.1%)	Ancillary	1,221,562	881,510	(340,052)	(38.6%)
62,087	28,674	(33,413)	(116.5%)	Skilled Nursing Facilities	625,588	350,505	(275,083)	(78.5%)
1,308,863	698,337	(610,526)	(87.4%)	Prescription Drugs	11,881,611	8,226,386	(3,655,225)	(44.4%)
159,079	40,039	(119,040)	(297.3%)	Medical Management	561,113	602,473	41,360	6.9%
850	1,332	482	36.2%	Other Medical Expenses	34,544	15,823	(18,721)	(118.3%)
3,639,990	**2,073,968**	**(1,566,022)**	**(75.5%)**	**Total Medical Expenses**	**35,273,614**	**24,293,492**	**(10,980,122)**	**(45.2%)**
1,780,354	**131,947**	**1,648,407**	**1249.3%**	**Gross Margin**	**2,787,701**	**1,116,279**	**1,671,422**	**149.7%**
				Administrative Expenses				
66,577	73,766	7,189	9.7%	Salaries, wages & employee benefits	910,832	880,619	(30,213)	(3.4%)
(18,822)	29,174	47,996	164.5%	Professional fees	308,777	350,000	41,223	11.8%
17,825	9,163	(8,662)	(94.5%)	Purchased services	153,244	110,000	(43,244)	(39.3%)
20,970	15,816	(5,154)	(32.6%)	Printing and postage	114,823	189,869	75,046	39.5%
-	1,031	1,031	100.0%	Other operating expenses	1,076	12,350	11,274	91.3%
252,692	50,918	(201,774)	(396.3%)	Indirect cost allocation, occupancy expense	909,867	611,082	(298,785)	(48.9%)
339,242	**179,868**	**(159,374)**	**(88.6%)**	**Total Administrative Expenses**	**2,398,620**	**2,153,920**	**(244,700)**	**(11.4%)**
1,441,112	**(47,921)**	**1,489,033**	**3107.3%**	**Change in Net Assets**	**389,081**	**(1,037,641)**	**1,426,722**	**137.5%**
67.2%	***94.0%***	***(26.9%)***		***Medical Loss Ratio***	***92.7%***	***95.6%***	***(2.9%)***	
6.3%	***8.2%***	***1.9%***		***Admin Loss Ratio***	***6.3%***	***8.5%***	***2.2%***	

CalOptima
PACE
Statement of Revenues and Expenses
For the Twelve Months Ending June 30, 2022

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
429	**440**	**(11)**	**(2.5%)**	**Member Months**	**4,999**	**4,953**	**46**	**0.9%**
				Revenues				
2,770,000	2,717,443	52,557	1.9%	Medi-Cal Capitation Revenue	31,250,544	30,672,852	577,692	1.9%
887,048	711,397	175,651	24.7%	Medicare Part C Revenue	8,305,034	7,805,791	499,243	6.4%
211,349	158,218	53,131	33.6%	Medicare Part D Revenue	2,436,409	1,795,396	641,013	35.7%
3,868,397	**3,587,058**	**281,339**	**7.8%**	**Total Operating Revenue**	**41,991,987**	**40,274,039**	**1,717,948**	**4.3%**
				Medical Expenses				
1,198,603	1,090,311	(108,292)	(9.9%)	Medical Management	10,504,096	12,273,434	1,769,338	14.4%
560,056	790,417	230,361	29.1%	Facilities Claims	8,217,050	8,945,278	728,228	8.1%
936,769	734,990	(201,779)	(27.5%)	Professional Claims	9,423,374	8,187,774	(1,235,600)	(15.1%)
175,109	226,182	51,073	22.6%	Patient Transportation	1,519,590	2,058,071	538,481	26.2%
363,657	362,876	(781)	(0.2%)	Prescription Drugs	3,958,177	3,994,675	36,498	0.9%
163,543	63,941	(99,602)	(155.8%)	MLTSS	990,339	582,220	(408,119)	(70.1%)
5,363	5,365	3	0.0%	Other Expenses	(37,644)	61,223	98,867	161.5%
3,403,100	**3,274,082**	**(129,018)**	**(3.9%)**	**Total Medical Expenses**	**34,574,982**	**36,102,675**	**1,527,693**	**4.2%**
465,297	**312,976**	**152,321**	**48.7%**	**Gross Margin**	**7,417,005**	**4,171,364**	**3,245,641**	**77.8%**
				Administrative Expenses				
103,679	159,201	55,522	34.9%	Salaries, wages & employee benefits	1,297,454	1,855,156	557,702	30.1%
474	163	(311)	(190.8%)	Professional fees	7,725	2,000	(5,725)	(286.3%)
131,433	40,925	(90,508)	(221.2%)	Purchased services	474,499	491,100	16,601	3.4%
25,743	19,242	(6,501)	(33.8%)	Printing and postage	175,649	230,860	55,211	23.9%
698	400	(298)	(74.5%)	Depreciation & amortization	9,040	4,800	(4,240)	(88.3%)
29,707	37,176	7,469	20.1%	Other operating expenses	110,115	221,717	111,602	50.3%
28,569	4,951	(23,618)	(477.0%)	Indirect Cost Allocation, Occupancy Expense	142,720	59,335	(83,385)	(140.5%)
320,302	**262,058**	**(58,244)**	**(22.2%)**	**Total Administrative Expenses**	**2,217,202**	**2,864,968**	**647,766**	**22.6%**
				Operating Tax				
-	-	-	0.0%	Tax Revenue	(104,667)	-	(104,667)	0.0%
-	-	-	0.0%	Premium Tax Expense	(104,667)	-	104,667	0.0%
-	-	-	**0.0%**	**Total Net Operating Tax**	-	-	-	**0.0%**
144,995	**50,918**	**94,077**	**184.8%**	**Change in Net Assets**	**5,199,802**	**1,306,396**	**3,893,406**	**298.0%**
88.0%	***91.3%***	***(3.3%)***		***Medical Loss Ratio***	***82.3%***	***89.6%***	***(7.3%)***	
8.3%	***7.3%***	***(1.0%)***		***Admin Loss Ratio***	***5.3%***	***7.1%***	***1.8%***	

CalOptima
Multipurpose Senior Select Program
Statement of Revenues and Expenses
For the Twelve Months Ending June 30, 2022

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
466	**623**	**(157)**	**(25.2%)**	**Member Months**	**2,751**	**3,408**	**(657)**	**(19.3%)**
				Revenues				
263,991	278,732	(14,741)	(5.3%)	Capitation Revenue	1,321,284	1,521,105	(199,821)	(13.1%)
263,991	**278,732**	**(14,741)**	**(5.3%)**	**Total Operating Revenue**	**1,321,284**	**1,521,105**	**(199,821)**	**(13.1%)**
				Medical Expenses				
131,189	164,060	32,871	20.0%	Medical Management	725,254	892,765	167,511	18.8%
				Waived Services				
314	165	(149)	(90.3%)	Minor home repairs	846	900	54	6.0%
10,150	10,301	151	1.5%	Non-medical home equipment	42,987	56,212	13,225	23.5%
4,249	4,189	(60)	(1.4%)	Chores	21,806	22,859	1,053	4.6%
4,185	3,589	(596)	(16.6%)	Personal care	21,321	19,587	(1,734)	(8.9%)
563	549	(14)	(2.5%)	In-home respite	2,457	2,996	539	18.0%
296	884	588	66.5%	Transportation	2,415	4,824	2,410	49.9%
752	1,319	567	43.0%	Home delivered meals	3,901	7,198	3,297	45.8%
(3)	209	212	101.5%	Food	381	1,140	759	66.6%
8,679	13,883	5,204	37.5%	Communications	57,026	75,780	18,754	24.7%
-	1,146	1,146	100.0%	Non-Covered Services	147	6,254	6,107	97.6%
(133)	-	133	0.0%	Protective Services	20,656	-	(20,656)	0.0%
131,189	164,060	32,871	20.0%	Total Medical Management	725,254	892,765	167,511	18.8%
29,053	36,234	7,181	19.8%	Other Medical Expenses	173,943	197,750	23,807	12.0%
160,242	**200,294**	**40,052**	**20.0%**	**Total Program Expenses**	**899,197**	**1,090,515**	**191,318**	**17.5%**
103,749	**78,438**	**25,311**	**32.3%**	**Gross Margin**	**422,087**	**430,590**	**(8,503)**	**(2.0%)**
				Administrative Expenses				
86,547	77,889	(8,658)	(11.1%)	Salaries, wages & employee benefits	354,891	427,770	72,879	17.0%
2,207	1,125	(1,082)	(96.2%)	Professional fees	11,743	6,750	(4,993)	(74.0%)
4,216	7,301	3,085	42.3%	Other operating expenses	28,128	43,846	15,718	35.8%
13,696	4,887	(8,809)	(180.2%)	Indirect Cost Allocation	35,981	29,307	(6,674)	(22.8%)
106,666	**91,202**	**(15,464)**	**(17.0%)**	**Total Administrative Expenses**	**430,743**	**507,673**	**76,930**	**15.2%**
(2,917)	**(12,764)**	**9,847**	**77.1%**	**Change in Net Assets**	**(8,656)**	**(77,083)**	**68,427**	**88.8%**
60.7%	***71.9%***	***(11.2%)***		***Medical Loss Ratio***	***68.1%***	***71.7%***	***(3.6%)***	
40.4%	***32.7%***	***(7.7%)***		***Admin Loss Ratio***	***32.6%***	***33.4%***	***0.8%***	

CalOptima
Building 505 - City Parkway
Statement of Revenues and Expenses
For the Twelve Months Ending June 30, 2022

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
-	-	-	0.0%	Rental Income	-	-	-	0.0%
-	-	-	**0.0%**	**Total Operating Revenue**	-	-	-	**0.0%**
				Administrative Expenses				
37,817	54,250	16,433	30.3%	Purchase services	453,633	651,000	197,367	30.3%
211,086	206,000	(5,086)	(2.5%)	Depreciation & amortization	2,125,164	2,472,000	346,836	14.0%
20,875	19,750	(1,125)	(5.7%)	Insurance expense	238,709	237,000	(1,709)	(0.7%)
174,883	162,837	(12,046)	(7.4%)	Repair and maintenance	1,456,870	1,704,000	247,130	14.5%
36,405	43,000	6,595	15.3%	Other Operating Expense	558,921	516,000	(42,921)	(8.3%)
(481,067)	(485,837)	(4,771)	(1.0%)	Indirect allocation, Occupancy	(4,833,296)	(5,580,000)	(746,704)	(13.4%)
-	-	-	**0.0%**	**Total Administrative Expenses**	-	-	-	**0.0%**
-	-	-	**0.0%**	**Change in Net Assets**	-	-	-	**0.0%**

CalOptima
Building 500 - City Parkway
Statement of Revenues and Expenses
For the Twelve Months Ending June 30, 2022

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
217,794	-	217,794	0.0%	Rental Income	330,203	-	330,203	0.0%
217,794	**-**	**217,794**	**0.0%**	**Total Operating Revenue**	**330,203**	**-**	**330,203**	**0.0%**
				Administrative Expenses				
(3,100)	-	3,100	0.0%	Professional Fees	-	-	-	0.0%
10,202	-	(10,202)	0.0%	Purchased Services	13,903	-	(13,903)	0.0%
-	-	-	0.0%	Depreciation & amortization	-	-	-	0.0%
72,569	-	(72,569)	0.0%	Insurance Expense	78,099	-	(78,099)	0.0%
25,205	-	(25,205)	0.0%	Repair and Maintenance	25,205	-	(25,205)	0.0%
18,981	-	(18,981)	0.0%	Other Operating Expense	18,981	-	(18,981)	0.0%
-	-	-	0.0%	Indirect allocation, Occupancy	-	-	-	0.0%
123,857	**-**	**(123,857)**	**0.0%**	**Total Administrative Expenses**	**136,187**	**-**	**(136,187)**	**0.0%**
93,937	**-**	**93,937**	**0.0%**	**Change in Net Assets**	**194,016**	**-**	**194,016**	**0.0%**

OTHER INCOME STATEMENTS – JUNE MONTH:

ONECARE INCOME STATEMENT

CHANGE IN NET ASSETS is $1.4 million, favorable to budget $1.5 million

PACE INCOME STATEMENT

CHANGE IN NET ASSETS is $0.1 million, favorable to budget $0.1 million

MSSP INCOME STATEMENT

CHANGE IN NET ASSETS is ($2,917), favorable to budget $9,847

BUILDING 500 INCOME STATEMENT

CHANGE IN NET ASSETS is $0.1 million, favorable to budget $0.1 million

- Net of $0.2 million in rental income and $0.1 million in expenses for the month of June

NET INVESTMENT INCOME

- Unfavorable variance of $4.4 million is due to unrealized gains from the rise in interest rates and widening credit spreads in the month of June

CalOptima
Balance Sheet
June 30, 2022

ASSETS		**LIABILITIES & NET POSITION**	
Current Assets		Current Liabilities	
Operating Cash	$823,489,434	Accounts Payable	$52,304,518
Short-term Investments	1,014,460,503	Medical Claims liability	1,278,015,349
Capitation receivable	405,190,937	Accrued Payroll Liabilities	19,568,204
Receivables - Other	71,719,307	Deferred Revenue	8,104,044
Prepaid expenses	22,564,000	Deferred Lease Obligations	92,171
		Capitation and Withholds	193,214,628
Total Current Assets	**2,337,424,181**	**Total Current Liabilities**	**1,551,298,916**
Capital Assets			
Furniture & Equipment	47,622,259		
Building/Leasehold Improvements	8,585,827		
505 City Parkway West	52,373,356		
500 City Parkway West	22,631,500		
	131,212,942		
Less: accumulated depreciation	(64,330,363)		
Capital assets, net	66,882,579	Other (than pensions) post	
		employment benefits liability	32,158,541
Other Assets		Net Pension Liabilities	577,854
Restricted Deposit & Other	300,051	Bldg 505 Development Rights	-
		GASB Liability	-
Homeless Health Reserve	40,636,739		
		TOTAL LIABILITIES	**1,584,035,311**
Board-designated assets:			
Cash and Cash Equivalents	4,332,184	Deferred Inflows	
Investments	566,159,456	Excess Earnings	686,563
Total Board-designated Assets	570,491,641	OPEB 75 Difference in Experience	536,000
		Change in Assumptions	1,909,305
Total Other Assets	611,428,430	OPEB Changes in Assumptions	773,000
		Net Position	
TOTAL ASSETS	**3,015,735,190**	TNE	107,345,455
		Funds in Excess of TNE	1,331,510,149
Deferred Outflows		**TOTAL NET POSITION**	1,438,855,605
Contributions	1,931,845		
Difference in Experience	2,353,671		
Excess Earning	-		
Changes in Assumptions	2,325,077		
OPEB 75 Changes in Assumptions	3,906,000		
Pension Contributions	544,000		
TOTAL ASSETS & DEFERRED OUTFLOWS	**3,026,795,783**	**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION**	**3,026,795,783**

CalOptima
Board Designated Reserve and TNE Analysis
as of June 30, 2022

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	232,027,155				
	Tier 1 - MetLife	230,643,052				
Board-designated Reserve		462,670,206	343,838,840	537,203,538	118,831,366	(74,533,332)
	Tier 2 - Payden & Rygel	54,010,235				
	Tier 2 - MetLife	53,811,199				
TNE Requirement		107,821,434	107,345,455	107,345,455	475,979	475,979
	Consolidated:	**570,491,640**	**451,184,295**	**644,548,993**	**119,307,345**	**(74,057,353)**
	Current reserve level	*1.77*	*1.40*	*2.00*		

CalOptima
Statement of Cash Flows
June 30, 2022

	Month Ended	Year-To-Date
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	(100,985,859)	130,074,812
Adjustments to reconcile change in net assets		
to net cash provided by operating activities		
Depreciation and amortization	672,736	6,610,745
Changes in assets and liabilities:		
Prepaid expenses and other	(4,684,926)	(10,585,389)
Catastrophic reserves		
Capitation receivable	(78,531,609)	(2,014,226)
Medical claims liability	269,762,207	333,696,401
Deferred revenue	86,382	(5,482,781)
Payable to health networks	(6,934,563)	48,434,840
Accounts payable	16,847,711	5,890,098
Accrued payroll	(27,507,474)	(26,142,326)
Other accrued liabilities	(2,994)	(35,157)
Net cash provided by/(used in) operating activities	68,721,611	480,447,017
GASB 68 CalPERS Adjustments	3,473,429	3,473,429
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	80,836,004	50,949,304
Change in Property and Equipment	195,551	(27,765,448)
Change in Restricted Deposit & Other	(51)	(51)
Change in Board designated reserves	3,211,225	18,388,512
Change in Homeless Health Reserve	-	16,162,174
Net cash provided by/(used in) investing activities	84,242,729	57,734,490
NET INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS	156,437,769	541,654,936
CASH AND CASH EQUIVALENTS, beginning of period	$667,051,665	281,834,499
CASH AND CASH EQUIVALENTS, end of period	**823,489,434**	**823,489,434**

BALANCE SHEET – JUNE MONTH:

ASSETS of $3.0 billion increased $150.8 million from May or 5.2%

- Operating Cash and Short-term Investments net increase of $75.6 million due primarily to:
  - Operating cash increased $156.4 million
  - Short-term Investments decreased $80.8 million
- Capitation Receivables increased $56.2 million due to timing of cash receipts
- Receivables - Other increased $22.3 million due to WCM receivable of $15.5 million for the Fiscal Year (FY) 2022 risk corridor and Part D receivables

LIABILITIES of $1.6 billion increased $252.3 million from May or 18.9%

- Claims Liabilities increased $269.8 million due to COVID-19 risk corridor estimates, ECM risk corridor estimates, timing of claim payments and changes in IBNR
- Accounts Payable increased $16.8 million due to the timing of capitation premium tax payments
- Net Pension Liabilities decreased $30.1 million due to the annual GASB 68 true-up of the annual CalPers pension liability, according to their actuarial certified report

NET ASSETS of $1.4 billion, decreased $101.0 million from May or 6.6%

CalOptima - Consolidated
Net Assets Analysis
For the Twelve Months Ended June 30, 2022

Category	Item Description	Resource Committed	Amount (millions)	%
	Total Net Position @ 06/30/2022:		**$ 1,438.9**	**100.0%**
Resources Assigned	Board Designated Reserve		**$ 570.5**	**39.6%**
	Capital Assets, net of depreciation		**$ 66.9**	**4.6%**
Resources Allocated, not yet Spent	Homeless Health Initiative*	100.0	**$ 25.5**	1.8%
	Intergovernmental Transfers (IGT)	80.8	**$ 20.5**	1.4%
	Mind OC Grant	1.0		0.0%
	CalFresh Outreach Strategy	2.0	**$ 1.6**	0.1%
	Digital Transformation and Workplace Modernization	100.0	**$ 100.0**	6.9%
	Coalition of Orange County Community Health Centers Grant	50.0	**$ 40.0**	2.8%
	Subtotal:	**333.8**	**$ 187.6**	**13.0%**
Resources Available for New Initiatives	Homeless Health Initiative		**$ 40.6**	
	Intergovernmental Transfers (IGT)		**$ 30.9**	
	Unallocated/Unassigned		**$ 542.4**	
	Subtotal:		**$ 613.9**	**42.7%**

*See Summary of Homeless Health Initiatives and Allocated Funds for list of Board approved initiatives

Summary of Homeless Health Initiatives and Allocated Funds
As of June 30, 2022

			Amount
Program Commitment		**$**	**100,000,000**
Funds Allocation, approved initiatives:			
Enhanced Medi-Cal Services at the Be Well OC Regional Mental Health and Wellness Campus	11,400,000		
Recuperative Care	8,250,000		
Medical Respite	250,000		
Day Habilitation (County for HomeKey)	2,500,000		
Clinical Field Team Start-up & Federal Qualified Health Center (FQHC)	1,600,000		
CalOptima Homeless Response Team	6,000,000		
Homeless Coordination at Hospitals	10,000,000		
CalOptima Days & QI Program - Homeless Clinic Access Program or HCAP	1,693,261		
FQHC (Community Health Center) Expansion and HHI Support	570,000		
HCAP Expansion for Telehealth and CFT On Call Days	1,700,000		
Vaccination Intervention and Member Incentive Strategy	400,000		
Street Medicine	8,000,000		
Outreach and Engagement Team	7,000,000		
Funds Allocation Total		**$**	**59,363,261**
Program Commitment Balance, available for new initiatives*		**$**	**40,636,739**

On June 27, 2019 at a Special Board meeting, the Board approved four funding categories.

This report only lists Board approved projects.

* Funding sources of the remaining balance are IGT8 and CalOptima's operating income, which must be used for Medi-Cal covered services for the Medi-Cal population

Budget Allocation Changes
Reporting Changes for June 2022

Transfer Month	Line of Business	From	To	Amount	Expense Description	Fiscal Year
August	Medi-Cal	Ground Floor Corridor Heating and Cooling Boxes Replacement	Multiple Bathroom Upgrades (Original Bathrooms on 2nd and 4th Floors)	$25,800	To transfer funds from capital project Ground Floor Corridor Heating and Cooling Boxes Replacement to capital project Multiple Bathroom Upgrades (Original Bathrooms on the 2nd and 4th Floors) to fund the final bathroom change order.	2020-21
November	Medi-Cal	Upgrade the System Backup Application Disk Storage - Hardware	Upgrade the Citrix Virtual Servers to Support Version - Hardware	$24,000	To transfer funds from capital project Upgrade the System Backup Application Disk Storage to capital project Upgrade the Citrix Virtual Servers to Support Version to provide additional funds for hardware purchases.	2021-22
November	Medi-Cal	Upgrade the System Backup Application Disk Storage - Hardware	Upgrade the Database Disk Storage Equipment - Hardware	$51,000	To transfer funds from capital project Upgrade the System Backup Application Disk Storage to capital project Upgrade the Database Disk Storage Equipment to provide additional funds for hardware purchases.	2021-22
December	Medi-Cal	Maintenance HW/SW - BMC	Maintenance HW/SW – SolarWinds	$10,500	To repurpose funds from BMC to SolarWinds to provide additional funds for maintenance contract renewal.	2021-22
December	Medi-Cal	Upgrade the Citrix Virtual Servers to Support Version - Hardware	Upgrade the Database Disk Storage Equipment - Hardware	$13,500	To transfer funds from capital project Upgrade the Citrix Virtual Servers to Support Version to capital project Upgrade the Database Disk Storage Equipment to provide additional funds for hardware purchases.	2021-22
December	Medi-Cal	Maintenance HW/SW – Optum/Ingenix ICD 10	Maintenance HW/SW – Smart Communications	$14,000	To repurpose funds from Optum/Ingenix ICD10 to Smart Communications to provide additional funds for maintenance contract renewal.	2021-22
December	Medi-Cal	Maintenance HW/SW – Microsoft True-Up	Maintenance HW/SW – Extreme Networks	$24,000	To repurpose funds from Microsoft True-UP to Extreme Networks to provide additional funds for maintenance contract renewal.	2021-22
January	Medi-Cal	Professional Fees – Citrix Pro Fees	Professional Fees – HIPPA Compliance (Risk Assessment & Network Penetration)	$10,500	To repurpose funds from Citrix professional fees to HIPPAA Compliance professional fees to provide additional funds.	2021-22
January	Medi-Cal	Maintenance HW/SW – Microsoft True-Up	Maintenance HW/SW – SSL Certs for Production Applications	$12,000	To repurpose funds from Microsoft True-UP to SSL Certs for Production Applications to provide additional funds for maintenance contract renewal.	2021-22
January	Medi-Cal	Purchased Services – Executive Coaching	Purchased Services – Concentra	$18,000	To reallocate funding from Executive Coaching to Concentra for additional funds needed.	2021-22
February	Medi-Cal	Purchased Services – Disaster Recovery Technology Services	Purchased Services – Offsite Backup Tape Storage and Services	$25,000	To repurpose funds from Purchased Services - Disaster Recovery Technology Services to Purchased Services - Offsite Backup Tape Storage and Services to provide additional funds.	2021-22
March	Medi-Cal	Cert/Cont. Education - Leadership Series Quarterly	Training & Seminar	$28,000	To reallocate funding from Cert/Cont. Education Leadership Series to Training & Seminar for the funding of company-wide training from Dale Carnegie	2021-22
April	Medi-Cal	Purchased Services - Executive Coaching	Purchased Services - Concentra	$15,000	To reallocate funding from Executive Coaching to Concentra for additional funds needed.	2021-22
May	Medi-Cal	Infrastructure – Professional Fees	Government Affairs – Professional Fees	$15,000	To reallocate funds from Infrastructure Professional Fees Budget to Government Affairs for funds needed on the state lobbyist.	2021-22
June	Medi-Cal	Community Relations – Public Activities	Community Relations – Food Services	$25,000	To reallocate funds from Public Activities to Food Services to provide additional funds for CalFresh food services.	2021-22
June	Medi-Cal	Human Resources - Certification/Continued Education	Human Resources – Public Activities	$25,000	To repurpose funds from Computer Classes in Cert./Cont. Education to provide funding for purchase of CalOptima Logo items in Public Activities.	2021-22
June	Medi-Cal	Human Resources – Purchased Services	Human Resources – Advertising for Recruitment	$30,500	To reallocate funds from Purchased Services to Advertising to provide additional funds for Job Elephant and others.	2021-22
June	Medi-Cal	Claims Administration – Purchased Services – CogniZant Robotics & IS Infrastructure – Purchased Services – Disaster Recovery	Cultural & Linguistic Services - Purchased Services – Translation & Interpreter Services	$97,000	To reallocate funds from Claims Administration Purchased Services (CogniZant Robotics) and IS Infrastructure Purchased Services (Disaster Recovery) to provide additional funds for Cultural & Linguistics Services translation and interpreter services.	2021-22

This report summarizes budget transfers between general ledger classes that are greater than $10,000 and less than $100,000.
This is the result of Board Resolution No. 12-0301-01 which permits the CEO to make budget allocation changes within certain parameters.

Board of Directors Meeting
August 4, 2022

Monthly Compliance Report

The purpose of this report is to provide compliance updates to CalOptima's Board of Directors including, but not limited to, updates on internal and health network monitoring and audits conducted by CalOptima's Audit & Oversight department, regulatory audits, privacy updates, fraud, waste, and abuse (FWA) updates, and any notices of non-compliance or enforcement action issued by regulators.

A. Updates on Regulatory Audits

1. OneCare and OneCare Connect

- 2022 Medicare Parts C and D Data Validation Audit (*applicable to OneCare and OneCare Connect*):

  On an annual basis, CalOptima is required to engage an independent auditor to validate all Medicare Parts C and D data reported for the prior calendar year. The validation audit includes a webinar validation and source documentation review for various Medicare Parts C and D measures. CalOptima engaged Advent to perform this audit.

  On June 27, 2022, Advent finalized the scores in HPMS. The scores for Part C and Part D reporting measures are 100%.

- 2021 CMS Program Audit/Independent Validation Audit (IVA) *(applicable to OneCare and OneCare Connect)*:

  CMS conducted a program audit on both OneCare and OneCare Connect. CMS released the preliminary draft audit report on 8/6/21 and completed the exit conference. On October 21, 2021, CMS issued the Draft Audit Report, which noted a total of 11 observations, 8 Corrective Action Required (CARs), and one ICAR. (The ICAR was issued on August 27th and the CAP was accepted by CMS on 9/13/21.) As there were no comments/rebuttals to the Draft Audit Report, CMS released the Final Audit Report, with no changes to the findings, on 11/5/21.

  CalOptima engaged Integritas to conduct the IVA. Four issues were noted in the IVA audit related to the Model of Care (MOC), one of which pertained to OneCare, and the other three pertained to OneCare Connect.

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On June 23, Integritas issued the final report to CalOptima, and it was submitted to CMS for review the following day. ***CalOptima is now pending CMS' review and feedback on the IVA report.***

- Triennial Network Adequacy Review *(applicable to OneCare)*:

  On June 13, 2022, CalOptima received formal notification for the OneCare D-SNP Triennial Network Adequacy review. RAC Medicare worked with Network Management to collect and submit the D-SNP Provider & Facility HSD files.

  On June 27, 2022, CMS provided the Automated Criteria Check" (ACC) reports which notified CalOptima that ***both provider and facility networks meet the network adequacy requirements***.

2. Medi-Cal

- 2024 Managed Care Plan (MCP) Operational Readiness Contract:

  CalOptima's CEO has signed and returned to DHCS the Calendar Year (CY) 2024 Operational Readiness agreement to ensure contract readiness with the new Medi-Cal MCP contract requirements, effective January 1, 2024. CalOptima's response to the Operational Readiness agreement confirms our commitment to make all necessary updates to ensure operational and contractual readiness by January 1, 2024. The Operational Readiness agreement is effective August 1, 2022 through December 31, 2023.

  Throughout CY 2022 and CY 2023, MCPs, including CalOptima will be required to submit a series of contract readiness deliverables to DHCS for review and approval. Staff will implement the broad operational changes and contractual requirements outlined in the Operational Readiness agreement to ensure compliance with all requirements by the January 1, 2024 contract effective date.

  The Office of Compliance has partnered with CalOptima's Enterprise Project Management Office to ensure all deliverables are tracked to completion and CalOptima remains compliant.

- 2021 DHCS Medical Audit:

  On October 7, 2021, DHCS formally engaged CalOptima for its annual medical audit. The audit covered CalOptima's provision of Medi-Cal services to its non-Seniors and Persons with Disabilities (non-SPD) and SPD members. The review period extended from February 1, 2020 through December 31, 2021 and assessed CalOptima's compliance with its Medi-Cal contract and regulations in the areas of utilization management, case management and coordination of care, member's rights, quality management, access & availability, and administrative and organizational capacity. DHCS selected Kaiser, Prospect, and FCMG to participate in various capacities.

  DHCS hosted its audit via webinar from January 24, 2022 through February 4, 2022. The Entrance Conference was held on January 24, 2022. On February 4, 2022, the DHCS

concluded its staff interviews and hosted a close-out meeting with the Office of Compliance to discuss preliminary observations. ***In partnership with the business areas, the Office of Compliance has worked to address preliminary observations, as appropriate***.

CalOptima is currently awaiting its draft findings report. Once DHCS finalizes its draft report, a formal Exit Conference will be scheduled to review CalOptima's draft audit findings. CalOptima will have fifteen (15) calendar days to review and confirm or rebut the draft findings. DHCS will provide CalOptima with a final audit report and formal request for corrective action, thirty (30) calendar days from the Exit Conference.

- 2022 Managed Care Entity (MCE) Program Integrity Review:

  On April 13, 2022, the DHCS notified CalOptima that it had been selected to provide feedback to the Centers for Medicare and Medicaid Services (CMS) in respect to CalOptima's internal Program Integrity (PI) efforts that are in place to ensure adequate oversight as well as to deter and address fraud, waste, and abuse (FWA). The review period for the MCE PI review covers the preceding 3 Federal Fiscal Year (FFYs) and focuses on CalOptima's Medi-Cal program. While the focus is largely on FWA, various internal stakeholders were also impacted.

  DHCS requested that CalOptima respond to a series of questions within the CMS Template and submit responses and supporting documentation to DHCS, for subsequent submission to CMS. On May 4, 2022, CalOptima provided its timely response to DHCS. ***Following CalOptima's submission, there may be additional questions or need for clarification, at which time DHCS will contact CalOptima for any follow-up information. At this time, Health Networks are not expected to participate.***

- 2022 Department of Managed Care (DMHC) Routine Examination:

  On February 9, 2022, the DMHC engaged CalOptima for the 2022 DMHC Routine Examination. This examination is routine and occurs every three (3) years. The examination reviewed CalOptima's fiscal and administrative affairs and included an examination of CalOptima's financial reports.

  The formal examination began on May 16, 2022 and was conducted remotely. CalOptima delegates did not participate.

  On June 7, 2022, DMHC hosted a closing conference and provided CalOptima with its Preliminary Report. ***The Preliminary Report included one (1) deficiency relative to a required simple language change regarding DMHC notification in the event of cancellation of the fidelity bond.*** CalOptima did not rebut the finding, and responded to DMHC accordingly on June 30, 2022, ahead of the July 22nd deadline. If DMHC has no additional questions regarding CalOptima's preliminary response, CalOptima should receive the Final report on or before August 5, 2022.

  In regard to the one finding**,** CalOptima has reached agreement with DMHC with respect to the language changes to the fidelity bond and the timing of the changes. Once the changes

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have been made to the fidelity bond language, CalOptima will provide an updated copy to DMHC.

B. Regulatory Notices of Non-Compliance

- On June 9, 2022, CMS issued a Notice of Non-Compliance Letter to CalOptima's OneCare line of business for failure to meet call center timeliness requirements. CMS found the quarterly average disconnect rates exceeded the 5% benchmark. OneCare Part C & D Customer Service had a disconnect rate of 7.14%.

  RAC had received the monitoring results prior to receipt of the NONC and issued a CAP on May 5 to Customer Service to address the disconnect rate.

  Customer Service identified the root cause to be a system software issue within the Avaya phone system (Voice mail Pro) which impacted the drop in the calls in January 2022. ITS reported the issue to Avaya and the fix was put in by applying a special patch update to Voicemail pro in February 2022.

  Customer Service and Information Technology Services conducted testing on 4/22/2022 to confirm that all call center calls routed to OneCare Customer Service during business hours and afterhours worked properly. There has not been a repeat of this issue since the fix was implemented.

  Additionally, Customer Service staff were reminded during a staff meeting held on 5/19/2022 to report any phone issues to management.

C. Updates on Internal and Health Network Monitoring and Audits

- CalOptima's Audit and Oversight (A&O) department completed annual audits on the following delegated health networks to assess their capabilities and performance with delegated activities:

  - Family Choice Medical Group – July 1, 2021 – February 28, 2022
  - Kaiser Foundation Health Plan – July 1, 2021 – March 31, 2022

  Audit tools and elements were derived from accrediting, regulatory and CalOptima contractual standards. For areas that scored below the 100% threshold, A&O issued a corrective action plan (CAP) request and is actively working with each health network to remediate findings.

Non-Clinical Policy Review

Delegated Entity	Access Availability	Claims	Compliance	Cultural & Linguistics	Customer Service	Grievance	Member Experience	Network Management	Provider Network Contracting	Provider Relations	Sub-Contractual
FCMG	100%	100%	100%	100%	100%	N/A	N/A	N/A	100%	100%	NTR
Kaiser	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Non-Clinical File Review

Delegated Entity	Claims, Approved	Claims, Denied	PDR' s	Customer Service	Grievance	Grievance, Exempt	Training, Provider	Training, Staff	Sub-Contractual (Delegated Entity)
FCMG	74%	56%	96%	72%	N/A	N/A	12%	17%	N/A
Kaiser	100%	100%	100%	92%	50%	100%	5%	44%	100%

Clinical Policy Review

Delegated Entity	Case Management	Case Management, Whole Child Model	Appeals	Medi-Cal Addendum	Quality Improvement	Utilization Management
FCMG	99.5%	85%	N/A	100%	N/A	100%
Kaiser	100%	100%	100%	100%	100%	100%

Clinical File Review

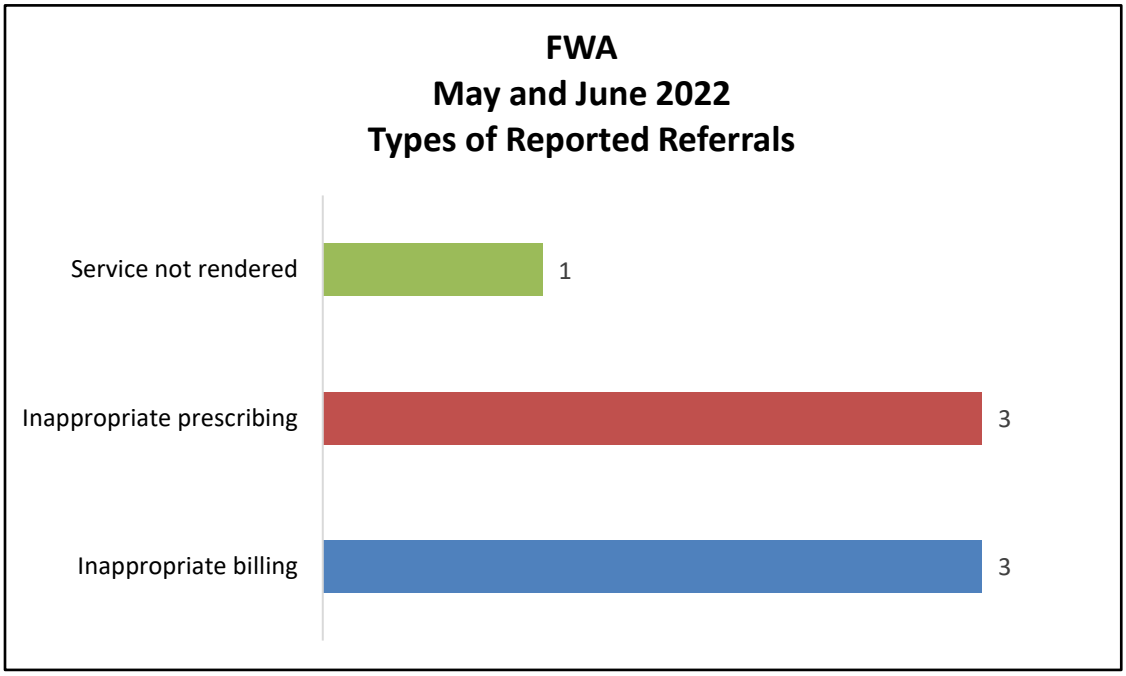
Delegated Entity	Blood Lead Screening	Case Management	Whole Child Model (MC)	Appeals (MC)	Community Support(s)	Expedited (MC)	SARAG (OCC)	NEMT (MC)	NOMNC	ODAG (OC)	PSA (MC)	Standard (MC)	Urgent Concurrent Denials (MC)
FCMG	NTR	82%	80%	N/A	100%	37%	15%	67%	0%	0%	62%	17%	38%
Kaiser	68%	100%	80%	100%	NTR	67%	N/A	NTR	N/A	N/A	NTR	20%	NTR

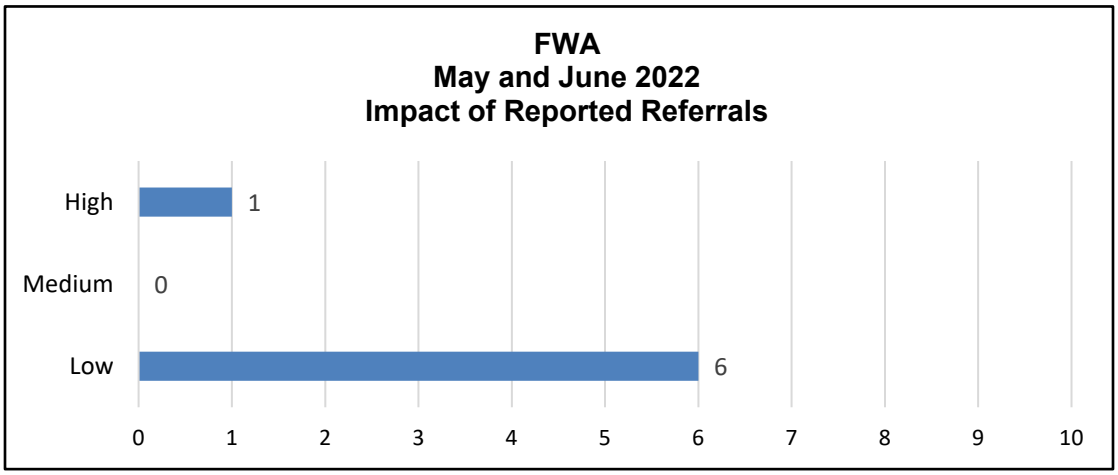
Credentialing and Recredentialing

Delegated Entity	Initial Credentialing File Review	Recredentialing File Review
FCMG	100%	100%
Kaiser	95%	100%

Delegated Entity	Organizational Providers Initial File Review	Organizational Providers Recredentialing File Review
FCMG	N/A	N/A
Kaiser	41%	73%

D. Fraud, Waste & Abuse (FWA) Investigations (May and June 2022)

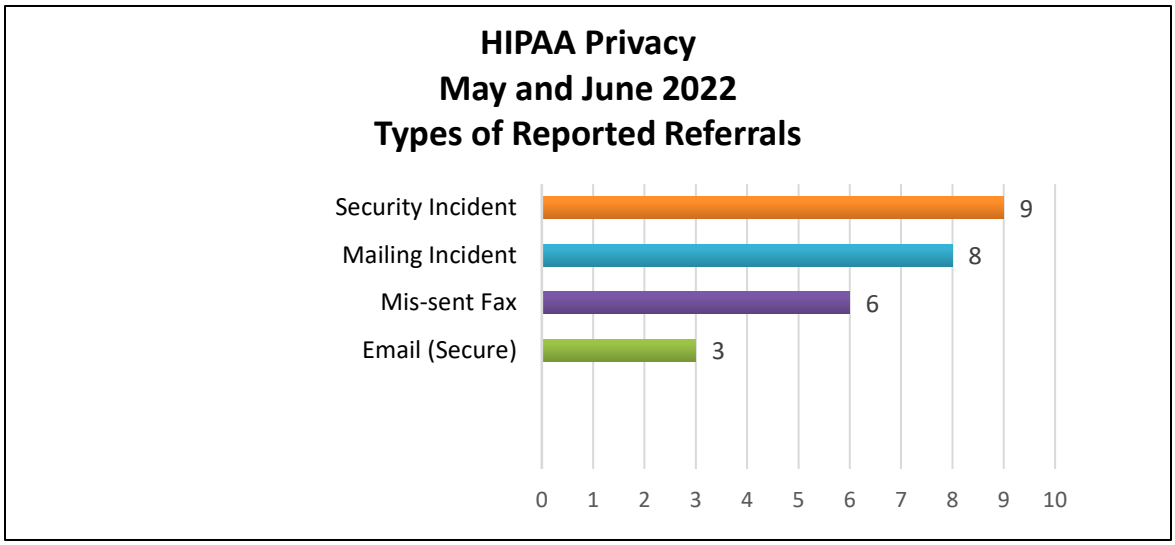


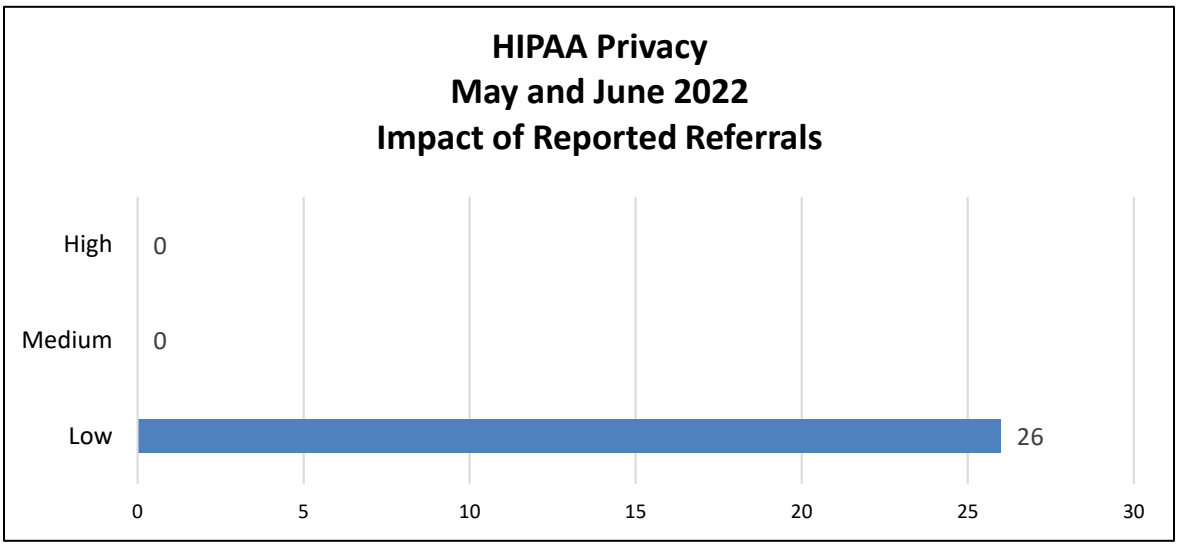


Total Number of New Cases Referred to DHCS (State)	7
Total Number of New Cases Referred to DHCS and CMS*	2
Total Number of Referrals (Subjects) Reported to Regulatory Agencies	**7**

*Effective January 1, 2022, CMS implemented a new portal to report suspicious FWA. Any potential FWA *with impact to Medicare* is reported to both DHCS and CMS at the start of an investigation.

E. Privacy Update: (May and June 2022)





Total Number of Referrals Reported to DHCS (State)	26
Total Number of Referrals / Breaches Reported to DHCS and Office for Civil Rights (OCR)	0

DEPARTMENT OF Managed Health Care

Gavin Newsom, Governor
State of California
Health and Human Services Agency
DEPARTMENT OF MANAGED HEALTH CARE
980 9th Street, Suite 500
Sacramento, CA 95814
Phone: 916-324-8176 | Fax: 916-255-5241
www.HealthHelp.ca.gov

July 15, 2022 **Via eFile**

Mr. Andrew Do
Chair of the Board of Directors
Orange County Health Authority
DBA: CalOptima
505 City Parkway West
Orange, CA 92868

FINAL REPORT OF A ROUTINE EXAMINATION OF ORANGE COUNTY HEALTH AUTHORITY, DBA: CALOPTIMA

Dear Mr. Do:

Enclosed is the final report (Final Report) of a routine examination for the quarter ended December 31, 2021 of the fiscal and administrative affairs of Orange County Health Authority, dba: CalOptima (Plan). The examination was conducted by the Department of Managed Health Care (Department) pursuant to Section 1382 of the Knox-Keene Health Care Service Plan Act of 1975.[1] The Department issued a preliminary report (Preliminary Report) to the Plan on June 7, 2022. The Department accepted the Plan's electronically filed response on June 30, 2022.

The Final Report includes a description of the compliance efforts included in the Plan's June 30, 2022 response, in accordance with Section 1382(c).

Section 1382(d) states, "If requested in writing by the plan, the director shall append the plan's response to the final report issued pursuant to subdivision (c). The plan may modify its response or statement at any time and provide modified copies to the department for public distribution not later than 10 days from the date of notification from the department that the final report will be made available to the public. The addendum to the response or statement shall also be made available to the public."

Please indicate within 10 days from the date of the Plan's receipt of this letter whether the Plan requests the Department to append its response. If so, please indicate which portions of the Plan's response should be appended, and electronically file copies of

[1] References to "Section" are to sections of the Knox-Keene Health Care Service Plan Act of 1975, as codified in California Health and Safety Code Section 1340 et seq.

those portions excluding information held confidential pursuant to Section 1382(c). If the Plan requests the Department to append a brief statement summarizing the Plan's response or wishes to modify any information provided to the Department in its June 30, 2022 response, please provide an addendum no later than 10 days from the date of the Plan's receipt of this letter. Please file this addendum electronically via the corrective action plan (CAP) system within the Department's eFiling web portal at https://wpso.dmhc.ca.gov/secure/login/, as follows:

- From the main menu, select "eFiling."
- From the eFiling menu, select "Online Forms."
- From the Online Forms menu, select "Details" for "CAP # S22-R-394."
- Go to the "Messages" tab, then:
    - Select "Addendum to Final Report" (note this option will only be available for 10 days after the issuance of the Final Report).
    - Select the deficiency(ies) that are applicable.
    - Create a message for the Department.
    - Attach and upload all documents with the name "Addendum to Final Report."
    - Select "Send Message."

The Department finds that the Plan's compliance efforts are responsive to the deficiencies cited and the corrective actions required. Therefore, no further response is required.

Questions or problems related to the electronic transmission of any addendum should be directed to Vijon Morales at 916-255-2447 or by e-mail at Vijon.Morales@dmhc.ca.gov. You may also e-mail inquiries to wpso@dmhc.ca.gov.

The Department will make the Final Report available to the public in 10 days from the Plan's receipt of this letter. The Final Report will be located at the Department's web site at http://www.dmhc.ca.gov/LicensingReporting/ViewFinancialExaminationReports.aspx.

If there are any questions regarding the Final Report, please contact me at 916-255-2425 or by e-mail at Anna.Belmont@dmhc.ca.gov.

Sincerely,

SIGNED BY

Anna Belmont
Corporation Examiner IV, Supervisor
Office of Financial Review
Division of Financial Oversight

cc: Annabel Vaughn, Director, Regulatory Affairs and Compliance (Medi-Cal), Orange County Health Authority
Pritika Dutt, CPA, Deputy Director, Office of Financial Review
Jennifer Clark, Supervising Examiner, Division of Financial Oversight
Eri Fukuda, Examiner, Division of Financial Oversight
Todd Griffin, Examiner, Division of Financial Oversight
Steven Coskie, Attorney III, Office of Plan Licensing
Laura Dooley-Beile, Supervising Health Care Service Plan Analyst, Office of Plan Monitoring
Chad Bartlett, Staff Services Manager II, Help Center

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STATE OF CALIFORNIA
DEPARTMENT OF MANAGED HEALTH CARE

OFFICE OF FINANCIAL REVIEW
DIVISION OF FINANCIAL OVERSIGHT

FINAL REPORT OF A ROUTINE EXAMINATION

OF

ORANGE COUNTY HEALTH AUTHORITY
DBA: CALOPTIMA

FILE NO. 933 0394

DATE OF FINAL REPORT: JULY 15, 2022

SUPERVISING EXAMINER: JENNIFER CLARK

OVERSIGHT EXAMINER: ANNA BELMONT

EXAMINER-IN-CHARGE: ERI FUKUDA

FINANCIAL EXAMINERS:

MICHAEL CEN

NINA MOUA

ERICA SHORT

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BACKGROUND INFORMATION FOR ORANGE COUNTY HEALTH AUTHORITY
DBA: CALOPTIMA

Date Plan Licensed:	June 28, 2000
Organizational Structure:	Orange County Health Authority, dba: CalOptima (Plan), a non-profit public agency, is a county organized health system serving primarily Medi-Cal beneficiaries in Orange County, California. Pursuant to the California Welfare and Institutions Code, the Plan was formed by the Orange County Board of Supervisors as a public/private partnership through the adoption of Ordinance Number 3896 in August 1992. The Plan is governed by an 11-member Board of Directors appointed by the Orange County Board of Supervisors.
Type of Plan:	As a full service health care plan, the Plan contracts exclusively with the California Department of Health Care Services to arrange for the provision of health care services to Medi-Cal members in Orange County. The Plan also acts as a Medicare Advantage Special Needs plan through a contract with the Centers for Medicare and Medicaid Services, providing services to members who are eligible for both Medicare and Medi-Cal benefits. In addition, the Plan offers the Program of All-Inclusive Care for the Elderly (PACE), which provides services to members 55 years of age and older who reside in the PACE service area and meet California nursing facility level of care requirements.
Provider Network:	The Plan subcontracts the delivery of health care services through health maintenance organizations, provider-sponsored organizations (known as Physician/Hospital Consortia) and shared-risk groups. Additionally, the Plan has direct contracts with hospitals and providers for its fee-for-service network.
Plan Enrollment:	The Plan reported 870,489 enrollees at December 31, 2021.
Service Area:	The Plan's service area is Orange County.
Date of Prior Final Routine Examination Report:	January 9, 2020

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FINAL REPORT OF A ROUTINE EXAMINATION OF ORANGE COUNTY HEALTH AUTHORITY, DBA: CALOPTIMA

This is the final report (Final Report) for the quarter ended December 31, 2021 of a routine examination of the fiscal and administrative affairs of Orange County Health Authority, dba: CalOptima (Plan). The examination was conducted by the Department of Managed Health Care (Department) pursuant to Section 1382 of the Knox-Keene Health Care Service Plan Act of 1975.[1] The Department issued a preliminary report (Preliminary Report) to the Plan on June 7, 2022. The Department accepted the Plan's electronically filed response on June 30, 2022.

This Final Report includes a description of the compliance efforts included in the Plan's June 30, 2022 response to the Preliminary Report, in accordance with Section 1382(c). The Plan's response is noted in italics within this Final Report.

The Department examined the Plan's financial report filed with the Department for the quarter ended December 31, 2021, as well as other selected accounting records and controls related to the Plan's various fiscal and administrative transactions.

The Department's findings are presented in this Final Report as follows:

Part I.	Financial Statements
Part II.	Calculation of Tangible Net Equity
Part III.	Compliance Issues

The Department finds the Plan's compliance efforts are responsive to the deficiencies cited and the corrective actions required. Therefore, no further response is required.

[1] References to "Section" are to sections of the Knox-Keene Health Care Service Plan Act of 1975, as codified in California Health and Safety Code Section 1340 et seq. References to "Rule" are to regulations promulgated pursuant to the Knox-Keene Health Care Service Plan Act of 1975 contained within title 28 of the California Code of Regulations.

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PART I. FINANCIAL STATEMENTS

The Department's examination did not result in any adjustments or reclassifications to the Plan's financial statements for the quarter ended December 31, 2021, as filed with the Department. A copy of the Plan's financial statements can be viewed by selecting "Orange County Health Authority" on the second drop-down menu of the Department's financial statement database available at http://wpso.dmhc.ca.gov/fe/search/#top.

No response was required to this Part.

PART II. CALCULATION OF TANGIBLE NET EQUITY (TNE)

Net Worth as reported by the Plan as of quarter ended December 31, 2021	$1,384,093,657
Less: Prepaid Expenses	307,968
TNE	$1,383,785,689
Required TNE	108,177,918
TNE Excess per Examination	$1,275,607,771

The Plan was in compliance with the TNE requirements of Rule 1300.76 as of December 31, 2021.

No response was required to this Part.

PART III. COMPLIANCE ISSUES

A. FIDELITY BOND

Rule 1300.76.3 requires each plan to maintain at all times a fidelity bond covering each officer, director, trustee, partner, and employee of the plan, whether or not they are compensated. In addition, the fidelity bond shall provide for 30 days' notice to the Director of the Department prior to cancellation.

The Department's examination disclosed that the fidelity bond policy provided did not comply with the aforementioned Rule due to the following:

- The policy included a cancellation notice that stated the insurer would "endeavor" to give 30-day advance notice to the Department, if bond is cancelled by the Underwriter. The word "endeavor" is defined as an "earnest attempt." Therefore, the word "endeavor" must be removed from the policy.

- The policy did not provide 30-day advance notice to the Department if a cancellation was initiated by the Plan.

The Plan was required to implement corrective actions to ensure the fidelity bond policy is amended to comply with the requirements of Rule 1300.76.3, provide clean and redlined versions of related policies and procedures when applicable, state the date of implementation, and identify the management position(s) responsible for ensuring ongoing compliance.

The Plan stated that the Department's 2019 routine examination found the previous bond carrier's language acceptable: there was a notice of cancellation endorsement that indicated the carrier would provide 30-days advance notice if the policy were cancelled.

In 2020, when the Plan changed carriers for the crime coverage, because the previous carrier exited the managed care space, the Plan addressed the issues surrounding the requirements of the Department with the broker and with the new carrier. An email was obtained from the Underwriting Officer, that they were precluded from amending the Notice of Cancellation and Loss Payee endorsements' verbiage (i.e.., removing "endeavor") due to the admitted filed status of policy forms in California; however, he agreed that he would send promptly any 30-day notice of cancellation from the carrier to the Department.

After recently learning that other Medi-Cal, Managed Care Plans were having issues with their crime policy wording because of the term "endeavor", the Plan proactively contacted the broker on April 25, 2022, for assistance with the carrier's "endeavor" language. The Plan was advised that the carrier had addressed the issue as best as they legally could by issuing two endorsements to the Plan and confirming via email that the carrier would notify the Department within 30 calendar days of cancellation of the policy.

The Plan's business insurance policies were renewed effective April 7, 2022. The Plan suggested to the Department, and the Department agreed, that new coverage that meets the Department language requirements be procured as part of the annual renewal process, with coverage to be effective April 7, 2023. This would avoid an estimated 10 percent cancellation penalty with the current carrier and allow the Plan's broker an opportunity to market the coverage with adequate time to gather viable competitive quotes and review the terms and conditions, including the cancelation policy language. The loss payee endorsement would also be removed.

Upon receipt of the new policy, which normally takes about two to three months, the Plan will provide the Department with a copy, highlighting the notice of cancellation endorsement, no later than July 15, 2023.

The Plan's Chief Financial Officer and Director III will be responsible for ensuring ongoing compliance.

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The Department finds that the Plan's compliance efforts are responsive to the deficiencies cited and the corrective actions required. The Department accepts the Plan's commitment to become compliant with the requirements of Rule 1300.76.3 during the next contract renewal. Therefore, no further response is required.

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POTOMAC PARTNERS DC

STRATEGIC HEALTH CARE

M E M O R A N D U M

July 8, 2022

To: CalOptima

From: Potomac Partners DC & Strategic Health Care

Re: July Board of Directors Report

FISCAL YEAR 2023 APPROPRIATIONS

The House Appropriations Committee completed consideration of its Fiscal Year 2023 (FY23) appropriations bills before the July 4th recess, advancing the final six spending bills (Energy & Water, Commerce-Justice-Science, State-Foreign Ops, Interior-Environment, Transportation-HUD, and Labor-HHS-Education) to the House floor in mostly party-line votes. The bills reflect the $1.6 trillion topline discretionary funding level proposed by House Democrats. As previously reported, House Leadership plans to bring the bills to the floor in July in hopes of passing all 12 spending bills (linked below) before the August recess period. The Senate is expected to begin marking up its bills in July.

House Appropriations Subcommittee	Bill Text	Report	Summary
Agriculture, Rural Development, Food and Drug Administration	Here	Here	Here
Commerce-Justice-Science	Here	Here	Here
Defense	Here	Here	Here
Energy and Water Development	Here	Here	Here
Financial Services and General Government	Here	Here	Here
Homeland Security	Here	Here	Here
Interior-Environment	Here	Here	Here
Labor, Health and Human Services, Education	Here	Here	Here
Legislative Branch	Here	Here	Here
Military Construction, Veterans Affairs	Here	Here	Here

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State, Foreign Operations	Here	Here	Here
Transportation, and Housing and Urban Development	Here	Here	Here

Behavioral Health Package

Congress is preparing to consider comprehensive behavioral/mental health legislation later this year, despite many moving parts. The Senate Finance Committee is expected to mark up a package after the 4th of July recess, and the Senate Health, Education, Labor and Pensions (HELP) Committee is also expected to hold a markup in July. House Ways and Means Committee Majority staff have been discussing ways to consolidate their legislation and has started to meet with outside groups on key priorities, but it is unclear on when they may hold a markup. The House Energy and Commerce Committee marked up and passed a bipartisan package on May 18th. Click here for the White House fact sheet.

Budget Reconciliation

This month, Senate Democrats began earnestly discussing a second budget reconciliation process that would primarily focus on drug pricing reforms. In response, Senate Minority Leader Mitch McConnell (R-KY) stated that the CHIPS+ Act regarding semiconductor investments will not pass the Senate where it needs Republican support if Senate Democrats pursue a second budget reconciliation bill, a process that only needs a simple majority vote of 51. Senate Majority Leader Chuck Schumer (D-NY) has been in talks with Senator Joe Manchin (D-WV) on a package that could garner votes from all 50 Democratic Senators, but thus far a final bill has not been released.

Medicare Trust Fund Solvency

It is now six years until the Medicare Trust Fund runs out of money according to the latest annual report by the Medicare Board of Trustees. That is a couple more years than the last time the Trustees reported on the Fund. The HI Fund, known as Medicare Part A, is projected to be higher than last year's estimates because both the number of covered workers and average wages are projected to be higher, and HI expenditures are projected to be lower, than last year's estimates. For the full report, click here.

Medicare Advantage

The House Energy and Commerce Subcommittee on Oversight and Investigations held a hearing to examine testimony that the government needs to take additional steps to better police and rein in abuses by private Medicare Advantage (MA) plans. The U.S. Department of Health and Human Services (HHS) Office of Inspector General, the General Accountability Office, and the Medicare Payment Advisory Commission all testified that more Congressional oversight is needed to ensure

that MA plans are providing quality care for program beneficiaries while being responsible stewards of taxpayer dollars. Click here to read written testimony and watch the hearing.

TELEHEALTH AND PROVIDER FUNDING PROVISIONS INCLUDED IN THE NEW GUN LAW

The Safer Communities Act, a gun bill enacted in the wake of the Uvalde shooting, also included new funding for telehealth. A section of the law would also require HHS to provide assistance to states to improve telehealth access for Medicaid and CHIP enrollees. The guidance would address adopting telehealth flexibilities to expand access to care, billing codes and practices, integration into value-based care models, and strategies to deliver culturally competent care via telehealth as well as other best practices. Click here for a 10-page committee summary of the legislation — health care provisions are at the beginning. The full bill can be found here.

EDELSTEIN GILBERT ROBSON & SMITH LLC

Donald B. Gilbert Michael R. Robson Trent E. Smith Jason D. Ikerd Associate Bridget E. McGowan Associate

July 21, 2022

LEGISLATIVE UPDATE
Edelstein Gilbert Robson & Smith LLC

The Legislature adjourned for their summer recess on June 30 and will return to Sacramento on August 1 to complete their final month of work. Before leaving town, the Legislature passed a record $300 billion State Budget.

The newly adopted State Budget provides $12 billion multi-year investments for local governments to build affordable housing and provide other critical services to address homelessness. Many of the details of how and where this funding is allocated will be developed further in August and next year.

An outline of the Governor's CARE Court proposal was also included in the final budget agreement. This proposal establishes a special court process to determine if a homeless individual would benefit from certain mental health services. Some of these services could be delivered without the consent of the individual if the court determines the care is in the best interests of the individual. The final details of CARE Court will be adopted in pending legislation.

In response to the recent US Supreme Court decision overturning Roe vs. Wade, the Budget also prioritized spending for many new reproductive health programs.

Funding to provide Medi-Cal services for all individuals, regardless of immigration status, was another spending priority included in the state's final spending plan. $3.1 billion was also included to continue implementation of CalAIM, the state's program to identify and manage comprehensive needs through whole person care approaches and social drivers of health.

AB 2724 (Arambula) was also adopted by the Legislature and signed into law by the Governor as part of the overall budget package. This measure includes the no-bid Kaiser contract to provide Medi-Cal services in counties throughout California, including Orange County. CalOptima and most other public health plans vigorously opposed AB 2724. We heard rumors that during the budget negotiations between the Governor and Legislative leadership, the Governor insisted that three items be included in the final budget deal. He wanted his version of inflation relief payments, which includes direct payments to Californians earning below a certain income. The Governor also insisted that the Legislature adopt his CARE Court proposal. Finally, he wanted AB 2724 passed without any further amendments or limitations on the Department of Healthcare Services' (DHCS) ability to implement the Kaiser contract as they wish. While we cannot verify that the Governor made AB 2724 one of his top three budget priorities, it appears this was the case based on the pushback that we and the Legislature received from DHCS at every step of the process. Amendments that the public health plans and

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www.egrslobby.com

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the Legislature proposed were rejected, and the final bill leaves many details unresolved. Ultimately, AB 2724 provides DHCS and Kaiser a blank check to proceed as they wish. While this was a disappointing outcome, we remain hopeful that between now and 2024, when Kaiser can begin directly contracting, more details will emerge, and CalOptima can provide further input leading to a productive outcome for Orange County's Medi-Cal enrollees.

Also, in the final weeks of June, we learned that Assemblywoman Sharon Quirk-Silva had submitted a letter to the Joint Legislative Audit Committee (JLAC) requesting an audit of CalOptima. This request includes a review of CalOptima's overall finances, including sources of revenue and expenditures, with a particular emphasis on what CalOptima is spending to address homelessness. The audit request also includes a review of Intergovernmental Transfers, as well as hiring practices/salaries. The committee approved the audit request in late June, and the State Auditor will start the audit sometime this summer. Prior to JLAC adopting the audit, CalOptima provided the Assemblywoman and JLAC members with responses and data addressing the specific items outlined in the request. CalOptima will provide the same information, and any other requested information, to the State Auditor. Once the audit is completed, the State Auditor will prepare a report, which will be published on their website.

Around the same time the audit request was made, Assemblywoman Quirk-Silva amended a bill dealing with county retirement systems to instead focus on CalOptima's governance. AB 498 locks into state statute CalOptima's current board governance established by SB 4 in 2017. This statute is due to expire at the end of the year unless new legislation is adopted. AB 498 also prohibits a person serving on the CalOptima board from taking a job with CalOptima for at least one year after leaving the board. The bill also adopts other standard conflict of interest provisions, such as prohibiting board members for one year after leaving the board from taking a job whereby they influence or lobby CalOptima. Most public entities are already subject to these "revolving door" restrictions. The measure also establishes goals for mental health services. One provision of the bill is concerning. In its current form, AB 498 restricts the Board of Supervisors members serving on CalOptima's board, as well as the person serving in the attorney/finance seat, from obtaining a job for one year after leaving the board from any entity that receives money from CalOptima in the previous five years. We are unaware of any other public entity where this restriction applies. Furthermore, we are unaware of any specific incident that demonstrates this restriction is necessary. As such, we are asking the author and sponsor to remove this post-employment restriction. If this change is made, CalOptima would have no further concerns with the bill.

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2021–22 Legislative Tracking Matrix

COVID-19 (CORONAVIRUS)

Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 4735 Axne (IA) **S. 2493 Bennet (CO)**	**Provider Relief Fund Deadline Extension Act:** Would delay the deadline by which providers must spend any funds received from the Provider Relief Fund (PRF) — created in response to the COVID-19 pandemic — until the end of 2021 or the end of the COVID-19 public health emergency (PHE), whichever occurs later. Funds that are unspent by any deadline must be repaid to the U.S. Department of Health and Human Services (HHS). ***Potential CalOptima Impact:*** *Increased financial stability for CalOptima's contracted providers.*	**07/28/2021** Introduced; referred to committees	CalOptima: Watch
H.R. 5963 Spanberger (VA) **S. 3611 Shaheen (NH)**	**Provider Relief Fund Improvement Act:** Would delay the deadline by which providers must spend any funds received from the PRF until the end of the COVID-19 PHE. Would also direct HHS to distribute any funds remaining in the PRF by March 31, 2022. Finally, would allow workplace safety improvements as an allowable use of PRF dollars. ***Potential CalOptima Impact:*** *Increased financial stability for CalOptima's contracted providers.*	**11/12/2021** Introduced; referred to committees	CalOptima: Watch

BEHAVIORAL HEALTH

Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 1368 Porter (CA) **S. 515 Warren (MA)**	**Mental Health Justice Act:** Would require HHS to award grants to states and local governments to hire, train and dispatch mental health professionals instead of law enforcement personnel to respond to behavioral health crises. ***Potential CalOptima Impact:*** *Increased access to behavioral health services for CalOptima members; decreased rates of arrest and incarceration.*	**02/25/2021** Introduced; referred to committees	CalOptima: Watch County of Orange: Support
H.R. 1914 DeFazio (OR) **S. 764 Wyden (OR)**	**Crisis Assistance Helping Out On The Streets (CAHOOTS) Act:** Would increase the Federal Medical Assistance Percentage (FMAP) for states to cover 24/7 community-based mobile crisis intervention services for those experiencing a mental health or substance use disorder (SUD) crisis from 85% to 95% for three years. Would also require HHS to issue an additional $25 million in planning and evaluation grants to states. ***Potential CalOptima Impact:*** *Increased behavioral health and SUD services to CalOptima Medi-Cal members.*	**03/16/2021** Introduced; referred to committees	**08/05/2021** CalOptima: Support

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 552 **Quirk-Silva**	**Integrated School-Based Behavioral Health Partnership Program:** Would establish the Integrated School-Based Behavioral Health Partnership Program to expand prevention and early intervention behavioral health services for students. This would allow a county mental health agency and local education agency to develop a formal partnership whereby county mental health professionals would deliver brief school-based services to any student who has, or is at risk of developing, a behavioral health condition or SUD. ***Potential CalOptima Impact:*** *Increased coordination with the Orange County Health Care Agency and school districts to ensure non-duplication of other school-based behavioral health services and initiatives.*	**06/15/2022** Passed Senate Health Committee; referred to Senate Appropriations Committee **06/01/2022** Passed Senate Education Committee **01/31/2022** Passed Assembly floor	CalOptima: Watch
SB 1019 **Gonzalez**	**Mental Health Benefit Outreach and Education:** Would require a Medi-Cal managed care plan (MCP) to conduct annual outreach and education to beneficiaries and primary care physicians regarding covered mental health benefits while incorporating best practices in stigma reduction. The California Department of Health Care Services (DHCS) must review an MCP's outreach and engagement plan for approval. Every three years, DHCS would conduct an assessment of Medi-Cal beneficiaries' experience with mental health services, which an MCP must supplement through regional surveys or listening sessions. ***Potential CalOptima Impact:*** *Additional member and provider outreach activities by CalOptima staff.*	**06/21/2022** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **05/26/2022** Passed Senate floor	CalOptima: Watch
SB 1338 **Umberg**	**Community Assistance, Recovery, and Empowerment (CARE) Court Program:** Would establish the CARE Court Program to facilitate delivery of mental health and SUD services to individuals with schizophrenia spectrum or other psychotic disorders who are unable to survive safely in the community. The program would connect a person in crisis with a court-ordered care plan for up to 12 months, with the option to extend an additional 12 months as a diversion from homelessness, incarceration or conservatorship. Care plans could include court-ordered stabilization medications, wellness and recovery supports, and connection to social services and housing resources. Eligible individuals may be referred by family members, counties, behavioral health providers or first responders among others. ***Potential CalOptima Impact:*** *Increased behavioral health and SUD services for eligible CalOptima members.*	**06/28/2022** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **06/21/2022** Passed Assembly Judiciary Committee **05/25/2022** Passed Senate floor	CalOptima: Watch CAHP: Concern

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BUDGET

Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 2471 **DeLauro (CT)**	**Consolidated Appropriations Act, 2022:** Appropriates $1.5 trillion to fund the federal government through September 30, 2022, including earmarks for the following projects in Orange County: ■ Children's Hospital of Orange County: $325,000 to expand capacity for mental health treatment services and programs in response to the COVID-19 pandemic ■ City of Huntington Beach: $500,000 to establish a mobile crisis response program ■ County of Orange: $2 million to develop a second Be Well Orange County campus in the City of Irvine ■ County of Orange: $5 million to develop a Coordinated Reentry Center to help justice-involved individuals with mental health conditions or SUDs reintegrate into the community ■ North Orange County Public Safety Task Force: $5 million to expand homeless outreach and housing placement services In addition, extends all current telehealth flexibilities in the Medicare program until approximately five months following the termination of the COVID-19 PHE. ***Potential CalOptima Impact:*** *Increased coordination with the County of Orange and other community partners to support implementation of projects that benefit CalOptima members; continuation of all current telehealth flexibilities for CalOptima OneCare, OneCare Connect and Program of All-Inclusive Care for the Elderly (PACE).*	**03/15/2022** Signed into law	CalOptima: Watch
AB 178 **Ting** **SB 154** **Skinner**	**Budget Act of 2022:** Makes appropriations for the government of the State of California for Fiscal Year (FY) 2022–23. Total spending is just over $300 billion, of which $234.4 billion is from the General Fund. ***Potential CalOptima Impact:*** *Impacts are discussed in the enclosed Analysis of the Enacted Budget.*	**06/30/2022** Signed into law	CalOptima: Watch
AB 186 **Committee on Budget**	**Skilled Nursing Facility (SNF) Financing Reform Trailer Bill:** Enacts budget trailer bill language containing the policy changes needed to implement FY 2022–23 budget expenditures regarding SNF financing. ***Potential CalOptima Impact:*** *Impacts are discussed in the enclosed Analysis of the Enacted Budget.*	**06/30/2022** Signed into law	CalOptima: Watch
SB 184 **Committee on Budget and Fiscal Review**	**Health Trailer Bill:** Consolidates and enacts certain budget trailer bill language containing the policy changes needed to implement health-related expenditures in the FY 2022–23 state budget. ***Potential CalOptima Impact:*** *Impacts are discussed in the enclosed Analysis of the Enacted Budget.*	**06/30/2022** Signed into law	CalOptima: Watch

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COVERED BENEFITS

Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 56 **Biggs (AZ)**	**Patient Access to Medical Foods Act:** Would expand the federal definition of medical foods to include food prescribed as a therapeutic option when traditional therapies have been exhausted or may cause adverse outcomes. Effective January 1, 2022, medical foods, as defined, would be covered by private health insurance providers and federal public health programs, including Medicare, TRICARE, Children's Health Insurance Program (CHIP) and Medicaid, as a mandatory benefit. ***Potential CalOptima Impact:*** *New covered benefit for CalOptima's lines of business.*	**01/04/2021** Introduced; referred to committees	CalOptima: Watch
H.R. 1118 **Dingell (MI)**	**Medicare Hearing Aid Coverage Act of 2021:** Effective January 1, 2022, would require Medicare Part B coverage of hearing aids and related examinations. ***Potential CalOptima Impact:*** *New covered benefit for CalOptima OneCare, OneCare Connect and PACE.*	**02/18/2021** Introduced; referred to committees	CalOptima: Watch
H.R. 4187 **Schrier (WA)**	**Medicare Vision Act of 2021:** Effective January 1, 2024, would require Medicare Part B coverage of vision services, including eyeglasses, contact lenses, routine eye examinations and fittings. ***Potential CalOptima Impact:*** *New covered benefits for CalOptima OneCare and PACE.*	**06/25/2021** Introduced; referred to committees	CalOptima: Watch
H.R. 4311 **Doggett (TX)** **S. 2618** **Casey (PA)**	**Medicare Dental, Vision, and Hearing Benefit Act of 2021:** Effective no sooner than January 1, 2022, would require Medicare Part B coverage of the following benefits: ■ Dental: Routine dental cleanings and examinations, basic and major dental services, emergency dental care, and dentures ■ Vision: Routine eye examinations, eyeglasses, contact lenses and low vision devices ■ Hearing: Routine hearing examinations, hearing aids and related examinations The Senate version would also increase the Medicaid FMAP for hearing, vision and dental services to 90%. ***Potential CalOptima Impact:*** *New covered benefits for CalOptima OneCare, OneCare Connect and PACE; higher federal funding rate for current Medi-Cal benefits.*	**07/01/2021** Introduced; referred to committees	CalOptima: Watch
H.R. 4650 **Kelly (IL)**	**Medicare Dental Coverage Act of 2021:** Effective January 1, 2025, would require Medicare Part B coverage of dental and oral health services, including routine dental cleanings and examinations, basic and major dental treatments, and dentures. ***Potential CalOptima Impact:*** *New covered benefits for CalOptima OneCare and PACE.*	**07/22/2021** Introduced; referred to committees	CalOptima: Watch

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Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 1929 **Gabriel**	**Violence Preventive Services:** Would add violence prevention services as a covered Medi-Cal benefit to reduce the rate of violent injury and trauma as well as promote recovery, stabilization and improved health outcomes ***Potential CalOptima Impact:*** *New covered benefit for CalOptima Medi-Cal members; additional credentialing and contracting for a new provider type.*	**06/16/2022** Passed Senate Appropriations Committee; referred to Senate floor **06/08/2022** Passed Senate Health Committee **05/25/2022** Passed Assembly floor	CalOptima: Watch
AB 1930 **Arambula**	**Perinatal Services:** Would require Medi-Cal coverage of additional perinatal assessments and services as developed by the California Department of Public Health and additional stakeholders for beneficiaries up to one year postpartum. A nonlicensed perinatal worker could deliver such services if supervised by an enrolled Medi-Cal provider or a non-enrolled community-based organization (CBO) if a Medi-Cal provider is available for billing. ***Potential CalOptima Impact:*** *New covered benefit for CalOptima Medi-Cal members up to one-year postpartum.*	**06/15/2022** Passed Senate Health Committee; referred to Senate Appropriations Committee **05/26/2022** Passed Assembly floor	CalOptima: Watch
AB 2697 **Aguiar-Curry**	**Community Health Workers (CHWs) and Promotores:** Would add preventive services provided by CHWs and promotores as a Medi-Cal covered benefit. Services include health education, navigation and advocacy for the purpose of preventing disease, prolonging life and promoting physical and behavioral health. CHWs would qualify to provide services upon completion of a certification program or after three years of analogous work experience. Medi-Cal MCPs would conduct annual benefit education to beneficiaries and providers as well as complete an annual assessment of CHW and promotores capacity and need. ***Potential CalOptima Impact:*** *New covered benefit for CalOptima Medi-Cal members; additional member and provider outreach activities; additional network adequacy analyses.*	**06/29/2022** Passed Senate Health Committee; referred to Senate Appropriations Committee **05/25/2022** Passed Assembly floor	CalOptima: Watch
SB 245 **Gonzalez**	**Abortion Services:** Would prohibit a health plan from imposing Medi-Cal cost-sharing on all abortion services, including any pre-abortion or follow-up care, no sooner than January 1, 2023. In addition, a health plan and its delegated entities may not require a prior authorization or impose an annual or lifetime limit on such coverage. ***Potential CalOptima Impact:*** *Modified Utilization Management (UM) procedures for a covered Medi-Cal benefit.*	**03/22/2022** Signed into law	CalOptima: Watch CAHP: Oppose

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Bill Number Author	Bill Summary	Bill Status	Position/Notes
SB 912 **Limón**	**Biomarker Testing:** No later than July 1, 2023, would add biomarker testing, including whole genome sequencing, as a Medi-Cal covered benefit to diagnose, treat or monitor a disease. ***Potential CalOptima Impact:*** *New covered benefit for CalOptima Medi-Cal members.*	**06/21/2022** Passed Assembly Health Committee; referred to Assembly Appropriation Committee **05/25/2022** Passed Senate floor	CalOptima: Watch CAHP: Oppose Unless Amended

MEDI-CAL ELIGIBILITY AND ENROLLMENT

Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 1738 **Dingell (MI)** **S. 646** **Brown (OH)**	**Stabilize Medicaid and CHIP Coverage Act of 2021:** Would provide 12 months of continuous eligibility and coverage for any Medicaid or CHIP beneficiary. ***Potential CalOptima Impact:*** *Increased number of CalOptima Medi-Cal members.*	**03/10/2021** Introduced; referred to committees	CalOptima: Watch ACAP: Support
H.R. 5610 **Bera (CA)** **S. 3001** **Van Hollen (MD)**	**Easy Enrollment in Health Care Act:** To streamline and increase enrollment into public health insurance programs, would allow taxpayers to request their federal income tax returns include a determination of eligibility for Medicaid, CHIP or advance premium tax credits to purchase insurance through a health plan exchange. Taxpayers could also consent to be automatically enrolled into any such program or plan if they would be subject to a zero net premium. ***Potential CalOptima Impact:*** *Increased number of CalOptima Medi-Cal members.*	**10/19/2021** Introduced; referred to committees	CalOptima: Watch ACAP: Support
H.R. 6636 **Trone (MD)** **S. 2697** **Cassidy (LA)**	**Due Process Continuity of Care Act:** Would allow states to extend Medicaid coverage to inmates who are awaiting trial and have not been convicted of a crime. ***Potential CalOptima Impact:*** *If DHCS exercises option and requires enrollment into managed care, increased number of CalOptima Medi-Cal members.*	**08/10/2021** Introduced; referred to committees	CalOptima: Watch
AB 2402 **Rubio, B.**	**Medi-Cal Continuous Eligibility for Children:** Would allow Medi-Cal beneficiaries under five years of age to remain continuously eligible for Medi-Cal regardless of income changes. ***Potential CalOptima Impact:*** *Increased number of CalOptima Medi-Cal members.*	**06/22/2022** Passed Senate Health Committee; referred to Senate Appropriations Committee **05/25/2022** Passed Assembly floor	CalOptima: Watch LHPC: Support
AB 2680 **Arambula**	**Community Health Navigator Program:** Would require DHCS to create the Community Health Navigator Program to issue direct grants to qualified CBOs to conduct targeted outreach, enrollment and access activities for Medi-Cal-eligible individuals and families. ***Potential CalOptima Impact:*** *Increased number of CalOptima Medi-Cal members.*	**06/30/2022** Passed Senate Health Committee; referred to Senate Appropriations Committee **05/25/2022** Passed Assembly floor	CalOptima: Watch

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MEDI-CAL OPERATIONS AND ADMINISTRATION

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 498 **Quirk-Silva**	**CalOptima Board of Directors:** Would remove the December 31, 2022, sunset date for the current structure of the CalOptima Board of Directors (Board). Would also prohibit an Orange County Supervisor who serves on the Board from being appointed to any other seat on the Board within one year of their Board service. In addition, would prohibit Board members, except for those representing the community clinic, health network and physician seats, from the following activities for one year following their Board service: ■ Lobbying CalOptima ■ Employment at CalOptima ■ Employment at any entity which has received funds from CalOptima within the previous five years ***Potential CalOptima Impact:*** *Permanent continuation of the current Board structure; new employment restrictions for one year following service on the Board.*	**06/29/2022** Passed Senate Finance and Governance Committee; referred to Senate Appropriations Committee **06/22/2022** Passed Senate Health Committee	CalOptima: Watch
AB 1355 **Levine**	**Medi-Cal Independent Medical Review (IMR) System:** Would require DHCS to establish an IMR system, effective January 1, 2023, for Medi-Cal services provided through the following: ■ County Drug Medi-Cal Organized Delivery Systems ■ County Mental Health Plans ■ Medi-Cal fee-for-service (FFS) ■ Medi-Cal MCPs without a Knox-Keene license from the California Department of Managed Health Care (DMHC) ■ PACE The proposed DHCS IMR would closely mirror the current DMHC IMR process for Knox-Keene licensed health plans. As a result, the bill would provide every Medi-Cal beneficiary with access to an IMR. ***Potential CalOptima Impact:*** *Implementation of an additional Grievance and Appeals process for CalOptima Medi-Cal and PACE.*	**06/14/2022** Passed Senate Judiciary Committee; referred to Senate Appropriations Committee **06/01/2022** Passed Senate Health Committee **01/27/2022** Passed Assembly floor	CalOptima: Watch
AB 1400 **Kalra, Lee, Santiago**	**California Guaranteed Health Care for All:** Would create the California Guaranteed Health Care for All program (CalCare) to provide a comprehensive universal single-payer health care benefit for all California residents. Would require CalCare cover a wide range of medical benefits and other services and would incorporate the health care benefits and standards of CHIP, Medi-Cal, Medicare, the Knox-Keene Act, and ancillary health care or social services covered by regional centers for people with developmental disabilities. ***Potential CalOptima Impact:*** *Unknown but potentially significant impacts to the Medi-Cal delivery system and MCPs, including changes to administration, covered benefits, eligibility, enrollment, financing and organization.*	**01/31/2022** Died on Assembly floor	CalOptima: Watch CAHP: Oppose

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Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 1937 **Patterson**	**Out-of-Pocket Pregnancy Costs:** No later than July 1, 2023, would require DHCS to reimburse pregnant Medi-Cal beneficiaries up to $1,250 for out-of-pocket pregnancy costs, including birth and infant care classes, midwife and doula services, lactation support, prenatal vitamins, lab tests or screenings, prenatal acupuncture or acupressure, and medical transportation. ***Potential CalOptima Impact:*** *Increased financial stability for CalOptima Medi-Cal members who are currently or were recently pregnant.*	**04/29/2022** Died in Assembly Health Committee	CalOptima: Watch
AB 1944 **Lee**	**Brown Act Flexibilities:** Would extend certain Brown Act flexibilities, temporarily enacted in response to the COVID-19 PHE, until January 1, 2030, regardless of the existence of a PHE. Specifically, teleconferencing locations for any members of a legislative body would not need to be identified or publicly accessible. If exercising these flexibilities, a legislative body must comply with the following requirements: ■ A quorum of members must participate in person at a single location identified on the agenda and publicly accessible. ■ The agenda must identify which members are teleconferencing. ■ Members of the public must have access to a video stream of the primary meeting location. ■ Members of the public must be able to provide public comment via in-person, audio-visual or call-in options. ***Potential CalOptima Impact:*** *Continued ability for members of the Board and advisory committees to participate in meetings by teleconference; modified posting and noticing requirements for the Clerk of the Board.*	**07/01/2022** Died in Senate Governance and Finance Committee **05/26/2022** Passed Assembly floor	CalOptima: Watch
AB 1995 **Arambula**	**Medi-Cal Premium and Copayment Elimination:** Would eliminate Medi-Cal premiums for low-income children whose family income exceeds 160% federal poverty level (FPL), working disabled persons with incomes less than 250% FPL and pregnant women and infants enrolled in the Medi-Cal Access Program. Would also eliminate copayments for all Medi-Cal beneficiaries. ***Potential CalOptima Impact:*** *Increased financial stability for CalOptima Medi-Cal members.*	**06/15/2022** Passed Senate Health Committee; referred to Senate Appropriations Committee **05/26/2022** Passed Assembly floor	CalOptima: Watch LHPC: Support
AB 2077 **Calderon**	**Medi-Cal Personal Needs Allowance:** Would increase the monthly income that a Medi-Cal beneficiary residing in a long-term care (LTC) facility or receiving PACE services is allowed to retain from $35 to $80. Beneficiaries must contribute remaining income as a share of cost to the facility before Medi-Cal pays remaining expenses. ***Potential CalOptima Impact:*** *Increased financial stability for CalOptima PACE participants and CalOptima Medi-Cal members residing in LTC facilities with a share of cost.*	**06/08/2022** Passed Senate Health Committee; referred to Senate Appropriations Committee **05/25/2022** Passed Assembly floor	CalOptima: Watch CalPACE: Support LHPC: Support

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Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 2449 **Rubio, B.**	**Brown Act Flexibilities:** Would extend certain Brown Act flexibilities, temporarily enacted in response to the COVID-19 PHE, until January 1, 2026, regardless of the existence of a PHE. Specifically, teleconferencing locations for any members of a legislative body would not need to be identified or publicly accessible. If exercising these flexibilities, a legislative body must comply with the following requirements: ■ A quorum of members must participate in person at a single location identified on the agenda and publicly accessible. ■ Teleconferencing members must participate through audio and visual technology. ■ Members of the public must be able to provide public comment via in-person, two-way audiovisual platform or two-way telephonic service with a live meeting webcast. ■ Members may only teleconference due to a medical emergency for themselves or family, or, at no more than two meetings per calendar year, another "just cause" for remote participation, such as a caregiving need, contagious illness, disability or travel while on official business. ***Potential CalOptima Impact:*** *Continued ability for members of the Board and advisory committees to participate in meetings by teleconference; modified posting and noticing requirements for the Clerk of the Board.*	**06/28/2022** Passed Senate Judiciary Committee; referred to Senate Appropriations Committee **06/22/2022** Passed Senate Governance and Finance Committee **05/26/2022** Passed Assembly floor	CalOptima: Watch
AB 2724 **Arambula**	**Alternate Health Care Service Plan:** No sooner than January 1, 2024, would authorize DHCS to contract directly with an Alternate Health Care Service Plan (AHCSP) as a Medi-Cal MCP in any region. An AHCSP is a nonprofit health plan with at least four million enrollees statewide that owns or operates pharmacies and provides medical services through an exclusive contract with a single medical group in each region. Enrollment into an AHCSP would be limited to the following Medi-Cal beneficiaries: ■ Previous AHCSP enrollees and their immediate family members ■ Dually eligible for Medi-Cal and Medicare benefits ■ Foster youth ■ A share of default enrollments when a Medi-Cal MCP is not selected ***Potential CalOptima Impact:*** *Additional Medi-Cal MCP in Orange County; decreased number of CalOptima Medi-Cal members; increased percentage of CalOptima members who are high-risk.*	**06/30/2022** Signed into law	**04/07/2022** CalOptima: Oppose Unless Amended LHPC: Oppose

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Bill Number Author	Bill Summary	Bill Status	Position/Notes
SB 250 **Pan**	**Prior Authorization "Deemed Approved" Status:** Beginning January 1, 2024, would require a health plan to review a provider's prior authorization requests to determine eligibility for "deemed approved" status, which would exempt the provider from prior authorization requirements for any plan benefit for two years. A provider would qualify if the health plan approved at least 80% of their prior authorization requests within the past year. ***Potential CalOptima Impact:*** *Implementation of new UM procedures to assess provider appeals rates and exempt certain providers from UM requirements.*	**06/28/2022** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **06/01/2021** Passed Senate floor	CalOptima: Watch CAHP: Oppose
SB 858 **Wiener**	**Health Plan Civil Penalties:** Would increase the civil penalty amount that DMHC could levy on a health plan from no more than $2,500 per violation to no more than $25,000 per violation. The penalty amount would be adjusted annually, beginning January 1, 2024. ***Potential CalOptima Impact:*** *Increased financial penalties for CalOptima OneCare, OneCare Connect and PACE.*	**06/28/2022** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **05/24/2022** Passed Senate floor	CalOptima: Watch CAHP: Oppose
SB 923 **Wiener**	**TGI Inclusive Care Act:** No later than January 1, 2024, would require Medi-Cal MCP and PACE organization staff in direct contact with beneficiaries to complete cultural competency training to help provide inclusive health care services for individuals who identify as transgender, gender diverse or intersex (TGI). In addition, no later than July 31, 2023, would require a Medi-Cal MCP and PACE organization to identify in its provider directory any in-network providers who share that they offer gender-affirming services. Finally, no later than January 1, 2025, would require the California Health and Human Services Agency to implement a quality standard that measures patient experience with TGI cultural competency. ***Potential CalOptima Impact:*** *Additional training requirement for member-facing CalOptima employees; additional requirement for provider directory publication.*	**06/21/2022** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **05/23/2022** Passed Senate floor	CalOptima: Watch

OLDER ADULT SERVICES

Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 3173 **DelBene (WA)** **S. 3018** **Marshall (KS)**	**Improving Seniors' Timely Access to Care Act:** Would require Medicare Advantage (MA) plans to issue real-time decisions for routine prior authorization requests. HHS would determine and biannually update the definitions of "real-time" and "routine." In addition, HHS would establish electronic prior authorization transmission standards for MA plans. ***Potential CalOptima Impact:*** *Modified UM procedures and timelines for CalOptima OneCare.*	**05/13/2022** Introduced; referred to committees	CalOptima: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 4131 **Dingell (MI)** **S. 2210** **Casey (PA)**	**Better Care Better Jobs Act:** Would make permanent the enhanced 10% FMAP for Medicaid home- and community-based services (HCBS) enacted by the American Rescue Plan Act of 2021. Would also provide states with $100 million in planning grants to develop HCBS infrastructure and workforces. Additionally, would make permanent spousal impoverishment protections for those receiving HCBS. ***Potential CalOptima Impact:*** *Continuation of current federal funding rate for HCBS; expansion of HCBS opportunities.*	**06/24/2021** Introduced; referred to committees	CalOptima: Watch NPA: Support
H.R. 4941 **Blumenauer (OR)**	**PACE Part D Choice Act of 2021:** Would allow a Medicare-only PACE participant to opt out of drug coverage provided by the PACE program and instead enroll in a standalone Medicare Part D prescription drug plan that results in equal or lesser out-of-pocket costs. PACE programs would be required to educate their participants about this option. ***Potential CalOptima Impact:*** *Increased enrollment into CalOptima PACE by Medicare-only beneficiaries due to decreased out-of-pocket costs.*	**08/06/2021** Introduced; referred to committees	CalOptima: Watch NPA: Support
H.R. 6770 **Dingell (MI)** **S. 1162** **Casey (PA)**	**PACE Plus Act:** Would increase the number of PACE programs nationally by making it easier for states to adopt PACE as a model of care and providing grants to organizations to start PACE centers or expand existing PACE centers. Would incentivize states to expand the number of seniors and people with disabilities eligible to receive PACE services beyond those deemed to require a nursing home level of care. Would provide states a 90% FMAP to cover the expanded eligibility. ***Potential CalOptima Impact:*** *Subject to further DHCS authorization, expanded eligibility for CalOptima PACE; additional federal funding to expand the size and/or service area of a current PACE center or to establish a new PACE center(s).*	**04/15/2021** Introduced; referred to committees	CalOptima: Watch NPA: Support
H.R. 6823 **Brownley (CA)** **S. 3854** **Moran (KS)**	**Elizabeth Dole Home and Community Based Services for Veterans and Caregivers Act:** Would require Veterans Affairs (VA) medical centers to establish partnerships with PACE organizations to enable veterans to access PACE services through their VA benefits. ***Potential CalOptima Impact:*** *Increased number of CalOptima PACE participants; increased care coordination for CalOptima PACE participants who are veterans.*	**07/19/2022** Passed House Committee on Veterans' Affairs; referred to House floor	CalOptima: Watch NPA: Support

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Bill Number Author	Bill Summary	Bill Status	Position/Notes
S. 3626 **Casey**	**PACE Expanded Act:** To increase access to and the affordability of PACE, would allow PACE organizations to set premiums individually for Medicare-only beneficiaries consistent with their health status. Would also allow individuals to enroll in PACE at any time during the month. In addition, would simplify and expedite the process for organizations to apply for the following: ■ New PACE program ■ New centers for an existing PACE program ■ Expanded service area for an existing PACE center Finally, would allow pilot programs to test the PACE model of care with new populations not currently eligible to participate in PACE. ***Potential CalOptima Impact:*** *Increased number of CalOptima PACE participants; expanded eligibility criteria; new premium development procedure; simplified process to establish new PACE centers.*	**02/10/2022** Introduced; referred to committee	CalOptima: Watch NPA: Support
SB 1342 **Bates**	**Older Adult Care Coordination:** Would allow a county and/or an Area Agency on Aging to create a multi-disciplinary team (MDT) for county departments and aging service providers to exchange information about older adults to better address their health and social needs. By eliminating data silos, MDTs could develop coordinated case plans for wraparound services, provide support to caregivers and improve service delivery. ***Potential CalOptima Impact:*** *Participation in Orange County's MDT; improved care coordination for CalOptima's older adult members.*	**06/21/2022** Passed Assembly Aging and Long-Term Care Committee; referred to Assembly Appropriations Committee **05/25/2022** Passed Senate floor	**03/29/2022** CalOptima: Support County of Orange: Sponsor

PHARMACY

Bill Number Author	Bill Summary	Bill Status	Position/Notes
SB 853 **Wiener**	**Medication Access Act:** Effective January 1, 2023, would require a health plan to cover a prescribed medication for the duration of any internal and external appeals if the drug was previously covered for the beneficiary by any health plan. ***Potential CalOptima Impact:*** *Modified UM and Grievance and Appeals requirements for prescribed drugs covered by CalOptima; increased CalOptima costs for drug coverage.*	**06/28/2022** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **05/25/2022** Passed Senate floor	CalOptima: Watch CAHP: Oppose
SB 958 **Limón**	**Medication and Patient Safety Act of 2022:** Would prohibit health plans from arranging for "brown bagging" or "white bagging," as follows, except under certain limited conditions: ■ "Brown bagging" involves specialty pharmacies dispensing an infused or injected medication directly to a patient who transports it to a provider for administration. ■ "White bagging" involves specialty pharmacies distributing such medications to a provider ahead of a patient's visit. ***Potential CalOptima Impact:*** *Increased CalOptima costs and decreased member access for certain physician-administered drugs covered by CalOptima.*	**07/01/2022** Died in Assembly Health Committee **05/25/2022** Passed Senate floor	CalOptima: Watch CAHP: Oppose LHPC: Oppose Unless Amended

PROVIDERS

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 2581 **Salas**	**Behavioral Health Provider Credentialing:** Effective January 1, 2023, would require health plans to process credentialing applications from mental health and SUD providers within 60 days of receipt. ***Potential CalOptima Impact:*** *Modified provider credentialing processes for Quality Improvement staff.*	**06/08/2022** Passed Senate Health Committee; referred to Senate Appropriations Committee **05/23/2022** Passed Assembly Health Committee	CalOptima: Watch
AB 2659 **Patterson**	**Midwife Access:** Would require a Medi-Cal MCP to include at least one licensed midwife (LM), certified-nurse midwife (CNM) and alternative birth center specialty clinic in each county within its provider network. An MCP would be exempt if such providers or centers are not located within the county or do not accept Medi-Cal payments. An MCP must reimburse an out-of-network provider who accepts the Medi-Cal FFS rate. ***Potential CalOptima Impact:*** *Additional provider contracting and credentialing; increased access to midwifery services for CalOptima Medi-Cal members.*	**04/29/2022** Died in Assembly Health Committee	CalOptima: Watch
SB 966 **Limón**	**Clinic Providers:** Effective 60 days following the termination of the COVID-19 PHE, would allow Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) to be reimbursed for visits with an associate clinical social worker or associate marriage and family therapist when supervised by a licensed behavioral health practitioner. ***Potential CalOptima Impact:*** *Increased member access to behavioral health providers at contracted FQHCs.*	**06/14/2022** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **05/25/2022** Passed Senate floor	CalOptima: Watch LHPC: Support
SB 987 **Portantino**	**California Cancer Care Equity Act:** Would require a Medi-Cal MCP to make a good faith effort to contract directly with at least one National Cancer Institute Designated Cancer Center in each county — where one exists — within the MCP's service area. In addition, an MCP must inform a beneficiary within seven days of a complex cancer diagnosis regarding their ability to request a referral to a Cancer Center. DHCS would establish payment rates for MCPs and Cancer Centers that do not already have an agreed-upon rate. ***Potential CalOptima Impact:*** *Modified UM procedures for CalOptima Medi-Cal members referred to the UCI Health Chao Family Comprehensive Cancer Center; increased access to cancer care.*	**06/28/2022** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **05/24/2022** Passed Senate floor	CalOptima: Watch LHPC: Oppose

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REIMBURSEMENT RATES

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 1892 Flora	**California Orthotic and Prosthetic Patient Access and Fairness Act:** Would require reimbursement for prosthetic and orthotic appliances and durable medical equipment (DME) to be at least 80% of the lowest maximum allowance for California established by the federal Medicare program. ***Potential CalOptima Impact:*** *Increased cost to CalOptima Medi-Cal due to higher reimbursement to DME providers; adjustment to DHCS capitation rates.*	**06/08/2022** Passed Senate Health Committee; referred to Senate Appropriations Committee **05/25/2022** Passed Senate floor	CalOptima: Watch
AB 2458 Weber	**Whole Child Model (WCM) Reimbursement Rates:** Effective January 1, 2023, would increase provider reimbursement rates for WCM services by 25% if provided at a medical practice in which at least 30% of pediatric patients are Medi-Cal beneficiaries. ***Potential CalOptima Impact:*** *Increased cost to CalOptima Medi-Cal due to higher reimbursement to WCM providers; adjustment to DHCS capitation rates.*	**05/20/2022** Died in Assembly Appropriations Committee **03/22/2022** Passed Assembly Health Committee	CalOptima: Watch

SOCIAL DETERMINANTS OF HEALTH

Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 379 Barragan (CA) **S. 104 Smith (MN)**	**Improving Social Determinants of Health Act of 2021:** Would require the Centers for Disease Control and Prevention (CDC) to establish a social determinants of health (SDOH) program to coordinate activities to improve health outcomes and reduce health inequities. CDC would be required to consider SDOH in all relevant grant awards and other activities as well as issue new grants of up to $50 million to health agencies, nonprofit organizations and/or institutions of higher education to address or study SDOH. ***Potential CalOptima Impact:*** *Increased availability of federal grants to address SDOH.*	**01/21/2021** Introduced; referred to committees	CalOptima: Watch
H.R. 943 McBath (GA) **S. 851 Blumenthal (CT)**	**Social Determinants for Moms Act:** Would require HHS to convene a task force to coordinate federal efforts on social determinants of maternal health as well as award grants to address SDOH, eliminate disparities in maternal health and expand access to free childcare during pregnancy-related appointments. Would also extend postpartum eligibility for the Special Supplemental Nutrition Program for Women, Infants, and Children from six months postpartum to two years postpartum. ***Potential CalOptima Impact:*** *Additional federal guidance or requirements as well as increased availability of federal grants to address social factors affecting maternal health.*	**02/08/2021** Introduced; referred to committees	CalOptima: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 2503 **Bustos (IL)** **S. 3039** **Young (IN)**	**Social Determinants Accelerator Act of 2021:** Would establish the Social Determinants Accelerator Interagency Council to award state and local health agencies up to 25 competitive grants totaling no more than $25 million (House version) or $10 million (Senate version) as well as provide technical assistance to improve coordination of medical and non-medical services to a targeted population of high-need Medicaid beneficiaries. ***Potential CalOptima Impact:*** *Increased availability of federal grants to address the SDOH of members with complex needs.*	**07/15/2021** Passed House Energy and Commerce Committee's Subcommittee on Health; referred to full Committee	CalOptima: Watch
H.R. 3894 **Blunt Rochester (DE)**	**Collecting and Analyzing Resources Integral and Necessary for Guidance (CARING) for Social Determinants Act of 2021:** Would require the Centers for Medicare & Medicaid Services (CMS) to update guidance at least once every three years to help states address SDOH in Medicaid and CHIP programs. ***Potential CalOptima Impact:*** *Increased opportunities for CalOptima to address SDOH.*	**12/08/2021** Passed House floor; referred to Senate Committee on Finance	CalOptima: Watch
H.R. 4026 **Burgess (TX)**	**Social Determinants of Health Data Analysis Act of 2021:** Would require the Comptroller General of the United States to submit a report to Congress outlining the actions taken by HHS to address SDOH. The report would include an analysis of interagency efforts, barriers and potential duplication of efforts as well as recommendations on how to foster private-public partnerships to address SDOH. ***Potential CalOptima Impact:*** *Increased opportunities for CalOptima to address SDOH.*	**11/30/2021** Passed House floor; referred to Senate Committee on Health, Education, Labor, and Pensions	CalOptima: Watch
SB 17 **Pan**	**Office of Racial Equity:** Would establish the independent Office of Racial Equity and the position of Chief Equity Officer to develop a Racial Equity Framework containing guidelines and strategies for advancing racial equity across the state government by January 1, 2023. Each state agency, including DHCS, would be required to implement a Racial Equity Plan by July 1, 2023, in alignment with the goals of the framework, and the office and each agency would prepare annual reports outlining progress toward achieving those goals. ***Potential CalOptima Impact:*** *Increased reporting requirements to DHCS.*	**06/30/2021** Passed Assembly Accountability and Administrative Review Committee; referred to Assembly Appropriations Committee **06/02/2021** Passed Senate floor	CalOptima: Watch

TELEHEALTH

Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 366 **Thompson (CA)**	**Protecting Access to Post-COVID-19 Telehealth Act of 2021:** Would allow HHS to waive or modify any telehealth service requirements in the Medicare program during a national disaster or PHE and for 90 days after one is terminated. Would also permit Medicare reimbursement for telehealth services provided by an FQHC or RHC as well as allow patients to receive telehealth services in the home without restrictions. ***Potential CalOptima Impact:*** *Continuation and expansion of certain telehealth flexibilities allowed during the COVID-19 pandemic for CalOptima OneCare, OneCare Connect and PACE.*	**01/19/2021** Introduced; referred to committees	CalOptima: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 1332 **Carter (GA)** **S. 368** **Scott (SC)**	**Telehealth Modernization Act of 2021:** Would permanently extend certain Medicare current telehealth flexibilities enacted temporarily in response to the COVID-19 pandemic. Specifically, would permanently allow the following: ■ FQHCs and RHCs may serve as the site of a telehealth provider ■ Beneficiaries may receive all telehealth services at any location, including their own homes ■ CMS may retain and expand the list of covered telehealth services ■ CMS may expand the types of providers eligible to provide telehealth services ***Potential CalOptima Impact:*** *Continuation of certain telehealth flexibilities allowed during the COVID-19 pandemic for CalOptima OneCare, OneCare Connect and PACE.*	**02/23/2021** Introduced; referred to committees	CalOptima: Watch
H.R. 2166 **Sewell (AL)**	**Ensuring Parity in MA and PACE for Audio-Only Telehealth Act of 2021:** Would require CMS to include audio-only telehealth diagnoses in the determination of risk adjustment payments for MA and PACE plans during the COVID-19 PHE. ***Potential CalOptima Impact:*** *For CalOptima OneCare, OneCare Connect and PACE, members' risk scores and risk adjustment payments would accurately reflect diagnoses.*	**03/23/2021** Introduced; referred to committees	**08/05/2021** CalOptima: Support ACAP: Support NPA: Support
H.R. 2903 **Thompson (CA)** **S. 1512** **Schatz (HI)**	**Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act of 2021:** Would expand telehealth services for those receiving Medicare benefits and remove restrictions in the Medicare program that prevent physicians from using telehealth technology. Specifically, would: ■ Remove all geographic restrictions for telehealth services ■ Allow beneficiaries to receive telehealth in their own homes, in addition to other locations determined by HHS ■ Remove restrictions on the use of telehealth in emergency medical care ■ Allow FQHCs and RHCs to provide telehealth services ***Potential CalOptima Impact:*** *Continuation and expansion of telehealth flexibilities for CalOptima OneCare, OneCare Connect and PACE.*	**04/28/2021** Introduced; referred to committees	CalOptima: Watch
H.R. 3447 **Smith (MO)**	**Permanency for Audio-Only Telehealth Act:** Would permanently extend the following current flexibilities, which have been temporarily authorized by CMS during the COVID-19 PHE: ■ Medicare providers may be reimbursed for providing certain services via audio-only telehealth, including evaluation and management, behavioral health and SUD services, or any other service specified by HHS. ■ Medicare beneficiaries may receive telehealth services at any location, including their homes. ***Potential CalOptima Impact:*** *Permanent continuation of certain telehealth flexibilities for CalOptima OneCare, OneCare Connect and PACE.*	**05/20/2021** Introduced; referred to committees	CalOptima: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 4058 **Matsui (CA)** **S. 2061** **Cassidy (LA)**	**Telemental Health Care Access Act of 2021:** Would remove the requirement that Medicare beneficiaries be seen in-person within six months of being treated for behavioral health services via telehealth. ***Potential CalOptima Impact:*** *For CalOptima OneCare and OneCare Connect, decreased in-person behavioral health encounters and increased telehealth behavioral health encounters.*	**06/22/2021** Introduced; referred to committees	CalOptima: Watch
H.R. 7573 **Axne (IA)** **S. 3593** **Cortez Masto (NV)**	**Telehealth Extension and Evaluation Act:** Would extend current Medicare telehealth payments authorized temporarily in response to the COVID-19 pandemic for two additional years following the termination of the PHE. Would require HHS to study the impact of telehealth flexibilities and report its recommendations for permanent telehealth policies to Congress. ***Potential CalOptima Impact:*** *Continuation of telehealth flexibilities for CalOptima OneCare, OneCare Connect and PACE.*	**02/08/2022** Introduced; referred to committee	CalOptima: Watch
S. 150 **Cortez Masto (NV)**	**Ensuring Parity in MA for Audio-Only Telehealth Act of 2021:** Would require CMS to include audio-only telehealth diagnoses in the determination of risk adjustment payments for MA plans during the COVID-19 PHE. ***Potential CalOptima Impact:*** *For CalOptima OneCare and OneCare Connect, members' risk scores and risk adjustment payments would accurately reflect diagnoses.*	**02/02/2021** Introduced; referred to committee	CalOptima: Watch ACAP: Support NPA: Support
AB 32 **Aguiar-Curry**	**Medi-Cal Telehealth Payment and Flexibilities:** Would permanently extend or modify certain Medi-Cal telehealth flexibilities currently authorized during the COVID-19 pandemic as follows: ■ FQHC and RHC encounters, including those which establish a new patient, include audiovisual, audio-only and asynchronous store and forward telehealth modalities reimbursed at the same rate as an in-person visit. ■ DHCS must specify the Medi-Cal covered benefits that may be delivered via telehealth as well as the other telehealth provider types allowed in addition to FQHCs and RHCs. ■ Medi-Cal telehealth providers may deliver services through audiovisual, audio-only, asynchronous store and forward, remote patient monitoring, and other virtual modalities subject to future DHCS billing and UM policies. ■ Remote patient monitoring and other virtual modalities may not be used to establish new patient relationships and may be subject to different reimbursement rates. ■ Medi-Cal providers delivering audiovisual and audio-only telehealth services must also offer in-person services. ■ PACE organizations may use audiovisual telehealth services to conduct eligibility assessments. Finally, would allow Medi-Cal MCPs to include telehealth encounters when determining compliance with network adequacy standards or alternative access requirements, subject to certain restrictions. ***Potential CalOptima Impact:*** *Continuation and modification of certain telehealth flexibilities for CalOptima Medi-Cal and PACE.*	**06/29/2022** Passed Senate Health Committee; referred to Senate Appropriations Committee **06/01/2021** Passed Assembly floor	CalOptima: Watch CAHP: Concern

YOUTH SERVICES

Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 66 **Buchanan (FL)**	**Comprehensive Access to Robust Insurance Now Guaranteed (CARING) for Kids Act:** Would permanently extend authorization and funding of CHIP and associated programs, including the Medicaid and CHIP express lane eligibility option, which enables states to expedite eligibility determinations by referencing enrollment in other public programs. ***Potential CalOptima Impact:*** *Continuation of current federal funding and eligibility requirements for CalOptima Medi-Cal members eligible under CHIP.*	**01/04/2021** Introduced; referred to committee	CalOptima: Watch
H.R. 1390 **Wild (PA)** **S. 453** **Casey (PA)**	**Children's Health Insurance Program Pandemic Enhancement and Relief (CHIPPER) Act:** Would retroactively extend CHIP's temporary 11.5% FMAP increase, enacted by the HEALTHY KIDS Act (2018), from September 30, 2020, until September 30, 2022, to meet increased health care needs during the COVID-19 PHE. ***Potential CalOptima Impact:*** *Increased federal funds for CalOptima Medi-Cal members eligible under CHIP.*	**02/25/2021** Introduced; referred to committees	CalOptima: Watch

Two-Year Bills

The following bills did not meet the deadline to be passed by both houses of the State Legislature in 2021 but are still eligible for reconsideration in 2022:

- AB 4 (Arambula)
- AB 114 (Maienschein)
- AB 470 (Carrillo)
- AB 540 (Petrie-Norris)
- SB 56 (Pan)
- SB 293 (Limón)
- SB 316 (Eggman)
- SB 523 (Leyva)
- SB 562 (Portantino)

2021 Signed Bills

- H.R. 1868 (Yarmuth [KY])
- AB 128 (Ting)
- AB 133 (Committee on Budget)
- AB 161 (Ting)
- AB 164 (Ting)
- AB 361 (Rivas)
- AB 1082 (Waldron)
- SB 48 (Limón)
- SB 65 (Skinner)
- SB 129 (Skinner)
- SB 171 (Committee on Budget and Fiscal Review)
- SB 221 (Wiener)
- SB 306 (Pan)
- SB 510 (Pan)

2021 Vetoed Bills

- AB 369 (Kamlager)
- AB 523 (Nazarian)
- SB 365 (Caballero)
- SB 682 (Rubio)

Information in this document is subject to change as bills proceed through the legislative process.

ACAP: Association for Community Affiliated Plans
CAHP: California Association of Health Plans
CalPACE: California PACE Association
LHPC: Local Health Plans of California
NPA: National PACE Association

Last Updated: July 25, 2022

2022 Federal Legislative Dates

January 3	117th Congress, Second Session convenes
April 11–22	Spring recess
August 1–12	Summer recess for House
August 8–September 5	Summer recess for Senate
December 10	Second Session adjourns

2022 State Legislative Dates

January 3	Legislature reconvenes
January 14	Last day for policy committees to hear and report to fiscal committees any fiscal bills introduced in that house in 2021
January 21	Last day for any committee to hear and report to the floor any bill introduced in that house in 2021
January 31	Last day for each house to pass bills introduced in that house in 2021
February 18	Last day for legislation to be introduced
April 7–18	Spring recess
April 29	Last day for policy committees to hear and report to fiscal committees any fiscal bills introduced in that house in 2022
May 6	Last day for policy committees to hear and report to the floor any non-fiscal bills introduced in that house in 2022
May 20	Last day for fiscal committees to hear and report to the floor any bills introduced in that house in 2022
May 23–27	Floor session only
May 27	Last day for each house to pass bills introduced in that house in 2022
June 15	Budget bill must be passed by midnight
July 1	Last day for policy committees to hear and report bills in their second house to fiscal committees or the floor
July 1–August 1	Summer recess
August 12	Last day for fiscal committees to report bills in their second house to the floor
August 15–31	Floor session only
August 25	Last day to amend bills on the floor
August 31	Last day for each house to pass bills; final recess begins upon adjournment
September 30	Last day for Governor to sign or veto bills passed by the Legislature

Source: 2022 State Legislative Deadlines, California State Assembly: http://assembly.ca.gov/legislativedeadlines

FY 2022–23 California State Budget: Analysis of the Enacted Budget

Table of Contents

Background

On January 10, 2022, Gov. Gavin Newsom released the Fiscal Year (FY) 2022–23 Proposed State Budget with total spending at $286.4 billion, including $213.1 billion General Fund (GF). The proposed budget also estimated a $45.7 billion surplus and proposed $34.6 billion in budget reserves, which could be attributed to federal COVID-19 stimulus funding and higher than expected tax receipts.

On May 13, 2022, Gov. Newsom released the FY 2022–23 Revised Budget Proposal (May Revise) at a total of $300.7 billion, including $227.4 billion in GF spending, representing an increase of $14.3 billion compared to the January Proposed Budget due to further revenue growth. The May Revise included an even larger $49.2 billion discretionary surplus and $37.1 billion in budget reserves.

To meet the constitutionally obligated deadline to pass a balanced budget, on June 14, 2022, the Senate and Assembly passed Senate Bill (SB) 154, the Budget Act of 2022, a preliminary state budget representing the Legislature's counterproposal to the May Revise. The Legislature's Budget included a spending plan of $300 billion, including $235.5 billion GF.

Following negotiations with the Legislature, Gov. Newsom signed into law the preliminary state budget (SB 154) on June 27 and the final budget revisions (Assembly Bill [AB] 178) on June 30. On the same day, he signed the consolidated Health Trailer Bill (SB 184) and the Skilled Nursing Facility (SNF) Financing Reform Trailer Bill (AB 186) containing the statutory policy changes needed to implement health-related budget expenditures. Together, these bills represent the Enacted Budget for FY 2022–23, effective July 1, 2022.

Overview

In summary, the enacted budget appropriates a total of just over $300 billion, of which $234.4 billion is from the GF. This represents an increase of $37.4 billion compared with the FY 2021–22 enacted budget. Specifically, the budget includes $135.5 billion ($36.6 billion GF) in Medi-Cal spending, an 11.2% increase from the current FY, with an assumption that Medi-Cal caseload will increase by 0.6% to 14.5 million beneficiaries as redeterminations resume this FY following termination of the COVID-19 public health emergency (PHE). Based on a record-high budget surplus, the budget allocates 93% towards one-time spending initiatives and $37.2 billion for reserves. Major components included in the enacted budget that may impact CalOptima are discussed below.

Behavioral Health

The Enacted Budget includes significant investments in behavioral health, particularly for children and youth. As expected, there is ongoing funding towards implementing the Children and Youth Behavioral Health Initiative (CYBHI), including the following components in FY 2022–23:

- Dyadic services as a new Medi-Cal benefit, as discussed later
- Evidence-based behavioral health practices
- School behavioral health partnerships and capacity
- Statewide behavioral health services platform and related e-consult service and provider training

While some CYBHI initiatives are directly managed by DHCS, CalOptima's Behavioral Health Integration department may still be involved in guiding certain programs or coordinating member access.

In addition, the budget includes an extra $290 million in one-time funding over three years to address urgent needs and emergent issues in children's behavioral health through the following initiatives:

- Wellness and mindfulness programs
- Parent training and education
- Digital supports for remote assessment and intervention
- School-based crisis response pilots to prevent youth suicide
- Peer-to-peer support programs

A total of $8 million in one-time finding is also allocated for National Suicide Prevention Lifeline crisis centers to prepare for the implementation of the 9-8-8 calling code on July 16, 2022.

Finally, to address the immediate housing and treatment needs of those with serious behavioral health conditions, the budget also includes $1.5 billion over two years to purchase and install tiny homes for immediate behavioral health bridge housing.

California Advancing and Innovating Medi-Cal (CalAIM)

The Enacted Budget includes $3.1 billion ($1.2 billion GF) in FY 2022–23 to implement CalAIM. CalAIM initiatives being implemented in FY 2022–23 continue to include:

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

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

In addition to $1.8 billion of previously allocated PATH funding, the budget provides an additional $50 million ($16 million GF) for counties and correctional entities to support capacity building, technical assistance, collaboration and planning. While plans are not eligible for this funding, CalOptima is expected to coordinate PATH and CalAIM Incentive Payment Program investments with the County of Orange.

COVID-19

As the COVID-19 pandemic enters its endemic phase, the budget allocates $1.9 billion to ensure ongoing pandemic response and preparedness for potential future surges of additional COVID-19 variants. This includes investments towards vaccinations (including boosters), rapid and school-based testing, enhanced surveillance, test to treat therapeutics and medical surge staffing.

In addition, with the PHE expected to terminate in the coming months, the budget includes funding to ensure continuity of Medi-Cal coverage as eligibility redeterminations resume. Funding supports additional county workloads, Health Enrollment Navigators expansion and media and outreach campaigns to collect updated member contact information. CalOptima is separately executing its own member communication strategies.

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

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

Housing and Homelessness

Building off a $12 billion multiyear investment to address homelessness as part of last year's enacted budget, this year's budget includes an additional $2 billion multiyear affordable housing package, including investments in the Multifamily Housing Program, Housing Accelerator Program, Farmworker Housing Program, Accessory Dwelling Unit financing and Veterans Housing and Homelessness Prevention Program. The budget also includes $700 million over two years for local jurisdictions to address encampments through short- and long-term rehousing strategies.

Contingent on passage of implementing legislation (SB 1338), the budget sets aside funding for the governor's proposed Community Assistance, Recovery, and Empowerment (CARE) Court. CARE Court would facilitate delivery of mental health and substance use disorder services to individuals with schizophrenia spectrum or other psychotic disorders who lack medical decision-making capabilities. The program would connect a person in crisis with a court-ordered care plan for up to 24 months as a diversion from homelessness, incarceration or conservatorship. Care plans could include court-ordered stabilization medications, wellness and recovery supports, and connection to social services and a housing plan. It is not yet known how Medi-Cal managed care plans (MCPs) may be involved in the delivery or coordination of care to their members.

Inflation Relief

In an effort to provide direct relief for rising costs due to inflation, the budget includes a $17 billion relief package, which includes the following elements:

- $1.3 billion for retention payments of up to $1,500 each for hospital and SNF workers
- Permanent extension of the State Premium Subsidy Program to provide financial assistance for individuals purchasing health care coverage through Covered California

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

Kaiser Medi-Cal Contract

As part of the budget packet, Gov. Newsom also signed into law AB 2724, which authorizes DHCS to enter into a direct, statewide contract with Kaiser Permanente to provide Medi-Cal services in any county, starting January 1, 2024. If the Centers for Medicare and Medicaid Services approves DHCS' waiver request, the contract is expected to result in significant negative impacts to CalOptima and its members and providers as well as the broader safety net health system. CalOptima and the County of Orange adopted positions of Oppose Unless Amended to prohibit a direct contract in counties with County Organized Health Systems (COHS), but the final bill still applies to COHS counties.

Medi-Cal Benefits

The Enacted Budget includes additional funding for several new Medi-Cal benefits.

As referenced earlier, the budget funds the implementation of dyadic services, effective January 1, 2023. Similar to Parent-Child Interaction Therapy, currently managed by the Orange County Health Care Agency (HCA), dyadic care provides integrated physical and behavioral health screening and services to the whole family. The goal of providing dyadic care is to improve access to preventive and coordinated care for children, rates of immunization completion, social-emotional health services, developmentally appropriate parenting and maternal mental health.

In addition, 24/7 mobile crisis intervention services will become a Medi-Cal benefit implemented through county behavioral health systems as soon as January 1, 2023. It is expected that HCA may operate this benefit out of the Be Well OC campus. While not provided by MCPs, this new benefit may still require increased coordination and follow-up care by CalOptima and its contracted providers.

The budget also delays implementation of the doula benefit from July 1, 2022, until January 1, 2023, and provides funding to increase the maximum reimbursement rate from an average of $450 to $1,094 per birth for doula services. Lastly, effective July 1, 2022, annual cognitive health assessments become a Medi-Cal benefit for beneficiaries ages 65 years and older if they are ineligible under Medicare.

Medi-Cal Eligibility

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

The budget also continues to include $53 million ($19 million GF) funding to eliminate Medi-Cal premiums for approximately 500,000 higher-income pregnant women,

children and disabled working adults covered under the Children's Health Insurance Program (CHIP), Medi-Cal Access Program (MCAP) and 250% Working Disabled Program.

Additionally, trailer bill language authorizes continuous Medi-Cal eligibility for children up to 5 years of age, beginning January 1, 2025, preventing disenrollment regardless of changes in family income. DHCS will also expand the Children's Presumptive Eligibility Program by allowing all Medi-Cal providers to enroll children under 19 years of age into Medi-Cal through the presumptive eligibility process.

No sooner than January 1, 2025, seniors and persons with disabilities who qualify for Medi-Cal under Medically Needy criteria will have reduced share of cost requirements by increasing the Medi-Cal Maintenance Need Income Level to match the income eligibility limit for Medi-Cal without a share of cost. As a result of CalAIM, these share of cost beneficiaries are currently covered under Medi-Cal FFS, as of January 1, 2022.

Provider Payments

The Enacted Budget includes $700 million over five years for Equity and Practice Transformation Payments, which are one-time provider payments focused on advancing equity, reducing COVID-19-driven care gaps, supporting upstream interventions to address social determinants of health and improving quality in maternity, children's preventive and integrated behavioral health care. It is anticipated that some if not all of these payments will flow through Medi-Cal MCPs, though key details on implementation have not been shared.

A new Workforce and Quality Incentive Program will provide $280 million in directed payments to SNFs that meet quality benchmarks or who have demonstrated substantial improvement. Medi-Cal MCPs will coordinate program implementation and issue payments. Other changes to SNF payments include:

- New reimbursement rate structure, beginning January 1, 2023
- Average 4% annual rate increase
- One-year extension of the temporary 10% rate increase effective during the COVID-19 PHE

The budget continues nearly all Proposition 56 supplemental payment programs, with several transferring to the GF to allow for ongoing funding regardless of fluctuations in Proposition 56 revenues. However, the Value Based Payment program still sunsetted on June 30, 2022, and the Behavioral Health Integration program is still set to sunset on December 31, 2022. The budget made permanent the Medi-Cal Physician and Dentist Loan Repayment Program, also funded through Proposition 56, and provided additional funds from the GF for FY 2022–23.

The Enacted Budget also eliminates most remaining Great Recession-era ("AB 97") Medi-Cal rate cuts for 35 additional provider types and services, effective either July 1, 2022, or January 1, 2023.

Telehealth

To build off telehealth flexibilities adopted during the COVID-19 pandemic, the budget authorizes a permanent telehealth policy that allows Medi-Cal providers, including FQHCs, to be reimbursed for both video and audio-only telehealth encounters at the same rate as an in-person visit. Providers must still provide an option for in-person visits. However, a new Medi-Cal patient relationship may not be established via audio-only telehealth.

Miscellaneous

The Enacted Budget also includes the following provisions that may impact CalOptima:

- $351.6 million over four years for workforce development, including:
  - $200 million for the behavioral health workforce
  - $76 million for the primary care, clinic and reproductive health workforce
  - $75.6 million for the public health workforce
- $350 million over three years to recruit, train and certify 25,000 new community health workers by 2025, with specialized training to work with those who are justice-involved, unhoused, older adults or disabled
- $200 million to improve access to reproductive health services
- $101 million to expand medication-assisted treatment to help address the opioid crisis
- $100 million for the CalRX Biosimilar Insulin Initiative to create public-private partnerships to increase generic insulin manufacturing and lower insulin costs
- $50 million over two years for technical assistance grants and capacity development programs for small and under-resourced providers to improve data exchange capabilities
- Development of an Alternative Payment Model for FQHCs, optionally allowing them to transition from a volume-based to value-based reimbursement methodology, no sooner than January 1, 2024
- Reclassification of diabetic products, including continuous glucose monitors, as pharmacy benefits covered under Medi-Cal Rx, effective July 1, 2022

Next Steps

The Legislature will continue to advance budget trailer bills and policy bills through the legislative process. Bills with funding allocated in the Enacted Budget are likely to be passed and signed into law. The Legislature has until August 31 to pass legislation, and Gov. Newsom has until September 30 to either sign or veto that legislation. Additionally, state agencies will begin implementing the policies enacted through the budget. Staff will continue to monitor these polices and provide updates regarding issues that have a significant impact to CalOptima.

About CalOptima

CalOptima, a county organized health system (COHS), is the single plan providing guaranteed access to Medi-Cal for all eligible individuals in Orange County and is responsible for almost all medical acute services, including custodial long-term care. CalOptima is governed by a locally appointed Board of Directors, which represents the diverse interests that impact Medi-Cal.

If you have any questions, please contact GA@caloptima.org.

Board of Directors Meeting
August 4, 2022

CalOptima Community Outreach Summary — July and August 2022

Background

CalOptima is committed to serving the community by sharing information with current and potential members and strengthening relationships with community partners. To this end, CalOptima attends community coalitions, collaborative meetings, and advisory groups, and supports our community partners' public activities.

CalOptima's participation in public activities promotes:

- Member interaction/enrollment in a CalOptima program
- Community awareness of CalOptima
- Partnerships that increase positive visibility and relationships with community organizations

CalOptima continues to participate in public activities virtually in most instances with limited in-person attendance. Participation includes providing CalOptima Medi-Cal educational materials and, if criteria are met, financial support and/or CalOptima-branded items.

Community Outreach Highlight

CalOptima hosted four CalFresh Enrollment Events and Resource Fairs in the months of May and June to increase awareness and enrollment in CalFresh. The events took place in the cities of Santa Ana, Anaheim, La Habra, and Garden Grove and were hosted in collaboration with the County of Orange Social Services Agency, who were on site to enroll CalOptima members and the community into CalFresh and educate the community about the CalFresh program. The events had a resource fair component to provide information for basic needs, mental health, early education, and services for older adults. There was food and diaper distribution along with free bike helmets and school supplies while supplies lasted. The events were designed to celebrate health and wellness and included family activities, such as a magic show, face painting and balloon artists. The County of Orange Social Services Agency processed 392 applications, approved 127 applications, and distributed 28 CalFresh EBT cards on site. CalOptima will continue these efforts to increase access to the CalFresh program with our members and to build community partnerships.

Summary of Public Activities

As of July 7, CalOptima plans to participate in, organize or convene 47 public activities in July and August. In July, there will be 24 public activities that include 15 virtual community/collaborative meetings, two community-based presentations, six community events and one Health Network Forum. In August, there will be 23 public activities that include 14 virtual community/collaborative meetings, seven community events, one Cafecito meeting and one Health Network Forum. A summary of CalOptima's participation in community events throughout Orange County is attached.

Endorsements

CalOptima provided zero endorsements since the last reporting period (e.g., letters of support, program/public activity events with support or use of name/logo). Endorsement requests must meet the requirements of CalOptima Policy AA.1214: Guidelines for Endorsements by CalOptima, for Letters of Support and Use of CalOptima Name and Logo. More information about policy requirements can be found at: https://www.caloptima.org/en/About/CommunityRelations/CommunityOutreach.aspx.

For additional information or questions, contact CalOptima Community Relations Manager Tiffany Kaaiakamanu at 657-235-6872 or tkaaiakamanu@caloptima.org.

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List of community events hosted by community partners and CalOptima in July and August 2022:

July 2022			
7/7 9 a.m.–2 p.m.	**Back to School Event hosted by the Boys and Girls Clubs of Garden Grove†** The Boys & Girls Clubs of Garden Grove 9860 Larson Ave., Garden Grove	At least one staff member attended (in-person). Sponsorship fee: $1,000; includes a resource table and recognition of sponsorship at the event.	• Health/resource fair • Open to the public
7/9 8 a.m.–12 p.m.	**Activate Your Health Event hosted by Latino Health Access†** Santa Ana College-Track Field 1530 W. 17th St., Santa Ana	At least one staff member attended (in-person).	• Health/resource fair • Open to the public
7/9 10 a.m.–1 p.m.	**Community Health and Resource Fair hosted by the Office of Senator Tom Umberg†** Ponderosa Park Family Resource Center 320 E. Orangewood Ave., Anaheim	At least one staff member attended (in-person).	• Health/resource fair • Open to the public
7/15 11:30 a.m.–12:30 p.m.	**CalOptima Medi-Cal Overview Presentation in English** Sea Country Community Center 24602 Aliso Creek Rd., Laguna Niguel	At least one staff member presented (in-person).	• Community-based organization presentation • Open to members only
7/18 11 a.m.–12 p.m.	**CalOptima Medi-Cal Overview Presentation in English** Linbrook Court 2240 W. Lincoln Ave., Anaheim	At least one staff member presented (in-person).	• Community-based organization presentation • Open to members only
7/20 11:30 a.m.–1:30 p.m.	**Safety Day Event hosted by the Westminster Family Resource Center†** Sigler Park 7200 Plaza St., Westminster	At least one staff member attended (in-person).	• Health/resource fair • Open to the public
7/21 9–11 a.m.	**Health Network Forum*** Virtual	At least 10 staff members attended.	• Forum • Open to health and human service providers
7/30 8 a.m.–12 p.m.	**Back to School Event hosted by the Collaborative to Assist McKinney Vento and Motel Families†** Gilbert High School 1800 W. Ball Rd., Anaheim	At least one staff member attended (in-person). Sponsorship fee: $1,500; included agency logo placement on the event banner as a premier sponsor and a resource table at the event.	• Health/resource fair • Open to the public
7/30 12–4 p.m.	**Carnival for Kids Event hosted by Illumination Foundation†** La Palma Park	At least one staff member attended (in-person). Sponsorship fee: $1,000; included a resource table, pre-event e-blast and recognition on all social media platforms.	• Health/resource fair • Open to the public

* CalOptima Hosted
† Exhibitor/Attendee

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	1151 N. La Palma Pkwy., Anaheim		
August 2022			
8/2 5–8 p.m.	**National Night Out hosted by Garden Grove Police Department†** Garden Grove Police Department 11301 Acacia Pkwy., Garden Grove	At least two staff members to attend (in-person).	• Health/resource fair • Open to the public
8/4 10 a.m.–2 p.m.	**Celebrating Families Resource Fair hosted by PHFE WIC†** Santa Ana East WIC 1701 S. Grand Ave., Santa Ana	At least one staff member to attend (in-person).	• Health/resource fair • Open to the public
8/4 5–7:30 p.m.	**Back-to-School Backpack Giveaway Event hosted by The Delhi Center†** The Delhi Center 505 E. Center Ave., Santa Ana	At least one staff member to attend (in-person).	• Health/resource fair • Open to the public
8/11 6–9 p.m.	**20th Anniversary Celebration hosted by the Buena Clinton Youth and Family Center†** The Buena Clinton Youth and Family Center 12661 Sunswept Ave., Garden Grove	At least two staff members to attend (in-person). Sponsorship fee: $1,000; includes a resource table, feature on a banner during the event, speaking opportunity, photo opportunity with dignitaries and recognition of sponsorship with a plaque.	• Health/resource fair • Open to the public
8/18 9–11 a.m.	**Health Network Forum*** Virtual	At least 10 staff members to attend.	• Forum • Open to health and human service providers
8/18 1:30–3 p.m.	**InfoSeries: A National and Local Snapshot on Family Homelessness *** Virtual	At least five staff members to attend.	• Forum • Open to community stakeholders; register prior to event
8/20 12–4 p.m.	**Community Health Fair hosted by the Anaheim Marketplace†** The Anaheim Marketplace 1440 S. Anaheim Blvd., Anaheim	At least one staff member to attend (in-person). Sponsorship fee: $1,000; includes a resource table, opportunity to place a banner at the event, organization's name mentioned in all social media advertising, live announcements and advertisements during the event entertainment, and 14 30-second brand spots on the KWIZ/La Ranchera stream prior to the event.	• Health/resource fair • Open to the public
8/30 9–10:30 a.m.	**Cafecito Meeting*** Virtual	At least five staff members to attend.	• Steering committee meeting • Open to collaborative members

These sponsorship request(s) and community event(s) met the requirements of CalOptima Policy AA.1223: Participation in Community Events Involving External Entities. More information about policy requirements can be found at: https://www.caloptima.org/en/About/CommunityRelations/CommunityOutreach.aspx

* CalOptima Hosted
† Exhibitor/Attendee

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CalOptima Board Action Agenda Referral

Action To Be Taken August 4, 2022
Regular Meeting of the CalOptima Board of Directors

Report Item

14. Authorize a Rebrand of CalOptima to Include a Name Change to "CalOptima Health" and a New Logo Mark

Contact

Deanne Thompson, Executive Director, Marketing and Communications, (714) 954-2141

Recommended Actions

1. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to modify Orange County Health Authority's DBA name to CalOptima Health, effective immediately with the filing of all necessary name mark documentation.
2. Authorize the CEO to direct the Communications department to implement a new logo mark that reflects an updated visual identity and includes the new agency name, effective immediately with the filing of all necessary logo mark documentation.

Background

CalOptima was chosen as the agency's name before the launch of its Medi-Cal plan in October 1995. "Optima" is an acronym for Orange Prevention & Treatment Integrated Medical Assistance. CalOptima has since expanded into other lines of business, including OneCare Connect, OneCare, and the Program of All-Inclusive Care for the Elderly (PACE). Further, CalOptima has grown to five times its original size at launch when it served 180,000 Medi-Cal members. However, despite the evolution of the agency and the expansion of its presence in Orange County's health care landscape, there has been no change to its name and no update to its logo since 2009.

Discussion

In late 2021, CalOptima's Communications department conducted a public opinion survey of 904 Orange County residents. The survey revealed that CalOptima has strong name recognition among residents; however, most people are not well informed about CalOptima's role or services. More than half (61%) of residents reported that they have heard of CalOptima; however, fewer than half the residents who recognized the CalOptima name were aware that the agency's primary role is to provide health coverage. Therefore, staff requests Board approval to modify CalOptima's brand by adding "Health" to the agency's name to raise awareness and closely associate the agency with its core function and mission to serve member health.

As part of rebranding, staff also seeks Board approval to modify CalOptima's visual identity with a new logo mark. Over the past three months, the Communications department undertook a comprehensive effort using internal and external resources to develop several logo options that reflected desired brand attributes. The priority concepts included connection, community, diversity, integration, inspiration, energy, and joy. Feedback on top logo options was gathered from staff, members, and community stakeholders in June. A favorite emerged and is now proposed for adoption. The new logo also functions

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as part of a strategy to refresh the branding of all current health plans (OneCare and PACE) as well as allow for the addition of future CalOptima Health lines of business.

Operationally, as printed materials are expended by internal departments across the agency, the new branding will be applied to reordered materials, thus limiting any additional expense for implementation.

Fiscal Impact
There is no additional fiscal impact. Administrative expenses related to Marketing and Communications were included in the CalOptima Fiscal Year 2022-23 Operating Budget approved by the Board on June 2, 2022.

Rationale for Recommendation
Approving the rebrand of CalOptima to CalOptima Health will support enhanced recognition of the agency's function in the community and improved understanding of our values and priorities.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. CalOptima Rebrand Presentation

/s/ Michael Hunn *07/28/2022*
Authorized Signature **Date**

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Brand Redesign

Board of Directors Meeting

August 4, 2022

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Brand Redesign Project

- Executive leadership requested a rebrand for CalOptima
  - Name in use since 1995; logo last updated in 2009
- Proposed Names
  - CalOptima Health and CalOptima Health Plan
  - CalOptima Health preferred as the broader option that functions as an umbrella brand for various health plans and other future programs
- Logo Design
  - Internal and external design teams developed many logo options
  - Executive leadership and Board Chair and Vice Chair provided preliminary feedback in April/May
  - Designs were further honed and shared in June with select staff, members and community stakeholders to gauge impact
  - CalOptima Board Strategic Ad Hoc Committee provided input in July about the final logo options

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CalOptima Health

Attributes

Connection, community, multicultural, integrated, safety net, inspiration, celebration, energy and joy

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CalOptima Health

CalOptima Health

CalOptima Health

Medi-Cal
CalOptima Health

OneCare
CalOptima Health

PACE
CalOptima Health

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 4, 2022
Regular Meeting of the CalOptima Board of Directors

Report Item
15. Approve Amendments to CalOptima Bylaws

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

Recommended Action
Approve amendments to CalOptima bylaws (Bylaws), effective August 4, 2022.

Background
CalOptima's Bylaws were formally adopted by the CalOptima Board of Directors (Board) on December 6, 1994. The Bylaws set forth the Board's purpose and provided direction to its proceedings. They also provided for the establishment of Board Committees and advisory committees.

Discussion
The Bylaws have served the Board and CalOptima staff for nearly 28 years and have not been amended since initial adoption. To modernize the Bylaws and to be consistent with similar public agency health plans, staff recommends the following amendments:

- **Add section 4.8: Prohibition on CalOptima Employment**
  A Director who is also a member of the Board of Supervisors may not be employed by CalOptima for a period of one year after the Director's term expires, or after the Director resigns or is removed from the Board.

- **Amend section 11.1: Claims**
  CalOPTIMA is subject to Division 3.6 of Title 1 of the California Government Code, pertaining to claims against public entities. The Chief Executive Officer or designee is authorized to perform those functions of the Board specified in Part 3 of that Division, including the allowance, compromise, or settlement of any claims if the amount to be paid from CalOPTIMA's treasury does not exceed $50,000 per individual claim, or $300,000 total per lawsuit, demand, or arbitration matter. Any allowance, compromise or settlement of any claim in which the amount to be paid from CalOPTIMA's treasury exceeds $10,000 per individual claim shall be approved personally by the Chief Executive Officer, rather than ~~his or her~~their designee.

In addition to the material changes above, staff recommends adding a definition for the term "resolution" and non-substantive grammatical edits.

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Fiscal Impact
There is no fiscal impact.

Rationale for Recommendation
The recommended amendments to the Bylaws modernize the Bylaws to serve the Board and the CalOptima staff into the future.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Amended Bylaws

/s/ Michael Hunn *07/28/2022*
Authorized Signature **Date**

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ADOPTED: December 6, 1994
Amended and Revised August XX, 2022

BYLAWS
OF
ORANGE COUNTY HEALTH AUTHORITY
ORANGE PREVENTION AND TREATMENT INTEGRATED MEDICAL ASSISTANCE

ARTICLE I
DEFINITIONS

1.1 "Ad Hoc Committee" means a committee or work group composed solely of Directors which are less than a quorum of the Board, which does not have continuing subject matter jurisdiction, and does not have a meeting schedule fixed by charter, ordinance, Resolution or other formal action of the Board.

1.2 "Board" means the Board of Directors of CalOPTIMA.

1.3 "Board of Supervisors" means the Board of Supervisors of the County of Orange.

1.4 "Brown Act" means the Ralph M. Brown Act (Gov. Code § 54950 et. seq.).

1.5 "Bylaws" means the bylaws of CalOPTIMA.

1.6 "Chair" means the Chairperson of the Board of Directors.

1.7 "Chief Executive Officer" means the non-Board officer designated in Section 9.1 of these Bylaws.

1.8 "Committee" shall include both committees and subcommittees of the Board, unless otherwise specified. "Committee" shall not include "Ad Hoc Committees." The Advisory Committees specified in Section 4-11-15 of the Ordinance are Committees.

1.9 "County" means the County of Orange.

1.10 "Director" means a member of the Board of Directors of CalOPTIMA.

1.11 "CalOPTIMA" means the Orange County Health Authority, doing business as Orange Prevention and Treatment Integrated Medical Assistance.

1.12 "Ordinance" means Ordinance No. 3896 of the County of Orange, adding Division 11 to Title 4 of the codified ordinances of the County of Orange.

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1.13 "Resolution" means any action taken by the Board which requires a vote and is thereafter evidenced in the Board meeting minutes.

ARTICLE II
ORGANIZATION, POWERS AND PURPOSES

2.1 Authority.

a. These Bylaws are adopted by CalOPTIMA to establish rules for its proceedings pursuant to the authority of Section 4-11-13 of the Ordinance. CalOPTIMA is a local public agency and political subdivision of the State of California created by the Ordinance, pursuant to authority for such creation conferred by Welfare and Institutions Code section 14087.54.

b. CalOPTIMA is an entity separate and distinct from the County. Any obligations of CalOPTIMA, statutory, contractual or otherwise, shall be the obligations solely of CalOPTIMA and shall not be the obligations of the County or of the State of California unless expressly provided for in a contract between CalOPTIMA and the County or State of California.

2.2 Purposes.

The purposes of CalOPTIMA are as set forth in the Ordinance.

2.3 Powers.

a. CalOPTIMA shall have and enjoy all rights, powers, duties, privileges and immunities vested in the County pursuant to Article 2.8 (commencing with Section 14087.5) of Chapter 7, Part 3 of Division 9 of the Welfare and Institutions Code, and shall have and enjoy such other rights, powers, duties, privileges and immunities as provided in applicable law or which are necessary and proper to carry out the purposes of CalOPTIMA.

b. Without limiting the generality of Section 2.3(a), CalOPTIMA shall have the right to:

(1) Acquire, possess and dispose of real or personal property, as may be necessary for the performance of its functions.

(2) Contract for services to meet its obligations.

(3) Employ personnel.

(4) To sue and be sued.

(5) To adopt a seal and file such seal with the office of the County Clerk and Secretary of State.

(6) Borrow such funds as may be necessary and proper.

(7) Other powers as may be specified in the Ordinance and by other provisions of law.

ARTICLE III
OFFICES

3.1 Principal Office.

The principal office for the transaction of business of CalOPTIMA shall be fixed and located at a location within the County designated by the Board.

ARTICLE IV
BOARD OF DIRECTORS

4.1 Powers.

The Board of Directors is the governing body of CalOPTIMA. Except as otherwise provided by the Ordinance or these Bylaws, the powers of CalOPTIMA shall be exercised, its property controlled and its business and affairs conducted by or under the direction of the Board. The Board may delegate the management of CalOPTIMA's activities to any person(s) or Committees, however composed, provided that all the activities and affairs of CalOPTIMA shall be managed and all powers shall be exercised under the ultimate direction of the Board. No assignment, referral or delegation of authority by the Board shall preclude the Board from exercising full authority over the conduct of CalOPTIMA' s activities, and the Board may rescind such assignment, referral or delegation at any time.

4.2 Number and Qualifications of Directors.

The number and qualifications of Directors are as set forth in the Ordinance.

4.3 Term of Office.

a. The Board of Supervisors shall establish the term of office for the Director who is also a member of the Board of Supervisors, which term shall not exceed four years or other length of time established by amendment to Section 4-11-12 of the Ordinance.

b. The term of office for the Directors who are not also members of the Board of Supervisors shall be four (4) years; provided, however, that the terms of the original Directors shall be staggered to provide that one-half of those original Directors shall serve a term of three (3) years and the other half shall serve a full term of four (4) years to ensure continuity of policy. The initial appointment terms for such Directors shall be drawn by lots.

c. Directors may serve for a maximum of two (2) terms.

d. An orientation shall be provided which familiarizes each new Director with their duties and responsibilities.

e. In accordance with the Brown Act, any person appointed to serve as a Director who has not yet assumed the duties of their office shall conform their conduct to the requirements of Article 5 below.

4.4 Attendance and Participation.

a. Directors must attend the regular and special meetings of the Board and of Committees to which they are appointed and shall contribute their time and special abilities as may be required for the benefit of CalOPTIMA. If a Director is unable to attend a meeting, he or she shall so inform the Clerk giving the reason therefor, and the Clerk shall in turn inform the Chair who may rule in their sole and absolute discretion that the absence shall be excused. Alternatively, the Chair may recommend to the Board that the absence be deemed unexcused, and the Board shall make the final determination as to whether the absence shall be excused.

b. Failure of a Director to attend a regular or special meeting of the Board, or of Committees to which he or she is appointed, without first notifying the Clerk of an inability to attend the meeting shall, except in cases of emergency or extreme hardship (as determined by the Chair in their sole absolute discretion), be treated as an unexcused absence.

4.5 Vacancies.

With the exception of the Director appointed by the Board of Supervisors who is also a County Supervisor, appointments to the Board are based on the Director's representation of a particular group, such as health care providers or other organizations. A seat on the Board shall become vacant if a Director no longer is a member of, no longer represents, the group that qualified the Director for an appointment to the Board, or otherwise is no longer eligible under applicable law to serve as a Director. Vacancies shall be filled by the Board of Supervisors for the remainder of the unexpired term in accordance with the Ordinance.

4.6 Resignation and Removal.

a. Any Director may be removed from office by a majority vote of the Board of Supervisors favoring such removal.

b. Any Director may resign effective upon giving written notice to the Chair, the Clerk of the Board, and the Clerk of the Board of Supervisors, unless the notice specifies a later time for the effectiveness of such resignation.

c. If a Director has unexcused absences from three consecutive regular meetings or from three of any five consecutive meetings of the Board, the Board may pass a Resolution which recommends that the Board of Supervisors immediately remove such Director from the Board and appoint a successor to fill the remainder of the unexpired term.

4.7 Expenses.

Board members shall be reimbursed for their reasonable traveling, incidental and other expenses, when traveling outside the County, and incurred in the performance of official business of CalOPTIMA, in accordance with a policy as approved by the Board.

4.8 Prohibition on CalOptima Employment

A Director who is also a member of the Board of Supervisors may not be employed by CalOptima for a period of one year after the Director's term expires, or after the Director resigns or is removed from the Board.

ARTICLE V
BOARD MEETINGS

5.1 Board Meeting.

a. A meeting of the Board is any congregation of a majority of the Directors at the same time and place to hear, discuss or deliberate upon any item that is within the subject matter jurisdiction of the Board.

b. A meeting of the Board is also the use of direct communication, personal intermediaries or technological devices that are employed by a majority of the Directors to develop a collective concurrence as to action to be made on an item by the Directors.

c. A meeting of the Board shall not be construed to exist when any of the following occur:

(1) A Director makes individual contact with any person not a Director.

(2) The attendance of a majority of the Directors at a conference or similar gathering open to the public that involves a discussion of issues of general interest to the public or to public agencies with similar functions or interests as CalOPTIMA, provided that a majority of the Directors do not discuss among themselves business of a specific nature that is within CalOPTIMA' s subject matter jurisdiction.

(3) The attendance of a majority of the Directors at an open and publicized meeting organized to address a topic of local community concern by a person or organization other than CalOPTIMA, provided that a majority of the Directors do not discuss amongthemselves business of a specific nature that is within CalOPTIMA's subject matter jurisdiction.

(4) The attendance of a majority of the Directors at an open and noticed meeting of the legislative body of another local public agency, provided that a majority of the Directors do not discuss among themselves, other than as part of the schedule meeting, business of a specific nature that is within CalOPTIMA's subject matter jurisdiction.

(5) The attendance of a majority of the Directors at a purely social or ceremonial occasion, provided that a majority of the Directors do not discuss among themselves business of a specific nature that is within CalOPTIMA's subject matter jurisdiction.

5.2 Regular Meetings.

a. Regular meetings of the Board shall be held at a location as may be designated by Board action from time to time by the Board.

b. The Board shall conduct an annual organizational meeting at a regular meeting to be designated in advance by the Board. At the annual organizational meeting, the Board shall:

(1) Adopt a schedule stating the dates, times and places of the Board's regular meetings for the following year. A tentative proposed schedule for the Board's regular meetings shall have been distributed at the regular Board meeting preceding the organizational meeting.

(2) Organize itself by the election of one of its Directors as Chair and one as Vice Chair, and by the election of such other officers as the Board may deem appropriate.

5.2 Notice and Meeting; Agendas.

a. The Chief Executive Officer shall prepare, or cause to be prepared, an agenda for every regular and special meeting of the Board, which shall set forth the time and location of the meeting, and a brief general description of each item of business to be transacted or discussed at the meeting, including items to be discussed in closed session. A brief general description of the item generally need not exceed twenty (20) words.

b. At least 72 hours before a regular meeting, the Chief Executive Officer shall cause to be posted the agenda for the meeting in a location that is freely accessible to members of the public.

c. Action may be taken by the Board only on items appearing on the posted agenda. "Action taken" means a collective decision, collective commitment or promise made by a majority of the Directors to make a positive or negative decision, or an actual vote by a majority of the Directors upon a motion, proposal, Resolution or order. No action shall be taken on any item not appearing on the posted agenda, unless one of the following conditions exists:

(1) The Board has determined, by a majority vote, that an emergency situation exists. An emergency situation, for purposes of these Bylaws, means either: (a) a work stoppage

or other activity which severely impairs public health, safety, or both, or (b) a crippling disaster which severely impairs public health, safety, or both.

(2) Upon a determination by a two-thirds vote of the Board, or, if less than two-thirds of the Directors are present, a unanimous vote of those Directors present, that there is a need to take immediate action and that the need for action came to the attention of the Board subsequent to the agenda being posted.

(3) The item was posted, as required above, for a prior meeting of the Board occurring not more than five calendar days prior to the date action is taken on the item, and at the prior meeting the item was continued to the meeting at which the action is being taken.

(4) The Board may briefly respond to statements made or questions posed by the public at the meeting. In addition, on its own initiative, or in response to questions posed by the public, the Board may ask a question for clarification, provide a reference to staff or other resources for factual information, or request staff to report back to the Board at a subsequent meeting. Furthermore, a Director or the Board itself may take action to place a matter of business on a future agenda.

d. Except as specified in Sections 5.3(d)(l) and 5.5(b) below, the Clerk shall give mailed notice of every regular meeting, and any special meeting which is called, at least one week prior to the date set for the meeting, to any person who has filed a written request for such notice with the Board.

(1) The Board may give such notice as it deems practical of special meetings called less than seven (7) days prior to the date set for the meeting, or in the case of an emergency meeting, telephonic notice in accordance with Section 5.S(b).

(2) Any request for notice shall be valid for one (1) year from the date on which it is filed unless a renewal request is filed. Renewal requests for notice shall be filed within ninety (90) days after January I of each year. The Board may establish by Resolution a reasonable annual charge for sending such notice based on the estimated cost of providing such service.

5.4 Members of the Public.

a. Every agenda for regular meetings shall provide an opportunity for members of the public to directly address the Board on items of interest to the public that are within the subject matter jurisdiction of the Board, provided that no action shall be taken on any item not appearing on the agenda unless the action is otherwise authorized by section 5.3.

b. The Chair may adopt reasonable regulations to insure that the intent of this section is carried out, including, but not limited to, regulations limiting the total amount of time allocated for public testimony on particular issues and for each individual speaker. If further public discussion and comment is needed on a particular issue, the Board may vote to allot further time in the same meeting, or allot time in the agenda of the following meeting.

c. Members of the public shall not be required, as a condition of attendance at a Board meeting, to register their name or provide other information. If an attendance list, register or other similar document is posted or circulated at the meeting, it shall state clearly that the signing, registering or completion of the document is voluntary and that all persons may attend the meeting regardless of whether a person does so.

d. The Board shall not prohibit public criticism of the policies, procedures, programs or services of CalOPTIMA or the acts or omissions of the Board or its officers, employees and/or consultants.

5.5 Special Meetings.

a. A special meeting may be called at any time by the Chair, or by four Directors, by delivering personally or by mail written notice to each Director and to each local newspaper of general circulation, radio or television station requesting notice in writing.

(1) Such notice must be delivered personally or by mail at least 24 hours before the time of such meeting as specified in the notice. The call and notice shall specify the time and place of the special meeting and the business to be transacted. No other business shall be considered at special meetings.

(2) The call and notice shall also be posted at least 24 hours prior to the special meeting in a location that is freely accessible to members of the public. Notice shall be required pursuant to this section 5.5 regardless of whether any action is taken at the special meeting.

(3) Such written notice may be dispensed with as to any Director who, at or prior to the time the meeting convenes, files with the Clerk a written waiver of notice. Such waiver may be given by telegram. Such written notice may also be dispensed with as to any Director who is actually present at the meeting at the time it convenes.

b. In the case of an emergency situation involving matters upon which prompt action is necessary due to the disruption or threatened disruption of public facilities, the Board may hold an emergency meeting without complying with either the 24-hour notice requirement or the 24-hour posting requirement, or both requirements. For purposes of this section, "emergency situation" shall have the same meaning as in Section 5.3(c)(l).

(1) In the event the notice and/or posting requirements are dispensed with due to an emergency situation, each local newspaper of general circulation and radio or television station which has requested notice of special meetings shall be notified by the Chair, or their designee, one hour prior to the emergency meeting, by telephone. All telephone numbers provided in the most recent request of such newspaper or station for notification of special meetings shall be exhausted. In the event that telephone services are not functioning, the notice requirements of this paragraph shall be deemed waived, and the Board, or its designee, shall notify those newspapers, radio stations or television stations

of the fact of the holding of the emergency meeting, the purpose of the meeting, and any action taken at the meeting as soon after the meeting as possible.

(2) Notwithstanding Section 5.8(b) of these Bylaws, the Board shall not meet in closed session during a meeting called as an emergency meeting. With the exception of the 24-hour notice and posting requirements, all special meeting requirements prescribed in this section shall be applicable to a meeting called due to an emergency situation.

(3) The minutes of a meeting called due to an emergency situation, a list of persons who the Chair, or his designee, notified or attempted to notify, a copy of the roll call vote, and any actions taken at the meeting shall be posted for a minimum of ten days in a public place as soon after the meeting as possible.

5.6 Quorum and Action at Board Meeting.

a. A majority of the Directors shall constitute a quorum for the transaction of business. Except as otherwise provided by law or these Bylaws, the act of a majority of the Directors present at a meeting at which a quorum is present shall be the act of the Board. No act of the Board shall be valid unless at least a majority of those Directors constituting a quorum concur therein. Any act of the Board shall be accomplished by a roll call vote when such a vote is requested by any Director in attendance. The Board shall not take action by secret ballot, whether preliminary or final.

b. The Board shall adopt a form of agenda for its regular and special meetings which may include consent, individual action, public, and board comments sections.

c. Items on the meeting agenda shall be considered in order by the Board unless the Chair shall announce a change in the order of consideration.

d. Unless an agenda item specifies a particular source for a report, the Chief Executive Officer, Board staff and consultants shall report first on the item. The item shall then be open to public comment upon recognition of the speaker by the Chair.

e. A Director shall disqualify himself or herself from voting on any matter before the Board, and shall take further appropriate action to remove himself or herself from Board consideration of any such matter, when required pursuant to the provisions of Article XII of these Bylaws or applicable law.

5.7 Adjournment and Continuance.

a. The Board may adjourn any regular, adjourned regular, special or adjourned special meeting to a time and place specified in the order of adjournment. Less than a quorum may so adjourn from time to time. If no Directors are present at a meeting, the Clerk may declare the meeting adjourned to a stated time and place and shall cause written notice to be given in the same manner as provided in section 5.5 of these Bylaws for special meetings, unless such notice

is waived as provided for special meetings.

b. A copy of the order or notice of adjournment shall be conspicuously posted on or near the door of the place where the meeting was held within 24 hours after the time of the adjournment. When a regular or adjourned regular meeting is adjourned as provided in this section, the resulting adjourned regular meeting is a regular meeting for all purposes.

c. The Board may continue any hearing being held or noticed or ordered to be held at any meeting to a subsequent meeting by order or notice of continuance provided in the same manner as set forth above for the adjournment of meetings; provided, that if the meeting is continued to a time less than 24 hours after the time specified in the order or notice of hearing, a copy of the order or notice of continuance of hearing shall be posted immediately following the meeting at which the order or declaration of continuance was adopted or made.

5.8 Public Meetings.

a. Meetings of the Board shall be open to the public, except as otherwise provided herein.

b. The Board may hold closed sessions during a meeting for the following purposes:

(1) To consider the appointment, employment, evaluation of performance or dismissal of a public employee or to hear complaints or charges brought against the employee by another person or employee unless the employee requests a public session. As a condition to holding a closed session on specific complaints or charges brought against an employee by another person or employee, the employee shall be given written notice of their right to have the complaint or charges heard in an open session rather than a closed session, which notice shall be delivered to the employee personally or by mail at least 24 hours before the time for holding the session. If notice is not given, any disciplinary or other action taken by the Board against the employee based on the specific complaints or charges in the closed session shall be null and void. The Board may exclude from that public or closed meeting, during the examination of a witness, any or all other witnesses in the matter being investigated by the Board. The term "employee" shall include an officer or an independent contractor who functions as an officer or an employee but shall not include any Director or other independent contractor. During the closed session, the Board shall not discuss or act on an employee's proposed compensation except for a reduction of compensation that results from the imposition of discipline.

(2) To meet with its designated representatives regarding the salaries, salary schedules, or compensation paid in the form of fringe benefits of its represented and unrepresented employees and for represented employees, any other matter within the statutorily-provided scope of representation. "Employee" shall have the same meaning for this closed session as described in section 5.8(b)(l) above. During the closed session, the Board may include discussions with CalOPTIMA's designated representatives of CalOPTIMA's available funds and funding priorities, but only as these discussions relate

to providing instructions to the designated representatives.

(3) To meet with its negotiator prior to the purchase, sale, exchange, or lease of real property by or for CalOPTIMA, or to give instructions to its negotiator regarding the price and terms of payment for the purchase, sale, exchange, or lease. However, prior to the closed session, the Board shall hold an open and public session in which it identifies the real property or real properties which the negotiations may concern and the person or persons with whom its negotiator may negotiate. For the purposes of this section, the negotiator may be a Director, and "lease" includes renewal or renegotiation of a lease.

(4) Based on advice of its legal counsel, to confer with, or receive advice from, its legal counsel regarding pending litigation when discussion in open session concerning those matters would prejudice the position of CalOPTIMA in the litigation. Prior to holding a closed session pursuant to this section, the Board shall state on the agenda or publicly announce the subdivision of Government Code section 54956.9 that authorizes the closed session. If the session is closed because of litigation to which CalOPTIMA is a party has been formally initiated, the Board shall state the title of or otherwise specifically identify the litigation to be discussed, unless the Board states that to do so would jeopardize CalOPTIMA' s ability to effectuate service of process upon one or more unserved parties, or that to do so would jeopardize its ability to conclude existing settlement negotiations to its advantage. For purposes of this section, "litigation" includes any adjudicatory proceeding, including eminent domain, before a court, administrative body exercising its adjudicatory authority, hearing officer, or arbitrator. For purposes of this section, litigation shall be considered pending when any of the following circumstances exist:

(a) Litigation to which CalOPTIMA is a party has been formally initiated.

(b) (i) A point has been reached where, in the opinion of the Board on the advice of its legal counsel, based on existing facts and circumstances, there is significant exposure to litigation against CalOPTIMA, or

(ii) based on existing facts and circumstances, the Board is meeting only to decide whether a closed session is authorized under subparagraph (b)(l) above.

(c) Based on existing facts and circumstances, the Board has decided to initiate or is deciding whether to initiate litigation.

(5) Any other closed session authorized pursuant to applicable state or federal law or regulation.

c. Prior to holding any closed session, the Board must disclose, in an open meeting, the item or items to be discussed in the closed session. The Board may use the sample closed session agenda descriptions contained in the Brown Act (Gov. Code § 54954.5). The disclosure may take the form of a reference to the item or items as they are listed by number or letter on the

agenda. In the closed session, only those matters covered in the statement can be considered by the Board.

d. After any closed session, the Board shall reconvene into open session prior to adjournment and shall make any disclosures required by the Brown Act concerning final actions.

5.9 Disrupted Meetings.

In the event that any meeting is interrupted by a group or groups of persons rendering the orderly conduct of such meeting unfeasible, and order cannot be restored by the removal of individuals who were willfully interrupting the meeting, the Board may order the meeting room closed and continue in session. Only matters appearing on the agenda may be considered in such a session. Representatives of the press or other news media, except those participating in the disturbance, shall be allowed to attend any session held pursuant to this section. The Board may establish a procedure for readmitting an individual or individuals not responsible for willfully disrupting the orderly conduct of the meeting.

5.10 Minutes.

The Clerk or designee shall prepare minutes of each meeting of the Board. Except as otherwise provided in the Brown Act for minutes of closed sessions, the minutes shall be an accurate summary of the Board's consideration of the matters before it and an accurate record of each action of the Board. Except for minutes of closed sessions, at a subsequent meeting, the Clerk shall submit the minutes to the Board for approval by a majority vote of the Directors in attendance at the meeting covered by the minutes. When approved, copies of the minutes shall be forwarded by the Clerk or designee to the Chief Executive Officer.

ARTICLE VI
BOARD COMMITTEES

6.1 Establishment: Appointment of Committee Members.

a. All Committees shall be established by these Bylaws or by Board action, and shall be established for any purpose as the Board deems necessary or beneficial in accomplishing the purposes of CalOPTIMA.

b. Committees shall be subject to the requirements of the Brown Act.

c. The Chair may designate alternate members of any Committee to stand in for any absent Director at any meeting of the Committee. The chair of each Committee shall be appointed by the Chair of the Board, except that the Chair of each of the Advisory Committees shall be elected by the Board

d. All Committees shall be advisory only to the Board unless otherwise specifically authorized to act by the Board.

6.2 Ad Hoc Committees.

a. Ad Hoc Committees may be appointed by the Chair for special tasks as circumstances warrant, and shall be composed solely of Directors, and upon completion of the task for which appointed, such Ad Hoc Committee shall stand discharged. Some of the functions that may be the topic of Ad Hoc Committees include, but are not limited to, the review of new projects, the review of special Bylaw changes or the review of the Bylaws periodically, meeting with other public agencies or health facilities on a specific topic, and the evaluation of the Board.

b. The Chair shall make assignments to Ad Hoc Committees to assure that each Director shall have equal participation on Ad Hoc Committees throughout the year.

c. Ad Hoc Committees shall always be advisory in nature.

6.3 Advisors.

A chair of a Committee or an Ad Hoc Committee may invite individuals with expertise in a pertinent area to meet with and assist the Committee or Ad Hoc Committee. Such advisors shall not vote or be counted in determining the existence of a quorum and may be excluded from any Committee session not otherwise open to the public.

6.4 Meetings and Notice.

a. Regular meetings of Committees shall be held at such times and places as are determined by the Board. Special meetings of Committees may be held at any time and place as may be designated by the Chair or the chair of the Committee, or by a majority of the voting members of the Committee.

b. Regular and special meetings of a Committee shall be noticed in accordance with sections 5.3 and 5.5, respectively, of these Bylaws.

c. Meetings of Ad Hoc Committees shall be noticed as directed by the chair of the Ad Hoc Committee.

6.5 Quorum.

A majority of the members of a Committee or Ad Hoc Committee shall constitute a quorum for the transaction of business at any meeting of such Committee or Ad Hoc Committee. Each Committee and Ad Hoc Committee shall keep minutes of its proceedings and shall report periodically to the Board.

6.6 Manner of Acting.

The act of a majority of the members of a Committee or Ad Hoc Committee present at a meeting at which a quorum is present shall be the act of the Committee or Ad Hoc Committee so meeting. Regular and special meetings of Committees shall be conducted in accordance with

applicable provisions of Article V of these Bylaws. Ad Hoc Committee action may be taken without a meeting by a writing setting forth the action so taken signed by each member of the Ad Hoc Committee entitled to vote.

6.7 Tenure.

Each member of a Committee or Ad Hoc Committee shall hold office until a successor is appointed. Any member of an Ad Hoc Committee may be removed at any time by the Chair. The Board may remove any member of a Committee. A Director shall cease to hold membership in an Ad Hoc Committee upon ceasing to be a Director.

6.8 Minutes.

The Clerk or designee shall prepare minutes of each meeting of every Committee. The minutes shall accurately summarize the consideration of all matters, and shall accurately record all action taken. At a subsequent meeting, the Clerk shall submit the minutes to the Committee for approval by a majority vote of the members in attendance at the meeting covered by the minutes. When approved, copies of the minutes shall be forwarded by the Clerk to the Board and Chief Executive Officer.

ARTICLE VII
ADVISORY COMMITTEES

7.1 Establishment.

a. The Board may establish and appoint Advisory Committees for any purpose that will be necessary and beneficial in accomplishing the work of CalOPTIMA, in a number and with qualifications as set forth in the Resolution of the Board establishing the Advisory Committee or the policy governing such Advisory Committee.

b. The following Advisory Committees are hereby established and appointed:

1. Provider Advisory Committee.

2. Member Advisory Committee.

7.2 Purpose.

Advisory Committees of CalOPTIMA shall be solely advisory in nature. As directed by the Board they are:

(1) Intended to provide advice and recommendations to the Board on issues concerning the CalOPTIMA program.

(2) To engage in study and research on issues assigned to them by the Board.

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(3) To assist the Board in obtaining public opinion on issues related to the CalOPTIMA program.

(4) To facilitate community outreach for CalOPTIMA and the Board.

7.3 Policy

The Board shall by Resolution adopt and, from time to time may amend, a policy setting forth member qualifications, requirements for meetings (including compliance with the Brown Act), items of procedure, and other matters relating to the overall operations and purposes of Advisory Committees established by the Board.

ARTICLE VIII
OFFICERS OF THE BOARD OF DIRECTORS

8.1 Chair.

a. The Board shall elect one of its Directors as Chair at an organizational meeting. In the event of a vacancy in the office of Chair, the Board may elect a new Chair.

b. The Chair shall be the principal officer of the Board, and shall preside at all meetings of the Board. The Chair shall appoint all members of the Ad Hoc Committees, as well as the chair of the Ad Hoc Committees and all Committees other than the Member and Provider Advisory Committees. In addition, the Chair shall perform all duties incident to the office and such other duties as may be prescribed by the Board from time to time.

8.2 Vice Chair.

The Board shall elect one of its Directors as Vice Chair at an organizational meeting. The Vice Chair shall perform the duties of the Chair if the Chair is absent from the meeting or is otherwise unable to act. If both the Chair and Vice Chair are absent from the meeting, or are unable to act, the Directors present at the meeting shall select one of the Directors present to act as temporary Chair, who, while so acting, shall have all of the authority of the Chair.

8.3 Tenure.

Each officer described above in this Article VIII shall serve a one (1) year term, commencing on the first day of the month after the organizational meeting at which he or she is elected to the position. Each officer shall hold office until the end of the one (1) year term, or until a successor is elected, unless he or she shall sooner resign or be removed from office.

8.4 Vacancies, Removal and Resignation.

a. A vacancy in any office for any cause whatsoever shall be filled by Resolution of the Board at any regular or special meeting of the Board.

b. An officer described above may be removed from office by the affirmative vote of four Directors, not counting the affected Director. In addition, an officer described above will automatically be removed from office when their successor is selected and is appointed as a Director.

c. Any officer may resign effective on giving written notice to the Clerk, unless the notice specifies a later time for their resignation to become effective. Upon receipt of such notice, the Clerk shall notify the Chair thereof and shall enter the notice in the proceedings of the Board.

8.5 Other Officers.

The Board may designate such other officers of the Board as the Board may from time to time determine that CalOPTIMA requires and may elect one of its Directors to discharge the duties of any such office.

ARTICLE IX
OTHER OFFICERS

9.1 Chief Executive Officer.

a. The Board shall select and employ a Chief Executive Officer, who shall report to the Board and who shall be the Board's direct executive representative in the development and management of the affairs of CalOPTIMA. The Chief Executive Officer shall serve at the pleasure of the Board, subject to the provisions of any contract of employment between CalOPTIMA and the Chief Executive Officer.

b. The Chief Executive Officer shall have such duties and responsibilities as the Board may from time to time reasonably direct. Without limiting the generality of the foregoing, the Chief Executive Officer shall be responsible for:

(1) Implementing the policies, procedures and practices of CalOPTIMA as adopted by the Board.

(2) Acting as the duly authorized representative of CalOPTIMA in all matters in which the Board has not formally designated some other person to act.

(3) Managing and directing the operations of CalOPTIMA, including responsibility for sound personnel, financial, accounting, legal and statistical information practices, such as preparation of CalOPTIMA budgets and forecasts, maintenance of proper financial and other statistical records, collection of data required by governmental and accrediting agencies, and special studies and reports required for efficient operation of CalOPTIMA problems.

(4) Providing leadership by promoting morale and resolving conflicts and problems

(5) Implementing community relations activities, including, public appearances, responsive communication with the media.

(6) Developing and maintaining positive ongoing relations with local, State and federal government officials and agencies.

(7) Assisting the Board in planning services and facilities and informing the Board of governmental legislation and regulations and requirements of official agencies and accrediting bodies, which affect the planning and operation of the facilities, services and programs sponsored by CalOPTIMA, and maintaining appropriate liaison with government and accrediting agencies and implementing actions necessary for compliance.

(8) Employing and discharging (subject to the pleasure of the Board, any contract of employment, and CalOPTIMA personnel employment policies), such subordinate officers and employees as are necessary for the purpose of carrying on the normal functions of CalOPTIMA.

(9) Administrating all contracts to which CalOPTIMA is a party.

(10) Providing the Board, Committees, and Ad Hoc Committees with adequate staff support.

(11) Sending periodic reports to the Board on the overall activities of CalOPTIMA and CalOPTIMA's finances and financial status, as well as pertinent federal, state and local developments that effect CalOPTIMA's operations.

(12) Maintaining insurance or self-insurance to cover the physical properties and activities of CalOPTIMA.

(13) Developing, amending, promulgating and implementing personnel policies for CalOPTIMA.

9.2 Chief Financial Officer.

a. The Chief Financial Officer shall keep and maintain, or cause to be kept and maintained, adequate and correct accounts of the properties and business or financial transactions of CalOPTIMA, shall prepare or cause to be prepared financial statements as law or these Bylaws require. The books of account shall at all times be open to inspection by any Director.

b. The Chief Financial Officer shall deposit all monies and other valuables in the name and to the credit of CalOPTIMA with depositories designated by the Board. The Chief Financial Officer shall disburse the funds of CalOPTIMA as ordered or authorized by the Board, shall render to the Chair and Directors, whenever they request it, an account of all transactions and of the financial condition of CalOPTIMA, and shall have other powers and perform other

duties as prescribed by the Board and/or the Chief Executive Officer.

9.3 Clerk.

a. The Clerk shall have the following duties:

(1) Keeping a book of the minutes of all meetings of the Board at the principal office of CalOPTIMA or other place ordered by the Board, and of its Committees.

(2) Giving or causing to be given appropriate notices in accordance with these Bylaws or as required by law.

(3) Attesting to the Chair's, Vice-Chair's, Chief Executive Officer's, or other authorized signatory's signature on documents executed on behalf of CalOPTIMA.

(4) Acting as custodian of CalOPTIMA's records and reports and of CalOPTIMA's seal, if one is adopted.

(5) Causing a statement meeting the requirements of Government Code section 53051 to be filed with the Secretary of State and the County Clerk to list CalOPTIMA on the "Roster of Public Agencies"; and causing an amended statement to be filed with the Secretary of State and County Clerk within ten (10) days of any change in the facts set forth in the original or a subsequently amended statement.

(6) Providing a copy of the Brown Act to each Director, and to each person appointed to serve as a Director who has not assumed the duties of office.

(7) Having such other duties as may be prescribed by Resolution of the Board or these Bylaws.

9.4 Subordinate Officers.

The Board may empower the Chief Executive Officer to select and employ such other non-Board officers as CalOPTIMA may require, each of whom shall hold office for such period, have such authority, and perform such duties as the Board or Chief Executive Officer may from time to time determine.

ARTICLE X
EXECUTION OF INSTRUMENTS

10.1 Contracts and Instruments.

a. The Board may authorize any officer or officers, agent or agents, employee or employees to enter into any contract or execute any instrument in the name of and on behalf of the Board, and this authority may be general or confined to specific instances; and, unless so

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authorized or ratified by the Board, no officer, agent, or employee shall have any power or authority to bind CalOPTIMA by any contract or engagement or to render it liable for any purpose or for any amount.

b. Notwithstanding the foregoing Section 9. l(a), the Chief Executive Officer is hereby authorized to enter into any contract or execute any instrument in the name of and on behalf of CalOPTIMA pursuant to policies established by the Board.

c. The Clerk shall have the authority to attest to the signatures of those individuals authorized to enter into contracts or execute instruments in the name of and on behalf of CalOPTIMA and to certify the incumbency of those signatures.

10.2 Checks, Drafts, Evidences of Indebtedness

All checks, drafts or other orders for payment of money, notes or other evidences issued in the name of or on behalf of CalOPTIMA or payable to the order of CalOPTIMA, shall be signed or endorsed by such person or persons and in such manner as, from time to time, shall be determined by Resolution of the Board.

ARTICLE XI
CLAIMS AND JUDICIAL REMEDIES

11.1 Claims

CalOPTIMA is subject to Division 3.6 of Title 1 of the California Government Code, pertaining to claims against public entities. The Chief Executive Officer or designee is authorized to perform those functions of the Board specified in Part 3 of that Division, including the allowance, compromise or settlement of any claims if the amount to be paid from CalOPTIMA's treasury does not exceed $50,000.00 per individual claim, or $300,000 total per lawsuit, demand, or arbitration matter. ~~action~~ Any allowance, compromise or settlement of any claim in which the amount to be paid form CalOPTIMA's treasury exceeds $10,000 per individual claim shall be approved personally by the Chief Executive Officer, rather than their designee.

Rev. 08/04/2022

11.2 Judicial Review

Section 1094.6 of the Code of Civil Procedure shall govern the rights of any person aggrieved by any decision of the Board or CalOPTIMA.

11.3 Claims Procedure

Notwithstanding any exceptions contained in Section 905 of the Government Code, no action based on a claim shall be brought against CalOPTIMA unless presented to CalOPTIMA within the time limitations and in the manner prescribed by Section 910 through 915.2 of the Government Code. Such claims shall further be subject to Section 945.4 of the Government Code.

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ARTICLE XII
CONFLICTS OF INTEREST

12.1 Conflict of Interest Code.

The Board shall by Resolution adopt and, from time to time may amend, a Conflict of Interest Code for CalOPTIMA as required by applicable statutes and regulations.

12.2 No Disqualifying Interest in Contracts.

A Director shall not be deemed to be interested in a contract entered into by CalOPTIMA 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 following requirements set forth in Welfare and Institutions Code section 14087.57 apply:

a. The Director was appointed to represent the interests of physicians, health care practitioners, hospitals, pharmacies or other health care organizations.

b. The contract authorizes the Director or the organization the member represents to provide services to Medi-Cal beneficiaries under CalOPTIMA's program.

c. The contract contains substantially the same terms and conditions as contracts entered into with other individuals and organizations that the Director was appointed to represent.

d. The Director does not influence or attempt to influence the Board or another Director to enter into the contract in which the member is interested.

e. Director discloses the interest to the Board and abstains from voting on the contract.

f. The Board notes the Director's disclosure and abstention in its official records and authorizes the contract in good faith by a vote of its membership sufficient for the purpose without counting the vote of the interested Director.

ARTICLE XIII
MISCELLANEOUS

13.1 Purchase, Hiring, and Personnel.

The Board shall by Resolution adopt and, from time to time may amend, procedures, practices and policies for purchasing and acquiring the use of equipment and supplies, acquiring, constructing and leasing real property and improvements, hiring employees, managing its personnel and for all other matters, in the determination of the Board, as are necessary and

appropriate for the proper conduct of CalOPTIMA' s activities and affairs and the furtherance of its authorized purposes. Copies of all such procedures, practices and policies shall be maintained with the minutes of proceedings of the Board.

13.2 Insurance.

CalOPTIMA shall procure and maintain property, casualty, indemnity and workers' compensation insurance, including without limitation directors' and officers' liability and professional liability coverage, in such amounts and with such carriers as the Board shall from time to time determine shall be prudent in the conduct of its activities; provided that the Board is authorized to arrange the provision of self-insurance or participate in consortia or similar associations to obtain coverage in lieu of commercial coverage.

13.3 Indemnification and Defense.

a. With respect to any civil claim or action against a Director, member of an Advisory Committee or Committee, officer, employee, or a person who formerly occupied such position, for an injury arising out of an act or omission occurring within the scope of such person's duties, CalOPTIMA shall indemnify, hold harmless and defend such persons to the full extent permitted or required under applicable sections of the California Tort Claims Act. (Gov. Code§ 810 et seq.; see, e.g. Gov. Code§§ 825, 825.2, 825.4, 825.6, 995.4, 995.6 and 995.8.)

b. Nothing herein shall be construed to require CalOPTIMA to indemnify and hold harmless any Director, member of an Advisory Committee or Committee, officer, employee, or a person who formerly occupied such position, if CalOPTIMA has elected to conduct the defense of such person(s) pursuant to an agreement reserving CalOPTIMA's rights not to pay a judgment, compromise or settlement until it is established that the injury arose out of an act or omission occurring within the scope of their duties with CalOPTIMA.

13.4 Bonds.

All Directors, as well as all officers, employees and agents or representatives of CalOPTIMA designated by the Board, shall obtain fidelity bonds as required by law and as the Board shall determine is prudent in the conduct of its activities and the activities of such officers, employees, and other designated agents or representatives of CalOPTIMA.

13.5 Public Records.

a. All documents and records of CalOPTIMA, not exempt from disclosure by applicable law, shall be public records under the California Public Records Act (Gov. Code § 6250 et seq.)

b. Any authorized representative of the County shall have the absolute right to inspect and copy all books, records and documents of every kind of CalOPTIMA to determine compliance with the provisions of Section 4-11-7 of the Ordinance, provided such inspection is conducted at a reasonable time following reasonable notice.

13.6 Submission of Bylaws to Board of Supervisors.

The Clerk shall deliver a certified copy of these Bylaws, and any amendments thereto, to the Board of Supervisors.

13.7 Conflict Between Bylaws and Ordinance.

In the event of a conflict between these Bylaws and the Ordinance, the applicable provisions of the Ordinance shall govern.

ARTICLE XIV
AMENDMENT

These Bylaws may be amended or repealed by the affirmative vote of at least two- thirds (2/3) of the authorized number of Directors at any Board meeting. Such amendments or repeal shall be effective immediately, except as otherwise indicated by the Board. The Clerk shall deliver a certified copy of any amendment or repeal of these Bylaws to the Board of Supervisors promptly following the Board meeting at which such amendment or repeal was adopted.

CERTIFICATE OF CLERK

I, the undersigned, do hereby certify:

That I am the duly appointed, qualified and acting Clerk of the Board of Directors for Orange Prevention and Treatment Integrated Medical Assistance ("CalOPTIMA"), a special commission of the County of Orange created pursuant to Section 14087.54 of the Welfare and Institutions Code, and Ordinance No. 3896 of the County of Orange, and

That the foregoing Bylaws attached hereto, comprising 26 pages, including this page, constitute a true, complete and correct copy of the current Bylaws of CalOPTIMA, as duly adopted by the Board of Directors of CalOPTIMA at a regular meeting, duly called and held on the _____ day of _____, at _____, California.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 4, 2022
Regular Meeting of the CalOptima Board of Directors

Report Item

16. Approve Actions Related to Be Well Wellness Hubs

Contacts

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

Recommended Actions

1. Approve an amendment to the contract with the County of Orange Health Care Agency (HCA) that:
    a. Expands the allowable qualified activities in order to increase quality and access to behavioral health services for CalOptima members at the Be Well Wellness Hub; and
    b. Redirects up to $10 million in IGT 5 funds previously allocated for sobering center and peer support services to increase access and quality behavioral health services to CalOptima Medi-Cal members;
2. Authorize the Chief Executive Officer to develop and execute a Grant Agreement with Mind OC, to improve quality and access to enhanced and integrated behavioral health services to CalOptima members at the Be Well Wellness Hub in the city of Irvine;
3. Appropriate funds and authorize unbudgeted expenditures in the amount of up to $15 million from existing reserves to fund the Grant Agreement with Mind OC; and
4. Make a finding that such expenditures are for a public purpose and in furtherance of CalOptima's mission and purpose.

Background

The County of Orange and numerous other local public agencies, hospital systems, non-profit organizations, faith-based organizations, and other community stakeholders came together to promote, facilitate and support existing mental health services and identify gaps in care that exist across the County. That coalition, called Be Well, formed a non-profit entity, Mind OC, to develop financial resources to support the goal of creating a high-quality behavioral health system of care. One priority of Mind OC is to develop regional wellness hubs to provide enhanced services for CalOptima's Medi-Cal members by integrating and co-locating CalOptima and County of Orange mental health and substance abuse services and community-based social support services in a central, easily accessible location that improves access, addresses whole-person care, improves outcomes, and reduces recidivism.

On December 6, 2018, CalOptima entered into an agreement with the HCA to provide $11.4 million as a prepayment for behavioral health services to be provided to CalOptima Medi-Cal members. These services include sobering center services and peer supports to be provided at the Be Well Wellness Hub in the city of Orange.

The Be Well Wellness Hub in Orange, while available to members from all parts of the county, is accessible mainly to members who reside in the surrounding area. To increase access to members who live further from Orange, Mind OC is developing a Wellness Hub in the city of Irvine on a 28-acre site. Once completed, this larger site will support the health and wellness of residents, patients, and the community. The development of the Irvine Wellness Hub will occur in three (3) phases, with services

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added at each phase. Phase 1 will include services targeted for adolescents and adults and will provide crisis stabilization services, sobering center services, residential treatment, and outpatient services. Phase 2 will focus on children and adolescents and will expand residential and outpatient services and provide integrated medical and behavioral health services. Phase 3 will complete the Wellness Hub as a community space with education and training services, community meeting and event space, youth and senior centers, and interfaith shared use space.

Discussion

Staff recommends the Board approve an amendment to the contract with the HCA, which currently provides for sobering and peer support services, to allow up to $10 million of the allocated funds to be redirected for qualified activities to increase quality and access to behavioral health services for CalOptima members. As of July 1, 2022, sobering center services are covered benefits for CalOptima members under CalAIM and funded with CalOptima operating funds. Staff recommends approval to use up to $10 million of the $11.4 million initially set aside for enhanced Medi-Cal services to use towards increasing quality and access to care. The amendment would also allow HCA to use some of those funds to build infrastructure to track and report expansions and quality measures.

Staff further recommend the Board authorize a grant agreement with, and allocate $15 million to, Mind OC to improve quality and access to enhanced and integrated behavioral health services to CalOptima members at the Be Well Wellness Hub in Irvine. CalOptima's commitment of $15 million to this initiative will extend CalOptima's efforts within the County of Orange to meet increasing behavioral health service needs.

Mind OC estimates Phase 1 of the development of the Be Well Wellness Hub in Irvine at an estimated $85 million effort. As planned, the Wellness Hub in Irvine will open in late 2024 for operations, providing CalOptima members with a one-of-a-kind integrated resource for health and wellness.

Fiscal Impact

The recommended action to amend the contract with the HCA, including the redirection of up to $10 million in IGT 5 funds has no additional fiscal impact on the CalOptima Operating Budget. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima Medi-Cal members and does not commit CalOptima to future budget allocations.

The recommended action to execute the Grant Agreement with Mind OC is unbudgeted. An allocation of up to $15 million from existing reserves will fund this action.

Rationale for Recommendation

The recommended actions will support the expansion of accessible and quality behavioral health services for CalOptima members across the county.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

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Attachments

1. Entities Covered by this Recommended Board Action
2. Amendment to the Contract with the County of Orange Health Care Agency

/s/ Michael Hunn *07/28/2022*
Authorized Signature **Date**

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Attachment to the August 4, 2022, Board of Directors Meeting – Agenda Item 16

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip Code
Orange County Health Care Agency	405 W. 5th Street, 7th Floor	Santa Ana	CA	92701
Mind OC	18650 MacArthur Blvd, Ste. 220	Irvine	CA	92612

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FIRST AMENDMENT
TO
BE WELL OC WELLNESS HUB SERVICES CONTRACT

This First Amendment ("**Amendment**") to the Be Well OC Wellness Hub Services Contract ("**Contract**") is made, entered into and effective as of [EFFECTIVE DATE] ("**Amendment Effective Date**") by and between Orange County Health Authority, a public agency dba CalOptima, ("**CalOptima**") and the County of Orange, through its agency, the Orange County Health Care Agency ("**County**"), a political subdivision of the State of California. CalOptima and County may each be referred herein as a "**Party**" and collectively as the "**Parties**".

RECITALS

WHEREAS, the Parties entered into the Contract on June 10, 2019, for the County to provide enhanced services to CalOptima's Members at the County's Be Well OC Wellness Hub that include mental health and substance abuse services, community-based social supportive services, and other related services.

WHEREAS, CalOptima provided the County with an Advanced Funding Amount pursuant to Section 4.10 of the Contract to draw down from as services were rendered to Members.

WHEREAS, the Parties desire to amend the Contract to expand the scope of services for support to CalOptima's Medi-Cal Members and allow the County to use the funds for quality improvement services.

AGREEMENT

NOW, THEREFORE, in consideration of the mutual promises and covenants hereinafter set forth, and for other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the Parties agree to the following:

1. Add the following new Section 3 to Attachment A, *LHA Services at Be Well OC Wellness Hub,* of the Contract:

3. **Enhance Access and Quality Improvement**
   a. Improve access to Medi-Cal services for Members.
   b. Improve the quality of services provided to Members.
   c. Enhance infrastructure to enable County to report quality and capacity outcomes regarding Members to CalOptima.

2. Add the following as the new Section 4.10.2.6 to the Contract:

4.10.2.6. County may use no more than ten million dollars ($10,000,000) of the Advanced Funding Amount on the access and quality improvement services in Section 3 of Attachment A.

3. This Amendment may be executed in multiple counterparts, and counterpart signature pages may be assembled to form a single, fully executed document. Capitalized terms not otherwise defined in this Amendment shall have the same meanings ascribed to them in the Contract.

4. If there is any conflict or inconsistency between this Amendment and the Contract, the provisions of this Amendment shall control and govern. Except as otherwise amended by this Amendment, all of the terms and conditions of the Contract will remain the same and in full force and effect. After the Amendment Effective Date, any reference to the Contract shall mean the Contract as amended and supplemented by this Amendment

IN WITNESS WHEREOF, the Parties hereby execute this Amendment.

COUNTY OF ORANGE, THROUGH ITS AGENCY, THE ORANGE COUNTY HEALTH CARE AGENCY
("**COUNTY**")

By:_____

Print Name:_____

Title: _____

Date:_____

ORANGE COUNTY HEALTH AUTHORITY
("**CALOPTIMA**")

By:_____

Print Name: Michael Hunn

Title: Chief Executive Officer

Date:_____

Approved as to Form:
County Counsel
County of Orange, California

By:_____

Date:_____

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 4, 2022
Regular Meeting of the CalOptima Board of Directors

Report Item
17. Authorize Amendments to the Voluntary Rate Range Intergovernmental Transfer Program for Calendar Year 2021 Health Plan Provider Agreements

Contact
Yunkyung Kim, Chief Operating Officer, (714) 246-8408

Recommended Actions
1. Authorize a reduction in CalOptima's Intergovernmental Transfer funds retention to a 2% administrative fee; and
2. Authorize the Chief Executive Officer to amend the health plan provider agreements with the University of California-Irvine, Children's Hospital of Orange County on behalf of First 5 Orange County Children & Families Commission, the County of Orange, the City of Orange, and the City of Newport Beach, to reflect that change.

Background
The Voluntary Intergovernmental Transfer (IGT) Rate Range Program allows the Department of Health Care Services (DHCS) and CalOptima to secure additional Medi-Cal dollars for eligible Orange County entities. Eligible entities include:

- California State Universities;
- University of California;
- Cities;
- Counties, including First 5 Commissions;
- Health or Hospital Districts; and
- Fire Districts that provide ambulance services.

For each IGT transaction, DHCS identifies the estimated member months for rate categories (e.g., adult, adult optional expansion, child, long term care, seniors and persons with disabilities, and whole child model) and provides the total amount available for Orange County to contribute through funding entities. To receive funds, entities provide a dollar amount to DHCS, which is then used to obtain a federal match. DHCS distributes the funds and the match to the eligible entities through CalOptima.

CalOptima has participated in the IGT program since 2010. For the first 4 IGTs, CalOptima partnered with UCI.

Date	Board Action	IGT
March 3, 2011	Approved CalOptima to initiate the required process and execute agreements, standard required documents and/or applications with the DHCS and UCI to secure additional Medi-Cal funds	IGT 1
March 7, 2013		IGT 2
March 6, 2014		IGT 3
May 7, 2015		IGT 4

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In 2014, CalOptima retained a consultant to assess the capacity of additional Orange County organizations to serve as funding entities for the program and maximize the funds for Orange County. CalOptima partnered with five (5) entities listed below for IGT 5 through IGT 11 and participated at 100% of the allowable non-federal share IGT amount for Orange County:

- UCI;
- County of Orange;
- City of Newport Beach;
- City of Orange; and
- First 5 Orange County (formerly known as the Children and Families Commission).

Date	Board Action	IGT
March 3, 2016	Authorized and/or ratified pursuit of proposal and execution of agreements with funding partners UCI, Children and Families Commission of Orange County, County of Orange, City of Orange, City of Newport Beach, and DHCS to secure additional Medi-Cal funds	IGT 5
March 2, 2017		IGT 6 and 7
December 7, 2017		IGT 8
September 6, 2018		IGT 9
February 6, 2020		IGT 10
December 3, 2020		IGT 11

At the inception of the IGT program in 2010-2011, the CalOptima Board of Directors approved to retain 50% of the net proceeds. At the time, CalOptima retained the flexible funds to support the increase in new CalOptima members through additional enhanced benefits. Funds from 2010 (IGT 1) through 2017 (IGT 7) were more flexible in their allowed use, focusing on enhanced benefits and services to CalOptima members. Funds from IGT 1 through IGT 7 went toward programs, including, but not limited to, personal care coordinators, provider incentives to increase autism screenings, recuperative care, a comprehensive Member Health Needs Assessment (MHNA), community grants to address areas of need identified by the MHNA, and advance funding for mental health services at the Be Well OC Regional Wellness Hub. Beginning in 2018 (IGT 8), DHCS modified the IGT program, limiting the use of IGT funds to contracted Medi-Cal services. With this new understanding of IGT program rules, CalOptima invested funds into programs like the Homeless Health Initiative, Whole Child Model Program, and COVID-19 Vaccination Member Incentive Program.

Discussion

Given the allowable use change of the IGT funds in 2018, staff recommends reducing the CalOptima retention rate to a 2% administrative fee, which allows more funds to funnel to the community through its partners.

CalOptima's current IGT contracts with funding entities allow CalOptima to retain 50% of the net proceeds of the IGT, or 31.71% of the Medi-Cal managed care rate increases paid to CalOptima by DHCS. CalOptima has been the only Medi-Cal managed care plan in California that retains 50% of the net proceeds. Other health plans either retain between 2-5% as an administrative fee or do not retain any funds.

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CalOptima anticipates receiving a total estimate of $121 million from DHCS for the Orange County IGT 11 transaction in quarter 4 of 2022. The estimated net proceeds (after reimbursing the funding entities' initial contribution for the transaction) of IGT 11 funds is approximately $76.76 million.

Reducing CalOptima's payment to 2% of net proceeds will decrease CalOptima's funding to $1.5 million and will increase the available distribution to the funding entities by more than $36.8 million.

Estimate of IGT 11 Transaction	Current Est. Amount	Recommended Est. Amount	Chg ($)
Increased Capitation Payment from DHCS to CalOptima	$121,030,620	$121,030,620	
Initial Contribution (Transfer + 20% DHCS Assessment Fee)	$44,265,760	$44,265,760	
Net IGT Transaction Revenue for Orange County	$76,764,860	$76,764,860	
• Funding Entities' Share	$38,382,430 *(50%)*	$75,229,563 *(98%)*	$36,847,133
• CalOptima' Share	$38,382,430 *(50%)*	$1,535,297 *(2%)*	($36,847,133)
Total Payment to Funding Entities, including 20% DHCS Assessment Fee*	$82,648,190	$119,495,323	$36,847,133

Rev. 8/4/2022

* Funding entities are responsible for sending the 20% DHCS Assessment Fee to the State upon receipt of IGT funds from CalOptima

The current and proposed estimated distribution to CalOptima and each funding entity would be as follows:

Funding Entity	IGT Net Distribution (Existing)	IGT Net Distribution (New)	Chg ($)
County of Orange Health Care Agency	$2,581,760	$5,060,250	$2,478,490
City of Orange Fire Department	$429,993	$842,785	$412,793
City of Newport Beach Fire Department	$262,047	$513,613	$251,566
Children and Families Commission of OC	$588,888	$1,154,220	$565,332
UC Irvine Health	$34,519,742	$67,658,695	$33,138,953
Total	**$38,382,430**	**$75,229,563**	**$36,847,133**
CalOptima (MCP)	**$38,382,430**	**$1,535,297**	**($36,847,133)**

Rev. 8/4/2022

DHCS will determine the actual IGT 11 amounts based on CalOptima's actual enrollment at the time of distribution for the date of service period. Therefore, the estimates provided above may be slightly different when CalOptima receives the final IGT funds.

With the recommended reduction to CalOptima's IGT retention amount, the additional resources to funding entities and/or their designee will support Orange County's safety net to provide better access and quality services to Medi-Cal beneficiaries.

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Fiscal Impact
Staff anticipates this recommended action will be net budget neutral. The recommended action is expected to generate approximately $1.5 million to offset expenses for the administration of the IGT program.

Rationale for Recommendation
CalOptima staff recommends this action for the funding entities or their designee to use additional dollars to pay for Medi-Cal covered services provided to the growing number of CalOptima Medi-Cal members.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Entities Covered by this Recommended Board Action

Board Action

Board Meeting Dates	Action	Term	Not to Exceed Amount
December 3, 2020	Consider Authorizing Pursuit of Proposals with Qualifying Funding Partners to Secure Medi-Cal Funds Through the Voluntary Rate Range Intergovernmental Transfer Program for Calendar Year 2021	N/A	N/A

/s/ Michael Hunn *07/28/2022*
Authorized Signatur **Date**

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Attachment to the August 4, 2022 Board of Directors Meeting – Agenda Item 17

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip code
Children's Hospital of Orange County (CHOC Hospital)	1201 W. La Veta Avenue	Orange	CA	92868
City of Newport Beach	100 Civic Center Drive	Newport Beach	CA	92660
City of Orange	300 E. Chapman Avenue	Orange	CA	92866
Orange County Health Care Agency	405 W. 5th Street, 7th Floor	Santa Ana	CA	92701
University of California, Irvine UCI Health	333 City Blvd. West, Suite 200	Orange	CA	92868

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 4, 2022
Regular Meeting of the CalOptima Board of Directors

Report Item

18. Authorize the Chief Executive Officer to Execute a New Contract with The Burgess Group, LLC to Implement a New Cloud Platform in Support of CalOptima's Digital Transformation Strategy, and Ratify an Amendment Extending the Current Contract with The Burgess Group, LLC

Contacts

Wael Younan, Chief Information Officer / Chief Information Security Officer, (657) 900-1154
Nora Onishi, Director, Information Technology Services, (714) 246-8630

Recommended Actions

1. Authorize the Chief Executive Officer to execute a new contract with The Burgess Group, LLC (The Burgess Group), a payment reimbursement system vendor, for an initial term not to exceed five years, with three one-year extension options, exercisable at CalOptima's sole discretion, with each extension option subject to prior Board of Directors (Board) approval; and
2. Ratify an amendment with The Burgess Group extending the current contract for an additional six months from July 1, 2022, to December 31, 2022.

Background

The Burgess Reimbursement System (BRS) was originally contracted on January 1, 2008, to support CalOptima's claims adjudication process with its first CMS Medicare Advantage D-SNP plan, OneCare. This software solution originally provided two key functions: (1) Correct CMS Medicare pricing for claims; and (2) current, up-to-date fee schedules to maintain accuracy. The Burgess Group has added system enhancements to its BRS software portfolio and incorporated the California Medi-Cal pricing schedules. CalOptima currently utilizes BRS for the Medi-Cal acute in-patient APR-DRG schedule for hospital claims payment and has built a tight integration with BRS and CalOptima's core claims system facets, supporting claims administration auto-adjudication of Medicare and Medi-Cal in-patient hospital claims. BRS has provided CalOptima with CMS pricing accuracy to support claims payment for over 14 years.

Discussion

At the December 6, 2018, Board meeting, The Burgess Group was one of several vendors approved for an extension of the existing contract through June 30, 2022.

In July 2020, The Burgess Group proposed a new platform software as a service (SaaS) model as a result of Microsoft ending support for the current BRS version in 2022. The model change necessitates a new contract between CalOptima and The Burgess Group. Considering the length of time CalOptima has contracted with The Burgess Group and as part of the recommended procurement process, CalOptima decided to explore other vendors. CalOptima released a request for proposal (RFP) to review the current market for pricing solution vendors. Staff completed the RFP selection in August of 2021.

CalOptima's review committee consisted of stakeholders from the Finance, Claims, GARS, and Information Technology Services departments. Consistent with CalOptima's procurement process,

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CalOptima conducted a review of bids and scored the applicants to select a vendor. CalOptima received four bids from vendors on the RFP. The approved scoring criteria used was based on five points per category and used a weighted average, placing the greatest weight on application functionality, and was as follows:

Criteria	Weighted Average
Completeness of Proposal	10%
Application Functionality	30%
Related Experience in Industry	20%
Qualifications of Vendor Team, Locations	15%
Price	15%
Contract Response	10%

Based on proposal reviews from four vendors, the results for the RFP are as follows:

RFP 22-012 Claims Pricing Solution Services		
Vendor	Score	Rank
The Burgess Group	4.16	1
Cognizant/Trizetto	2.91	2
PayerCompass	2.66	3
NTT Data	2.56	4

The Burgess Group was re-selected by CalOptima Staff based on the scoring above.

In the December 20, 2021, Board special meeting, the Board approved a request for reallocation of funds. The original budget for Fiscal Year (FY) 2021-2022 was expected to have transitioned to the new contract after the first quarter of 2021. Due to multiple circumstances, the proposed new contract negotiation took longer than expected.

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Fiscal Impact
The recommended actions are budgeted items. The CalOptima FY 2022-23 Operating Budget approved by the Board on June 2, 2022, included $525,000 to fund the extension of the current contract with The Burgess Group from July 1, 2022, through December 31, 2022, and $981,000 to fund the new contract through June 30, 2023.

Rationale for Recommendation
Based on the scoring above, staff recommends that the Board approve execution of a new contract with The Burgess Group. Staff also recommends that the Board ratify the contract amendment extending the current contract to allow time to implement the platform changes. The extension is required as a result of contract negotiations with The Burgess Group along with the Statement of Work (SOW) and Business Associate Agreement (BAA). These negotiations took longer than expected and were delayed further during the transition of legal services and ensuring that CalOptima was protected in commitments on both sides.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Entities Covered by this Recommended Action
2. Pricing_Solution_SOW_RFP_22-012
3. Previous Board Action dated September 1, 2016: "Consider Extension of Contracts Related to CalOptima's Core Systems
4. Previous Board Action dated December 6, 2018: "Consider Extension of Contracts Related to CalOptima's Key Operational and Human Resource Systems
5. Previous Board Action dated December 20, 2021: "Consider Authorization of Proposed Budget Reallocation of Fiscal Year 2021-22 Operating Budget Funds and Authorization of Unbudgeted Expenditures and Appropriation of Funds for Information Services Items

Board Actions

Board Meeting Dates	Action	Term	Not to Exceed Amount
September 1, 2016	Extension amendment of contract	1/1/2017 – 12/31/2019	Annual cost of $ 811,700
December 6, 2018	Extension amendment of contract	1/1/2020 - 6/30/2022	Annual cost of $ 811,700

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Board Meeting Dates	Action	Term	Not to Exceed Amount
December 20, 2021	Reallocation of funds	1/1/2022 – 6/30/2022	$120,000

/s/ Michael Hunn *07/28/2022*
Authorized Signature **Date**

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CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
The Burgess Group, L.L.C.	1701 Duke Street, #300	Alexandria	VA	22314
HealthEdge	30 Corporate Drive	Burlington	MA	01803

RFP 22-012 Claims Pricing - Scope of Work

1. Objective

The purpose of this RFP is to identify and implement a claims pricing tool which will support and enhance CalOptima's ability to accurately and efficiently process Medicare and California's Medicaid (Medi-Cal) claims. The solution must be able to support CalOptima's current requirements, as well as, new or changing requirements mandated by federal and state regulators.

2. Scope of Work

CalOptima seeks to procure a software-as-a-service (SaaS), solution capable of delivering real-time and batch-processed medical claims pricing calculations, using up-to-date payment policies, rates, and provisions as defined by the Centers for Medicare and Medicaid Services (CMS) and, California's Department of Health Care Services (DHCS). The solution must be integrated with CalOptima's claims administration system (Facets) to apply pricing calculations during batch processing, as well as, during the manual adjudication process. In addition, CalOptima requires the ability to seek pricing results using a web application.

CalOptima would like to secure a contract with a vendor on or before October 31, 2021 and start implementation efforts on or before December 1, 2021. Implementation of an integrated solution will need to be complete no later than February 1, 2022.

3. Requirements

In order to meet its current and future business needs, CalOptima will select a solution that aligns most with the functional and technical capabilities delineated in this section.

All materials submitted by the vendor become the property of CalOptima and may be evaluated by any employee or agent of CalOptima. CalOptima reserves the right to proceed or not to proceed with plans to acquire information systems.

a. Comments Column:

Please answer each question as completely and concisely as possible. Be sure that the responses provide sufficient detail to objectively evaluate the response while not providing irrelevant information. Insert narrative responses within the "Vendor Response" column. Any unclear or incomplete answers may be disregarded and considered non-responsive.

If the response requires a relevant attachment, note it within the response field, identify the attachments by the requirement number and provide the attachments in electronic form with your response.

b. Requirements that cannot be met:

If a requirement cannot be met please indicate “cannot be met as requested” and provide the performance level offered or an alternative option.

Please respond to each item completely, concisely and accurately. Failure to provide appropriate data may eliminate the evaluation of this proposal.

Item #	System Requirements/Core Functions	Vendor Response
1.1	Must support the following Medicare Provider Type, Pricing Schedules, Rates and Methodologies with ongoing regulatory updates:	
	a) Professional • Resources Based Relative Value Scale (RBRVS)	
	b) Anesthesia • American Society of Anesthesiologists (ASA)	
	c) Merit-based Incentive Payment System (MIPS) including: • Option to apply a custom % to MIPS Adjustments on portion paid by Medicare • Option to turn on/off positive, negative and neutral MIPS adjustments • Option to apply 100% MIPS adjustments for Medicare Waived Coinsurance services • Ability to “bypass” MIPS adjustment based on Facets field (for integration)	
	d) Acute Inpatient Hospital • Medicare Severity Diagnoses Related Group (MS-DRG) Rates and Weights	
	e) Hospital Outpatient Department • Ambulatory Payment Classification (APC) Rates and Weights	

Item #	System Requirements/Core Functions	Vendor Response
	• Hospital Outpatient Payment Rates • Comprehensive APC Complexity Adjustments Rates	
	f) Ambulatory Surgery Center (ASC) • ASC Payment Rates	
	g) Critical Access Hospital (CAH)	
	h) End-Stage Renal Disease (ESRD) • ESRD Outlier Services	
	i) Federally Qualified Health Center (FQHC) • FQHC Rates	
	j) Home Health Agency (HHA) • Billable Services	
	k) Hospice	
	l) Inpatient Psychiatric Facility (IPF) • Age Adjustments • Comorbidity Codes and Adjustments • Diagnosis-Related Group (DRG) Adjustment Factors	
	m) Inpatient Rehabilitation Facility (IRF) • Case Mix Group (CMG) Rates and Weights	
	n) Long Term Care Hospital • DRG Rates and Weights	
	o) Skilled Nursing Hospital (SNF) • Resource Utilization Groups (RUG) Rates • Patient-Driven Payment Model (PDPM) Rates	
	p) Ambulance • Ambulance fee schedule • Price fractional mileage (based on Facets field for integration)	

Item #	System Requirements/Core Functions	Vendor Response
	• Price based on pick up zip code (based on Facets field for integration)	
	q) Durable Medical Equipment (DME)/Parenteral and Enteral Nutrition (PEN) • Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule • PEN Fee Schedule	
	r) Other • Drugs and Immunizations • Clinical Lab Fee Schedule • Drugs – Not Otherwise Classified (NOC) • National Drug Code (NDC) – Average Sales Price (ASP) mapping	
1.2	Must support Medicare Claims Payment Policies with ongoing regulatory updates:	
	a) Medicare Code Edits (MCE) • Option to apply MCE for informational purposes only • Option to not run or apply MCE to reimbursement results • Option to not pay claim if MCE edit is present	
	b) Non-Medicare Certified National Provider Identifier (NPI) Pricing • Option to not apply non-Medicare certified NPI pricing	
	•	
	d) DME • Medically Unlikely Edits • Option to not enforce DMEPOS CB Pricing rules	
	e) SNF	

Item #	System Requirements/Core Functions	Vendor Response
	• CMS Medicare Administrative Contractors (MACs) • Health Insurance Prospective Payment System (HIPPS) Codes • Lab National Coverage Determinations (NCD) by Diagnosis • Lab NCD by Service • Local Coverage Determination (LCD) by Diagnosis • LCD by Service	
	f) Long-Term Care (LTC) • Minimal Care Evaluation Studies (MCE) by Diagnosis •	
	g) Inpatient Psychiatric Facility • MCE by Diagnosis •	
	h) Home Health Agency • CMS MACs • HIPPS Codes • Patient-Driven Groupings Model (PDGM) HIPPS Codes • LCD by Diagnosis • LCD by Service • National Correct Coding Initiative (NCCI) for Outpatient Providers	
	i) Federally Qualified Health Center (FQHC) • FQHC Qualifying Visits • Outpatient Code Editor	
	j) End-Stage Renal Disease • CMS MACs • Lab NCD by Diagnosis • Lab NCD by Service	

Item #	System Requirements/Core Functions	Vendor Response
	• LCD by Diagnosis • LCD by Service • NCCI for Outpatient Providers	
	k) Critical Access Hospital • CMS MACs • Lab NCD by Diagnosis • Lab NCD by Service • LCD by Diagnosis • LCD by Service • Medically Unlikely Edits • Outpatient Code Editor	
	l) Ambulatory Surgery Center • CMS MACs • LCD by Diagnosis • LCD by Service • Medically Unlikely Edits • National Correct Coding Initiative • Payment Status Indicators	
	m) Hospital Outpatient Department • CMS MACs • Lab NCD by Diagnosis • Lab NCD by Service • LCD by Diagnosis • LCD by Service • Medically Unlikely Edits • NCCI for Outpatient Providers • Payment Status Indicators • Outpatient Code Editor (OCE) ○ Option to Apply OCE edit to all reimbursement results ○ Option to Ignore OCE edit for all reimbursement results	

Item #	System Requirements/Core Functions	Vendor Response
	○ Option to Apply OCE edit for informational purposes only	
	n) Acute Inpatient Hospital • MCE by Diagnosis • MCE by Procedure • PDA Exempt Codes	
	o) Professional • CMS MACs • Lab NCD by Diagnosis • Lab NCD by Service • LCD by Diagnosis • LCD by Service • Medically Unlikely Edits • National Correct Coding Initiative	
1.3	Must support Medi-Cal Provider type/Pricing/Payment Policy with ongoing regulatory updates:	
	a) Medi-Cal Inpatient • All Patient Refine Diagnosis Related Groups (APR-DRG) Rates and Weights • California Inpatient Ancillary Codes Payment Policies ○ Option to not apply Transitional Rates • Provider Listing with pricing related information – CA Inpatient Providers	
	b) Medi-Cal Home Health	
	c) Medi-Cal Hospice	
	d) Medi-Cal Long Term Care	
	e) Medi-Cal Outpatient	
	f) Medi-Cal Professional	
	g) Medi-Cal Anesthesia	
1.4	Must provide authorized users secure access to a web-based user interface.	

Item #	System Requirements/Core Functions	Vendor Response
1.5	Web application has the capacity to look up and export code listings, including: • Healthcare Common Procedure Coding System (HCPCS) Level II Codes • HIPPS Codes • ICD10-CM Diagnosis Codes • ICD10-PCS Procedure Codes • Medicare Waived Coinsurance services	
1.6	Web application includes the functionality to look up and export current and historical rates and pricing related information rates, including: • Professional ○ Anesthesia calculator ○ Anesthesia Conversion Factor ○ CMS Locality table ○ Combined Rate table with Rate Source (Physician, Physician Assistant, Nurse Midwife, Clinical Social Worker) (by locality) ▪ Source of rate: RBRVS, DME, LAB, Drug, Anesthesia, PEN, Ambulance, ASC, Outpatient Prospective Payment System (OPPS), Outpatient Mental Health Payment Level, Screening Mammography, Locality Neutral) ○ Professional Rate table (Physician, Physician Assistant, Nurse Midwife, Clinical Social Worker) (by locality) ○ RBRVS Rates by Service and Modifier table	

Item #	System Requirements/Core Functions	Vendor Response

1.7	Web application includes the functionality to look up and export provider listing with pricing-related information, including:
	• Acute Inpatient Hospital
	  ○ Inpatient Prospective Payment System (IPPS) Providers
	• Hospital Outpatient Department
	  ○ OPPS Providers
	• Ambulatory Surgery Center
	  ○ ASC Providers
	• Critical Access Hospital
	  ○ CAH Providers
	• End-Stage Renal Disease
	  ○ ESRD Providers
	• Federally Qualified Health Center
	  ○ FQHC Providers
	• Home Health Agency
	  ○ HHA Providers
	• Hospice
	  ○ Hospice Providers
	• Inpatient Psychiatric Facility
	  ○ IPF Providers
	• Inpatient Rehabilitation Facility
	  ○ IRF Providers
	• Long Term Care Hospital
	  ○ LTC Providers
	• Skilled Nursing Hospital
	  ○ SNF Providers	

1.8	Ability to return pricing specific to claim type upon manually entering (non-PHI) data elements into web application pricing tool.	
1.9	For the purposes of claims modeling or claims repricing, describe functions within	

Item #	System Requirements/Core Functions	Vendor Response
	the web application which allow users to submit an external claims data file for pricing claims via batch process, with all of the various pricing schedules as previously defined.	
1.10	Must provide standard, out of the box pricing and payment policies which follow Medicare and Medi-Cal guidelines • Any and all Medicare and Medi-Cal published pricing and payment policy information should automatically be incorporated into pricing tool.	
1.11	Must update pricing tool with any and all Medicare and Medi-Cal published pricing and payment policy information without client intervention.	
1.12	Describe how frequently published pricing and payment policy information are incorporated into the application.	
1.13	Describe the frequency by which your clients are notified of product releases (including, content and system updates). Summarize the type of content that are included in your product release notices.	
1.14	Must allow users to turn off payment policies either globally or on a per-policy basis.	
1.15	Ability to apply a unique payment policy to a rate structure.	
1.16	Medicare and Medi-Cal pricing must be independent of each other.	

Item #	Integration Requirements	Vendor Response
2.1	Automatically pass required (non-PHI) data elements from Facets to and from pricing tool for auto-pricing of the claim through daily batch process.	
2.2	Automatically return pricing to Facets in real-time.	
2.3	Pricing to occur real time with batch-loaded claims.	

Item #	Integration Requirements	Vendor Response
2.4	Must provide the ability to manually pass (non-PHI) data elements from Facets to pricing tool to return pricing real time.	
2.5	Automatically return and retain pricing detail per claim, for both claim line and claim level, to Facets to include all pricing information.	
2.6	Ability to return pricing detail on a claim line without overlaying exception pricing in Facets.	
2.7	Return the most critical pricing explanation code to Facets claim line.	
2.8	Automatically determine the provider type/rate to price against based on the data elements on the claim in Facets, and when applicable other areas of Facets, such as but not limited to member zip code and/or provider record.	
2.9	Ability to look to other areas of Facets as applicable to determine payment, including but not limited to claim history, provider record, ambulance fractional mileage, ambulance pick up zip code.	
2.10	Ability to price to a different provider type than customary. For example, price outpatient hospital at Clinical Lab schedule.	
2.11	Ability to price to a different geographical area other than provider zip code. For example, price an Area 18 zip code at Area 26 rates.	
2.12	Pricing results of exact same claim data should be exactly the same regardless of manually entering data into stand-alone pricing tool or through integration	
2.13	Ability to return roll-up pricing (MS-DRG, APR-DRG) to Facets at a claim level.	
2.14	Ability to return claim line pricing at line level to Facets.	
2.15	Ability to return MIPS adjustment pricing specific to Medicare portion to primary for DUAL Facets module and not affect coordination of secondary amounts.	

Item #	Integration Requirements	Vendor Response
2.16	Ability to map and return pricing tool explanation codes/remarks to a Facets explanation code.	
2.17	Ability to provide calculation details and values for each claims transactions processed in a daily data extract to CalOptima to load into our tables. Data elements to pass are collaboratively determined, but must contain elements to support our response to Provider questions or audit questions.	
2.18	Must provide edit messages back to Facets when the solution is unable to return price based on missing claims data.	
2.19	Ability to incorporate coinsurance value into a separate field in Facets. • Ability to exclude coinsurance value for Medicare Waived Coinsurance services values	

Item #	Technical Requirements	Vendor Response
3.1	SaaS solution must be hosted in the United States.	
3.2	Must provide a test environment for Facets non-production environments.	
3.3	Must deliver the ability to “transfer” configuration between test pricing tool and production pricing tool, and from production pricing tool to test pricing tool	
3.4	Secure integration is required. Describe the overall topology of the hosted solution and explains how it functions.	
3.5	In regards to technical requirements, please describe all client hardware and third party software requirements to implement your hosted solution, if any.	
3.6	In regards to technical requirements, please describe the kind of extension programs that CalOptima will need to install in order to integrate Facets with real-time pricing services, if any.	

Item #	Technical Requirements	Vendor Response
3.7	Must be able to validate installation of extension programs, if any. Describe your company's standard process for verifying that all application components are properly installed.	

Item #	System & Training Documentation	Vendor Response
4.1	Must deliver a user application manual that provides operator-level information.	
4.2	Must provide clear cut instructions for installation, assuming an extension program must be installed.	
4.3	Must provide technical documentation and instructions as needed.	
4.4	Must provide training onsite (or virtual) at CalOptima facilities during the project timeline. Describe the training approach and schedule your firm recommends for initial training of the CalOptima implementation team.	
4.5	Must provide user level training on the solution to review and troubleshoot issues.	
4.6	In regards to system & training documentation, please describe any regularly held seminars, webinars, or user group meetings available to users of your system and content.	

Item #	Technology	Vendor Response
5.1	Must be compatible with Microsoft Windows platform; Windows 10 or newer, and Citrix clients (XenApp 7.15 and higher)	
5.2	Vendor integration tools must be compatible with Microsoft SQL Server 2017 or newer.	
5.3	Must support integration with Facets version 5.6 or newer.	
5.4	Vendor must support role-based security access and administration (assuming	

Item #	Technology	Vendor Response
	administration services exist for hosted solution)	

Item #	HIPAA Compliance	Vendor Response
6.1	Vendor and its cloud-hosting partner must utilize an industry recognized security framework like HITRUST, PCI, NIST, etc.	

Item #	Implementation / Professional Services	Vendor Response
7.1	Describe the standard process used by your company to implement your products and services at a new client site. Provide a sample implementation work plan including: • Tasks required • Relative sequence of tasks and any key dependencies between tasks • Responsible parties for each task (vendor and CalOptima) • Include major areas of subcontractor work • Estimated time to complete each task • Vendor testing process • Coordination of user acceptance testing	
7.2	Based on your knowledge of CalOptima, please list specific client resource requirements for implementation you believe are necessary to meet the above timeline, including: • Approximate percentage of time each resource should be dedicated to the implementation phase by month • Roles and responsibilities of each resource	
7.3	Provide information on average customization, time and costs for other	

Item #	Implementation / Professional Services	Vendor Response
	clients during an implementation, if any. Provide customization that clients have requested post-implementation, if applicable.	
7.4	Provide an example of standard Service Level Agreement (SLA) in vendor contracts. SLA must include both incentives and penalties for performance thresholds.	

Item #	Production Support Requirements	Vendor Response
8.1	Please provide all staffing resources and skills required to support production environment.	

Item #	Customer Service and Support	Vendor Response
9.1	Describe your company's support organization, addressing specifically: • Number of support personnel by title (programmer, support rep, account rep) • Title, training and experience of persons responding to calls about technical issues • Routing and escalation procedures of technical issues • Call tracking, resolution and call monitoring procedures. • The location of your customer service and support staff	
9.2	Indicate your support organization's ability to accommodate CalOptima's business hours. That is, 8 a.m. to 5 p.m. PST, Monday through Friday.	
9.3	Describe how your support organization accommodates urgent support requests during non-business hours and/or holidays.	

9.4	Describe the method and frequency by which your clients are notified of software defects identified by support personnel or other clients. (Will you make your current internal defect tracking log available to CalOptima?)	
9.5	Customer Support must be able to respond to questions and clarifications related to pricing. Describe your standard response time to client inquiries.	

Item #	Security (client & member)	Vendor Response
10.1	User authorization and authentication is required. Please detail the methodology provided by solution. Describe registration process for new users.	
10.2	Role-based access control is required. Describe how role-based access control is administered within the web application.	
10.3	Audit trail is required for user access, usage tracking, and auditing purposes. Describe availability of access and usage logs.	
10.4	Secure interface to Facets is required. Explain and detail the design and methodologies used by the proposed solution (e.g., HTTPS, API, AES 256 etc.)	

Item #	Miscellaneous	Vendor Response
11.1	Describe the reporting capabilities that are available within the solution, if any. Include specific types of reports that are available out-of-the-box, reports that can be customized by the user, or ability to extend reporting as needed by the organization.	
11.2	Please explain how client staff will be able to access the solution for analytical and reporting purposes.	

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 1, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item
5. Consider Extension of Contracts Related to CalOptima's Core Systems

Contact
Len Rosignoli, Chief Information Officer, (714) 246-8400
Ladan Khamseh, Chief Operating Officer, (714) 246-8400

Recommended Actions
Authorize the Chief Executive Officer (CEO) to:

1. Extend the contracts with the following vendors as listed below through the dates indicated in the attached Tables 1, 2, and 3:
    a. Burgess-Burgess Reimbursement System (Medicare/Medi-Cal Fee Schedules and Claims Pricing)
    b. Medecision (Provider Portal (CalOptima Link)
    c. Edifecs-XEngine (Claims Electronic transaction standardization tool)
    d. Microstrategy (Enterprise Business Analytics and Intelligence)
    e. Office Ally (Claims Clearinghouse)
    f. Change Healthcare (Claims Clearinghouse)
    g. HMS (Medi-Cal Cost Containment)
    h. SCIO Health Analytics-My Socrates (Third Party Liability and Subrogation Recovery Services)
    i. OptumInsight (Credit Balance Recovery Services)
    j. MCG-CareWebQI (Evidence-based Clinical Guidelines
    k. Intelli-Flex (Telephone system and supporting Customer Service applications)
    l. TW Telcom/Level III (CalOptima's carrier for telecommunications as well as Internet connectivity); and

2. Authorize payment of maintenance and support fees to these vendors through the dates and up to the amounts indicated in the attached Tables 1, 2, and 3.

Background
CalOptima contracts with many vendors that provide a variety of software solutions to support the overall business model. Two Core Systems are central to this infrastructure while many other supporting solutions surround the Core.

Within the managed care industry, this is standard practice, as no commercially-available single solution is able to meet the demands of the industry for all functions. The trend over the past ten years or more has been to utilize this approach by using the Core for what those systems handle best, and to use specialty solutions to surround the Core. CalOptima, as well as the other 15 Local Health Plans of California, and virtually all health plans, use this approach.

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At the center and in the Core for CalOptima are two systems:

- TriZetto Facets – This solution handles the key functions of enrollment of members, health benefit configuration, claims processing and adjudication, and customer service.
- Altruista Guiding Care – This solution handles the key functions of Care Management, including Case Management, Utilization Management, Authorizations/Referrals, Disease Management, and Appeals & Grievances.

Supporting Systems include:

a. Burgess Reimbursement System – This solution provides two key functions. It enables continuous monitoring of the hundreds of claims reimbursement Medicare fee schedules maintained by the Federal Centers for Medicare and Medicaid Services (CMS) ensuring that CalOptima's Medicare fee schedules are up-to-date as soon as Medicare makes a change. It also uses sophisticated algorithms to calculate the reimbursement pricing for all CalOptima Medicare related claims. In the future, this solution will be expanded to perform the same functions for the Medi-Cal fee schedules and claims pricing.
b. Medecision - Aerial Care Coordination - This solution is the current CalOptima provider portal – more commonly known to the CalOptima provider partners as CalOptima Link. This portal enables the over 5,000 provider users to verify eligibility, review claims status, view patient rosters, and submit service authorization requests.
c. Edifecs – XEngine – This tool supports quality for the CalOptima Facets Claims process. XEngine is a tool that helps to validate compliance with regulatory transaction standards and streamline operational efficiency.
d. Microstrategy – This is the current CalOptima Business Intelligence and Analytics solution. Many routine analytics processes developed within Microstrategy have become part of the standard operations of CalOptima, providing data analytics to support all business functions.
e. and f. Office Ally and Change Healthcare – These vendor solutions are known as Claims Clearinghouses. Essentially, providers in the community interact with their systems to submit claims for payment to a variety of health plans/payers. The Office Ally Clearinghouse services the vast majority of California providers. Office Ally also provides Claims Submission, Electronic Health Record, and Practice Management solutions at no cost to provider offices, including hundreds of CalOptima provider offices. Change Healthcare (formerly known as Emdeon) is the largest claims Clearinghouse in the Country. In 2015, Change Healthcare handled over 8.5 billion transactions, covering $1.7 trillion in claims.
g. Health Management Systems (HMS) – HMS is a cost containment service vendor. For CalOptima, as well as the California Department of Health Care Services (DHCS), HMS is contracted to identify, audit and recover improper Medi-Cal payments. HMS' mission is to help protect the integrity of government-sponsored health and human services programs. HMS provides similar services to 23 states including 41 state Medicaid programs.
h. SCIO Health Analytics - My Socrates – My Socrates is a subrogation service solution used to support CalOptima's Medicare Claims processing. This service handles and identifies third-party liability, for example, subrogation with motor vehicle accidents, often a contributor to total claims cost. SCIO's services reach more than 400 million medical claims and 1.3 billion prescription claims nationwide.
i. OptumInsight – For CalOptima, OptumInsight provides Credit Balance Recovery services. There is a Medicare regulation dictating that providers may not retain any overpayments. An overpayment is where a health insurer reimburses a provider in excess of what should be

reimbursed, most often caused by billing or processing errors. There are a variety of significant penalties that can be assessed if overpayments are not identified and handled appropriately. This service helps CalOptima recover overpayments and its provider partners to identify procedural and system issues that create credit balances to identify opportunities to prevent future overpayments.

j. MCG, part of the Hearst Health Network – CareWebQI – This solution is embedded and tightly integrated within the Altruista Guiding Care solution for Care Management. CareWebQI provides electronic, automated access to evidence-based best practices and clinical criteria for the support and documentation of care management decisions.

The next two solutions support the overall Information Technology Infrastructure:

k. Intelliflex – This is the vendor that provides CalOptima's Avaya telephone System. The Avaya equipment is used for all employees. In addition, Avaya Contact Center and TelStrat Call Recording services are tightly embedded into CalOptima's Customer Service Operation, helping maintain regulatory compliance and policy adherence.
l. TW Telecom / Level 3 – This is CalOptima's carrier for telecommunications as well as Internet connectivity. This vendor supports this particular area of the County.

Discussion

The vendors listed in the attached table represent the solutions described above with contracts expiring over the next six months.

Many of these solutions are tightly embedded/integrated into either Facets and/or Altruista (the Core Systems) – see Table 1. Unless Facets or Altruista were to be replaced, replacing these tightly integrated solutions is infeasible without substantial investment and significant disruption to operations. Some also represent the most viable solution considering CalOptima's operating environment. See Table 2. Those falling into this category will not enter the competitive bidding process at this time.

Other solutions are less tightly integrated, less costly, less complex to replace, and are handled by competing vendors within the marketplace. For these vendors, a competitive bidding process is planned, and the approximate date to issue the RFI or RFP is listed in Table 3.

Fiscal Impact

The CalOptima Fiscal Year 2016-17 Operating Budget includes the annual fees for the listed contracted vendors related to CalOptima's core and supporting systems through June 30, 2017. Management will include expenses for the recommended contract extension periods on or after July 1, 2017, in future CalOptima Operating Budgets.

Rationale for Recommendation

Extension of the contracts for these systems that support the Core Systems will ensure there is no disruption to the services provided by each of the solutions and allow continuity of operations throughout the organization and with CalOptima's member and provider community.

Concurrence
Gary Crockett, Chief Counsel
Chet Uma, Chief Financial Officer

Attachment
Proposed Contract Extensions

/s/ Michael Schrader — *8/25/2016*
Authorized Signature — **Date**

Attachment - Proposed Contract Extensions

Table 1 – Solutions tightly integrated with Facets and/or Altruista

Number from List, Vendor, Solution Name (if applicable)	Description of Service	Original Contract Start Date	Current Contract Expires	Recommend Contract Extension Through:	Competitive Bid Initiation (approximate):	Annual Cost Based on Fiscal Year 2016-17 Budget
a. Burgess – Burgess Reimbursement System	Medicare/Medi-Cal Fee Schedules and Claims Pricing	1/1/2008	12/31/2016	12/31/2019	N/A	$811,700
b. Medecision – Aerial Care Coordination	Provider Portal (Calopima Link)	3/23/2011	9/1/2016	12/31/2019	N/A	$1,531,935
c. Edifecs – XEngine	Claims Electronic transaction standardization tool	3/9/2011	3/30/2017	12/31/2019	N/A	$93,702
d. Microstrategy	Enterprise Business Analytics and Intelligence	9/13/2011	9/19/2016	9/19/2019	N/A	$155,000

Table 2 – Solutions defined as “most viable” based on market standards, lack of competition, or related to State consistency

Number from List, Vendor, Solution Name (if applicable)	Description of Service	Original Contract Start Date	Current Contract Expires	Recommend Contract Extension Through:	Competitive Bid Initiation (approximate):	Annual Cost Based on Fiscal Year 2016-17 Budget
e. Office Ally	Claims Clearinghouse	7/1/2004	12/31/2016	12/31/2020	N/A	$474,579
f. Change Healthcare	Claims Clearinghouse	10/12/2000	10/18/2016	12/31/2020	N/A	$94,916
g. HMS	Medi-Cal Cost Containment	5/15/2008	5/14/2017	5/14/2020	N/A	$398,646
k. Intelli-Flex	Telephone system and supporting Customer Service applications.	12/7/2009	1/1/2017	12/31/2019	N/A	$306,936

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Number from List, Vendor, Solution Name (if applicable)	Description of Service	Original Contract Start Date	Current Contract Expires	Recommend Contract Extension Through:	Competitive Bid Initiation (approximate):	Annual Cost Based on Fiscal Year 2016-17 Budget
l. TW Telecom / Level III	CalOptima's carrier for telecommunications as well as Internet connectivity.	2/15/2012	1/1/2017	12/31/2021	N/A	$720,000

Table 3 – Solutions with sufficient market competition with approximate RFP issue years listed

Number from List, Vendor, Solution Name (if applicable)	Description of Service	Original Contract Start Date	Current Contract Expires	Recommend Contract Extension Through:	Competitive Bid Initiation (approximate):	Annual Cost Based on Fiscal Year 2016-17 Budget
h. SCIO Health Analytics - My Socrates	Third Party Liability and Subrogation Recovery Services. (No cost, only contingency fee on percentage of recoveries).	2/19/2010	12/31/2016	12/31/2018	2017	Recovered in FY 2015-2016: $219,258.00 Fee (25%): $54,814.50 Net Recovery: $164,443.50
i. OptumInsight	Credit Balance Recovery Services. (No cost, only contingency fee on percentage of recoveries).	11/1/2011	12/31/2016	12/31/2018	2017	Recovered in FY 2015-2016: $44,834.00 Fee (12%): $5,380.08 Net Recovery: $39,453.92
j. MCG – CareWebQI	Evidence-based Clinical Guidelines	4/1/2008	3/31/2017	3/31/2021	2019	$641,300

CalOptima Board Action Agenda Referral

Action To Be Taken December 6, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

11. Consider Extension of Contracts Related to CalOptima's Key Operational and Human Resource Systems

Contact

Len Rosignoli, Chief Information Officer, (714) 246-8400
Ladan Khamseh, Chief Operating Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO) to:

1. Extend the contracts with the following vendors as listed below through the dates indicated in the attachment:
    a. Altruista Guiding Care
    b. Burgess Reimbursement System
    c. Edifecs XEngine
    d. Catalyst Solutions
    e. Medecision
    f. Star MTM
    g. Ansafone
    h. Ceridian Dayforce
    i. Silk Road Open Hire and Wingspan

2. Authorize payment of maintenance and support fees to these vendors through the dates and up to the amounts indicated in the attachment, Table 1.

Background

CalOptima contracts with many vendors that provide a variety of software solutions to support the overall business model. Two core systems are central to this infrastructure while many other supporting solutions surround the core.

Within the managed care industry, this is standard practice, as no commercially-available single solution meets the demands of the industry for all functions, especially when considering the varying lines of business, government regulations, and the uniqueness of each health plan. The trend over the past ten years or more has been to utilize this approach by using a core administrative processing system surrounded by specialty solutions. CalOptima, as well as the other 15 Local Health Plans of California, and virtually all health plans, use this approach.

The two core systems for CalOptima are:

1. Cognizant Facets – This solution handles the key functions of enrollment of members, health benefit configuration, claims processing and adjudication, provider contract reimbursement, and customer service.

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2. Altruista Guiding Care – This solution handles the key functions of Care Management, including Case Management, Utilization Management, Authorizations/Referrals, Disease Management, as well as Appeals & Grievances.

The systems included in this staff recommendation are:

a. Altruista Guiding Care – As mentioned above, this is one of CalOptima's two core systems. CalOptima originally contracted with Altruista in April of 2014 for a term of seven total years, including an initial term and five one-year optional renewal terms extending to 4/6/2021. The system was live as of April 2015. There are two years remaining on the current contract, supporting the decision to recommend approval to extend for those two years, to 4/6/2021. Replacement of this core system was a substantial investment in money and time. It can take years for a core system of this type to fully stabilize. There are additional features yet to be explored, including the Population Health modules. No later than during Fiscal Year (FY) 2019-2020, a Request for Information (RFI) will be issued, primarily to remain informed and evaluate the marketplace for systems of this type, to help determine how long this system will remain or when it may be considered for replacement through a Request for Proposal (RFP) process.

b. Burgess Reimbursement System – This solution provides two key function. One - it enables continuous monitoring of the hundreds of claims reimbursement Medicare fee schedules maintained by the Federal Centers for Medicare and Medicaid Services (CMS) ensuring that CalOptima's Medicare fee schedules are up-to-date as soon as Medicare makes a change. Two - it uses sophisticated algorithms to calculate the reimbursement pricing for all CalOptima Medicare related claims. In the future, this solution will be expanded to perform the same functions for the Medi-Cal fee schedules and claims pricing. This system is very tightly integrated within the Facets core system software.

c. Edifecs – XEngine – This tool supports quality for the CalOptima Facets Claims process. XEngine is a tool that validates and ensures compliance with regulatory transaction standards and streamlines operational efficiency.

d. Catalyst Solutions – This vendor provides essential supplemental maintenance services and support of the Facets system based on their depth of knowledge of Facets and the inner workings of the software.

e. Medecision - Aerial Care Coordination - This solution is the current CalOptima provider portal – more commonly known to the CalOptima provider partners as CalOptima Link. This portal enables thousands of provider office users to verify eligibility, review claims status, view patient rosters, and submit service authorization requests. This will ultimately be replaced by the new CalOptima Provider Portal.

f. Star MTM – This vendor provides the system and services to support the Pharmacy Medication Therapy Management process required by The Centers for Medicare and Medicaid Services (CMS) for both the OneCare and OneCare Connect lines of business. This process is tightly integrated within the overall administration of CalOptima's pharmacy benefit. An RFP will be issued during FY 2020-2021 to re-evaluate this service.

g. Ansafone – This vendor provides critical services supporting both CalOptima's Customer Service function and the Medical Affairs function. Ansafone provides after-hours call center support for both general customer service calls as well as more specific medical affairs calls. Ansafone also periodically conducts designed member outreach calls, as needed. An RFP for this service will be issued during FY 2018-2019 to evaluate the marketplace and to determine if CalOptima will retain the existing vendor or consider other alternatives.

h. Ceridian Dayforce – This is the primary Human Resources (HR) system handling employee benefits and payroll.

i. Silk Road Open Hire and Wingspan – Open Hire is the current HR applicant tracking and recruitment system. Wingspan is the current performance management system where all CalOptima employee performance evaluations are stored.

These three HR systems are tightly woven into the support and management of the CalOptima employees and are mission-critical for ongoing smooth operations. CalOptima has been on these systems for nearly ten years. During FY2019-20, CalOptima will issue an RFP for these functions to evaluate the marketplace to determine if a replacement is warranted, and if a single comprehensive HR solution can be procured rather than separate systems.

Discussion
The vendors listed in the attached table represent the solutions described above with contracts expiring in 2019 or sooner.

Many of these solutions are tightly embedded/integrated into either Facets and/or Guiding Care or are mission critical to the Human Resources function. Replacing any of these solutions would require a substantial additional investment, time commitment, and significant disruption to operations.

Fiscal Impact
The CalOptima FY 2018-19 Operating Budget includes the annual fees for the listed contracted vendors related to CalOptima's core and HR systems through June 30, 2019. Management will include expenses for the recommended contract extension periods on or after July 1, 2019, in future CalOptima Operating Budgets.

Rationale for Recommendation
Extension of the contracts for these systems will ensure there is no disruption to the services provided by each of the solutions and allow continuity of operations throughout the organization and with CalOptima's member and provider community, and its employees.

Concurrence
Gary Crockett, Chief Counsel

Attachments

1. Proposed Contract Extensions – Table 1
2. Contracted Entities Covered by this Recommended Board Action

/s/ Michael Schrader
Authorized Signature

11/28/2018
Date

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Attachment – Table 1 - Proposed Contract Extensions

Vendor – Solution Name	Description of Service	Original Contract Start Date	Current Contract Expires	Recommend Contract Extension Through	Comments	Annual Cost Based on Fiscal Year 2018-19 Fees
Altruista Health – Guiding Care	Core Care Management Solution	4/6/2014	4/6/2019	4/6/2021	2 years remaining on the original contract	$1,485,000
Burgess – Burgess Reimbursement System	Medicare/Medi-Cal Fee Schedules and Claims Pricing	1/1/2008	12/31/2019	6/30/2022	Tightly Integrated with Facets	$442,162
Edifecs – XEngine	Electronic transaction standardization tool	3/9/2011	12/31/2019	12/31/2021	Tightly Integrated with Facets	$90,000
Catalyst Solutions	Facets Support Services	4/21/2014	12/31/18	6/30/2022	Integral supplemental maintenance services for Facets	$35,000
Medecision – Aerial Care Coordination	Provider Portal (CalOptima Link)	3/23/2011	12/31/2019	12/31/2020	Eventually to be replaced with Provider Portal	$1,560,000
Star MTM	Pharmacy Medication Therapy Management Services	11/1/2014	3/21/2020	3/21/2022	Tightly Integrated into the Pharmacy process. Expect to issue RFP during Fiscal Year 2020-2021.	$156,000
Ephonamation.com, Inc., DBA Ansafone	After hours customer service call center; after hours medical affairs call center; member outreach.	9/1/2016	8/31/2019	8/31/2020	Tightly integrated within Customer Service and Medical Affairs. RFP to be issued during Fiscal Year 2018-2019.	$213,000
Ceridian - Dayforce	The main Human Resources System for Benefits and Payroll	6/29/2008	6/30/2019	12/31/2021	Plan to issue RFP during Fiscal Year 2019-2020	$254,000

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Vendor – Solution Name	Description of Service	Original Contract Start Date	Current Contract Expires	Recommend Contract Extension Through	Comments	Annual Cost Based on Fiscal Year 2018-19 Fees
Silk Road – Open Hire and Wingspan	Human Resources Support Systems – Performance Management, Applicant Tracking	6/19/2009	6/30/2019	12/31/2021	Plan to issue RFP during Fiscal Year 2019-2020	$58,500

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Altruista Health, Inc.	11800 Sunrise Valley Dr Suite 1000	Reston	VA	20191
Burgess Group, LLC	1701 Duke St	Alexandria	VA	22314
Edifecs, Inc.	1756 114th Ave SE	Bellevue	WA	98004
Catalyst Solutions, LLC	2353 S Broadway	Denver	CO	80210
Medecision, Inc.	550 E Swedesford Rd Building D, Suite 220	Wayne	PA	19087
Star MTM, LLC DBA Clinical Support Services	701 Seneca St	Buffalo	NY	14210
Ephonamation.com, Inc., DBA Ansafone Communications	145 E Columbine Ave	Santa Ana	CA	92707
Ceridian Corporation	3311 E Old Shakopee Rd	Minneapolis	MN	55425
SilkRoad Technology, Inc.	100 S Wacker Dr Suite 425	Chicago	IL	60606

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 20, 2021
Special Meeting of the CalOptima Board of Directors

Report Item

30. Consider Authorization of Proposed Budget Reallocation of Fiscal Year 2021-22 Operating Budget Funds and Authorization of Unbudgeted Expenditures and Appropriation of Funds for Information Services Items

Contacts

Yunkyung Kim, Chief Operating Officer, (714) 246-8408
Nora Onishi, Director, Information Services, (714) 246-8630

Recommended Actions

1. Authorize the reallocation of $120,000 for The Burgess Group, LLC, to different budget categories within the budget for the same vendor as follows:
    a. $50,000 from Medi-Cal: "Other Operating Expenses: Maintenance" to expense category "Medi-Cal: Purchased Services;" and
    b. $70,000 from "Medi-Cal: Other Operating Expenses: Maintenance" to expense category "OneCare Connect: Purchased Services."

2. Authorize unbudgeted expenditures and appropriate funds from existing reserves for Information System expenses based on existing contracts with the referenced vendors in amounts up to:
    a. $8,000 to expense category "OneCare Connect: Purchased Services" for Infocrossing, A WIPRO Company; and
    b. $60,000 to expense category "Medi-Cal: Other Operating Expenses: Purchased Services" for Imagenet, LLC.

Background

Pursuant to CalOptima Policy GA. 5003: Budget and Operations Forecasting, budget allocation changes that are not otherwise specifically delegated to the Chief Executive Officer require approval of the Board of Directors. Under CalOptima Policy GA.3202: CalOptima Signature Authority, for an expenditure to be authorized, it must appear in a budget line item as part of the Operating or Capital Budgets, or by way of an individual Board of Directors' action. To ensure compliance with CalOptima policies, there are four budget items for Information Services that require Board of Directors' approval, as follows:

1. The Burgess Group, L.L.C. is a contracted vendor that supports CalOptima's regulatory standard fee schedule pricing for claims through the Burgess Reimbursement System (BRS). This solution enables continuous monitoring of the hundreds of claims reimbursement Medicare fee schedules maintained by the Centers for Medicare & Medicaid Services (CMS), ensuring that CalOptima's Medicare fee schedules are up to date when Medicare makes changes. BRS uses algorithms to calculate the reimbursement pricing for all CalOptima Medicare-related claims. The BRS solution performs the same functions for the Medi-Cal fee schedules and claims pricing. Recently, staff conducted a Request for Proposal (RFP) and re-selected this vendor's upgraded platform to provide these services.

2. Infocrossing, A WIPRO Company, is a CMS third party vendor that supports CalOptima's process to submit enrollment and disenrollment updates to CMS. Infocrossing provides CMS data files for membership reconciliation for OneCare, OneCare Connect, and PACE. CalOptima's Infocrossing budget for the past two years has averaged approximately $2,000 per month, with a total annual budget of $24,000.

3. Imagenet, LLC. is a CalOptima vendor that provides imaging, scanning, data extraction and document archive solutions for various departments, including Claims Administration and Customer Service. The Grievance and Appeals Resolution Services (GARS) Department has utilized this vendor in the past for the archiving of documents and plans to utilize the scanning and data extraction options to facilitate entry of information into the GARS tracking system. This vendor's scanning and data extraction options allow staff to more efficiently utilize their time in handling and addressing member and provider cases, rather than manually scanning records.

Discussion

When the budget was developed in March of 2021, staff used the most accurate information available at the time. The proposed changes reflect more current information and take into consideration changes in volume as well as other developments and program requirements.

1. **The Burgess Group, L.L.C.:** The RFP and re-selection of BRS will change the budget categories associated with the use of BRS. The new platform changes the contract from a license and purchased service agreement to a full software as a service (SAAS) agreement that incorporates the claims run rate. Purchased services would only apply if CalOptima exceeded the contract threshold. During the FY 2021-2022 budget process, staff anticipated that CalOptima would be up and running on the new contract terms within the first quarter of this fiscal year. Therefore, the amount authorized and appropriated in the adopted budget only included a limited amount in the purchased services category for the fiscal year. Staff now anticipates the contracting process to be executed by the third quarter of this fiscal year. Therefore, staff requests a budget reallocation totaling $120,000 to more accurately align budget amounts with the appropriate expense categories to be consistent with the current version of the contract.

2. **Infocrossing, A WIPRO Company:** In May 2021, CMS identified a gap in CalOptima's data submissions and requested that CalOptima review and resubmit its encounter transactions. In July and August 2021, CalOptima staff created resubmission files totaling almost 325,000 encounter transactions covering calendar years 2016 through 2018. Staff completed the analysis and resubmitted the required transactions to fulfill the identified data gap from CMS. Staff requests an additional $8,000 for the OneCare Connect Budget to cover these unplanned costs for Infocrossing associated with the resubmission of additional encounters for services within Calendar Years 2016-2018. The resubmission of encounter data records is a CMS regulatory requirement and may help improve CalOptima's risk scores with the additional data set.

3. **Imagenet, LLC.:** With the increase in CalOptima's membership, there has been an increase in provider appeal cases. These appeal submissions often include the attachment of medical records and other relevant documentation consisting of up to hundreds of pages that need entry into CalOptima's system. The request to increase funding for Imagenet is based on the last ten months' volume of cases, as well as anticipated increases in the volume of OneCare and OneCare Connect non-contracted provider appeals due to regulatory requirements. Use of the current vendor for scanning and data extraction allows staff to focus on addressing and resolving cases in a timely manner. Staff requests approval and appropriation of $60,000 for Imagenet, LLC to address costs associated with scanning and data extraction services. This will ensure timely entry of provider appeal cases for resolution and will maintain compliance with regulatory timelines.

Fiscal Impact

Recommended Action #1: The recommended action is budget neutral. Unspent budgeted funds from expense category "Medi-Cal: Other Operating Expenses: Maintenance" approved in the FY 2021-22 Operating Budget will fund the total budget reallocation of $120,000 for this action.

Recommended Action #2: The recommended action to authorize expenditures and appropriate funds is unbudgeted. An appropriation and authorization of up to $68,000 from existing reserves will fund this action.

Rationale for Recommendation

The Burgess Group, LLC: The reallocation of funds will ensure budget categories are properly aligned with the current operating contract supporting CalOptima's fee schedule pricing.

Infocrossing, A Wipro Company: The resubmission of encounter data records is a CMS regulatory requirement and may help improve CalOptima's risk scores with the additional data set.

Imagenet, LLC: The appropriation and authorization of funds to cover scanning and data extraction services will ensure timely entry of provider appeal cases and compliance with regulatory timelines.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Entities Covered by this Recommended Board Action
2. Summary of Contract History
3. Board Action date October 7, 2021: Consider Extension of Contracts Related to CalOptima's Key Operational Systems
4. Contract and amendments Board Action dated December 6, 2018: Consider Extension of Contracts Related to CalOptima's Key Operational and Human Resource Systems

/s/ Michael Hunn *12/15/2021*
Authorized Signature **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
The Burgess Group, L.L.C.	1701 Duke Street, 3rd Floor	Alexandria	VA	22314
Infocrossing, A WIPRO Company	2 Tower Center	East Brunswick	NJ	08816
Imagenet, LLC	5401 W. Kennedy Blvd.	Tampa	FL	33609

APPENDIX TO AGENDA ITEM 30

Summary of Contract History

Vendor	Contract Number(s)	History of Contract Changes (Summary)	Last Approval
1. The Burgess Group, LLC.	OC 03194	There have been 17 amendments to the contract. The amendments included date extensions along with services modifications required to meet CalOptima and regulatory requirements.	Board Approval December 6, 2018
2. Infocrossing, A Wipro Company	PO 06195	There have been eight amendments to the contract. The amendments included date extensions along with service modifications required to meet Centers for Medicare & Medicaid Services (CMS) regulatory requirements. An additional extension was most recently approved at the October 7, 2021, Board of Directors meeting. The amendment is in progress.	Board Approval October 7, 2021
3. Imagenet, LLC	18-10184	There have been seven amendments to the contract. The amendments include service additions to accommodate changes to regulatory and business requirements as well as exercising options to extend the contract. An additional extension was most recently approved at the October 7, 2021, Board of Directors meeting. The amendment is in progress.	Board Approval October 7, 2021

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

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

Contacts
Ladan Khamseh, Chief Operations Officer, (714) 246-8866
Nora Onishi, Director, Information Services, (714) 246-8630

Rev 10/7/21: All contracts below extended for 3 years, except c. and d. were extended for 3.5 years.

Rev. 10/7/21: Option for one-year extensions exercisable at the Board's discretion.

Recommended Actions
Authorize the Chief Executive Officer (CEO) to:

1. Extend the contracts with the following vendors through the dates indicated in the attached Tables 1, 2 and 3:
    a. Cognizant TriZetto Software Group, Inc.
    b. Catalyst Solutions, LLC
    c. Edifecs, Inc.
    d. Imagenet, LLC
    e. LexisNexis Risk Solutions FL Inc, and Enclarity, Inc.
    f. Symplr
    g. Change Healthcare Technologies, LLC
    h. Ceridian Corporation
    i. Silk Road Technology, Inc.
    j. Varis, LLC
    k. SmartComms, LLC
    l. InfoCrossing, A WIPRO Company
    m. Intuitive Technology Group, Inc.
    n. Lumen Technologies
2. Authorize payment of maintenance and support fees to these vendors through the dates and up to the amounts indicated in the attached Tables 1, 2 and 3.

Background
CalOptima contracts with several vendors that provide a variety of software solutions to support CalOptima's overall business model. There are two core systems, Facets and Guiding Care, that are central to CalOptima's infrastructure while many other supporting solutions surround them.

Within the managed care industry, it is standard practice to have multiple systems because no commercially available single solution can meet the demands of the industry for all necessary functions. The trend over the past ten years or more has been to utilize each core application for what that system handle best, and to use specialty solutions to supplement the core. CalOptima, along with virtually all other local health plans in the state, use this approach.

Primary and supporting systems include:

a. **Cognizant TriZetto Software Group, Inc. –** Facets is CalOptima's core business system that manages Membership/eligibility data, Customer Service, Claims and Provider Dispute

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Rev. 10/7/21: Option for one-year extensions exercisable at the Board's discretion.

Requests. In 2018, CalOptima initiated a Request for Information (RFI) to review available systems within the industry to determine whether it would make sense for CalOptima to replace the current system. There is no one system that handles everything well, and although we identified systems that can perform some functions better than CalOptima's current core system, there are trade-offs to consider. To replace a core system like this would require a minimum of two to three years to issue a Request for Proposal (RFP), enter into a contract and implement the transition. In addition, the cost would be at a minimum of $10–15 million (based on information from other county organized health systems (COHS) that have recently gone through this process). In further review and discussion with Gartner[1], the recommendation was to consider procuring supplemental systems to offset some of the functionality gaps within the core system. At the February 2020 meeting of the Finance and Audit Committee (FAC) of the Board, staff recommended staying with our current core system and to consider supplemental functions to fill any gaps. One such supplemental initiative include the Provider Data Management System RFP that is currently in progress. Staff recommends approval of extending the Facets contract for three additional years with the options to extend the agreement for two additional one-year terms (through June 2027) in order to provide staff with sufficient time to implement supplemental systems and re-evaluate whether the functional gaps have been fully addressed.

b. **Catalyst Solutions, LLC** is a vendor utilized for technical support for Facets. This vendor has supported many of our Facets upgrades over the years. The vendor is extremely familiar with our infrastructure and the Facets product. Catalyst Solutions' contract was extended by the Board on December 6, 2018, in line with the Facets Core System extension, due to the vendor's knowledge of CalOptima's infrastructure and the application. Staff recommends extending the contract for three additional years with the options to extend the agreement for two additional one-year terms (through June 2027) in alignment with the Facets contract.

c. **Edifecs, Inc.** is a software tool that supports quality for the CalOptima Facets Claims processes. XEngine through Edifecs is a tool that validates and ensures compliance with regulatory transaction standards and streamlines operational efficiency. This vendor has provided solutions that are tightly integrated with our core system. Staff recommends approval of extending the contract for three and a half additional years with the option to add two one-year extensions (through June 2027) to match the extension date of the Facets contract.

d. **Imagenet, LLC** is the vendor that provides imaging, scanning, data lift and document archive solutions. Multiple departments utilize their scanning and image data lift to provide data files for claims and enrollment selection processes. Along with that, Imagenet provides the electronic data imaging archives for provider documents and Medication Therapy Management (MTM) letter documentation, as well as historical Grievance and Appeals documentation. This vendor has provided solutions that are tightly integrated with our core system. Staff recommends approval of extending the contract for three and a half additional years with the option to add two one-year extensions (through June 2027) to match the extension date of the Facets contract.

e. **LexisNexis Risk Solutions FL Inc. and Enclarity, Inc.** provides a solution to validate Provider Data used at CalOptima, including demographic data and identification of providers that are on Federal exclusion lists. This software is tightly integrated to the core system. Staff

[1] Gartner is a leading technical research and advisory company that provides senior CalOptima leaders with the indispensable business insights and advice to achieve the mission-critical priorities.

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Rev. 10/7/21: Option for one-year extensions exercisable at the Board's discretion.

recommends approval of extending the contract for an additional two years and eight months with the option to add three one-year extensions (through June 2027) to match the extension date of the Facets contract.

Provider Credentialing and Contracting Systems:

The following two contracts are for provider credentialing (Symplr) and provider contracting (Change Healthcare Technologies). Staff is currently in the RFP process to select and implement an integrated solution for Provider Data Management, Contracting and Credentialing. This integrated solution will potentially replace the current Credentialing and Contracting systems if new vendor(s) are selected consistent with the Board-approved Purchasing policy. Due to the complexity of this effort, staff estimates that the integrated solution implementation will be completed by the end of 2024. Staff recommends approval of extending both contracts annually for up to two additional years (through December 2024) to allow sufficient time for completion of the RFP and implementation of the selected system.

a. **Symplr** provides provider credentialing software. As noted above, staff plans to complete the RFP process and implement a new solution by the end of 2024. Staff recommends approval of extending the contract for one additional year and sixteen days with an option for two additional one year extensions.(through December 2024).
b. **Change Healthcare Technologies, LLC** is a provider contract management software system. As noted above, staff plans to complete the RFP process and implement a new solution by the end of 2024. Staff recommends approval of extending the contract for an additional one year and one day with an option for two additional one year extensions (through December 2024).

Human Capital Management (HCM) Systems:

The following three systems support our Human Resources (HR) function. CalOptima's HR Department currently utilizes several disparate systems to assist in managing employee information and applicant tracking. The RFP planned for FY 2019–2020 to replace these three systems was deferred due to other priorities related to the COVID pandemic. Staff is currently preparing a Human Capital Management (HCM) solution RFP to be issued in Fall 2021 to review products in the marketplace. This RFP seeks an integrated solution to support several HR and Finance functions, including, but not limited to, core HR functions, benefits, workforce management, payroll, applicant tracking and recruitment, and performance management, which are currently provided by several different systems. By allowing a one-year extension to these three systems below, staff will have time to complete the RFP, contract with the successful vendor, and implement a new solution for HCM.

a. **Ceridian Corporation-** Dayforce is the primary HR and Finance system handling employee benefits and payroll. As noted above, by allowing a one-year extension to this contract, staff will have sufficient time to complete the HCM RFP and implement a new solution. Staff recommends approval of extending the contract for one additional year (through January 6th 2023).
b. **Silk Road Technology, Inc.-** OpenHire is the current HR applicant tracking and recruitment system. WingSpan is the current employee performance management system where all CalOptima staff performance evaluations are created and stored. As noted above, by allowing a one-year extension to this contract, staff will have sufficient time to complete the HCM RFP and implement a new solution. Staff recommends approval of extending the contract for one additional year (through December 2022).

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Rev. 10/7/21: Option for one-year extensions exercisable at the Board's discretion.

Other Systems

a. **Varis LLC** provides overpayment identification and post-payment recovery services of potential overpayment of services that utilized Diagnosis Related Group (DRG) for Inpatient Medicare and Medi-Cal and Outpatient or Ambulatory Payment Classification (APC) payment guidelines to determine the claims payment amount. To summarize the audit review process, Varis conducts the data and clinical analysis based on CalOptima's paid files and review of medical records, as needed, and identifies the dollar recovery amounts based on their audit findings. By allowing a one-year extension, staff will have time to complete the RFP process, and if the same vendor is not selected, it will allow sufficient time to contract and implement a new solution. Staff recommends approval of extending the contract for one additional year (through September 24th, 2023).

b. **SmartComms, LLC** provides system generated letters for claims requests as well as claims denials. This solution was originally selected to support the Care Management vendor solution. With the decision to process a RFP to select a Care Management solution, the letter generating solution may change with that direction. Staff recommends approval of extending the contract for one additional year (through December 30th, 2022) to allow time to complete the Care Management System RFP which will impact the letter communication system.

c. **InfoCrossing, A WIPRO Company** is a CMS third party vendor that supports our process to submit enrollment and disenrollment updates to CMS. The vendor provides CMS data files for membership reconciliation for OneCare, OneCare Connect, and PACE. WIPRO supports file transfers between CalOptima and CMS. This vendor has maintained our stability to process regulatory file requirements to CMS. With the Duals Demonstration coming to an end and the transition of member planning in progress, it would be best to stay with the existing vendor to assure stability in transition. Staff recommends approval of extending the contract for an additional three years, two months and three days, to cover the period of the transition and the first year thereafter (through December 31st, 2024). Post transition, staff will issue an RFP to review the available systems in the market.

d. **Intuitive Technology Group, Inc.** Tableau is an enterprise-wide reporting and analysis tool that provides staff with the capability to review and analyze clinical, financial, and other data to monitor and improve performance. In addition to costs associated with selecting and implementing a new tool, to replace a system like this, it would require the use of a new tool for staff to perform data analysis and to be re-trained to re-create the many reports and dashboards developed over the last four years. Staff's recommendation is to approve extending the contract for three additional years (through November 28th, 2024).

e. **Lumen Technologies** is CalOptima's carrier for telecommunications as well as Internet connectivity. This vendor supports this particular area of the County. Internet and telecommunication stability during the pandemic has been essential to keep our communications functioning. We have not experienced any major issues with the vendor during the pandemic. Staff's recommendation is to approve extending the contract for three additional years (through 12/31/2024).

Discussion

The vendors listed above and in the attached tables represent the solutions described and contracts expiring in 2021 and 2022. Replacing any of these solutions in the short term would require substantial additional investment, time commitment, as well as significant disruption to operations.

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Many of these solutions are tightly embedded and integrated into either Facets or Guiding Care (the core systems):

I. Table 1. Unless core systems are replaced, replacing these tightly integrated solutions is not feasible without substantial investment and significant disruption to the operations. Some of the vendors also represent the most viable solution considering CalOptima's operating environment.

II. Table 2. The vendors in this category have expiring contracts, but due to the complications related to the COVID-19 pandemic during the past 18 months, staff needs additional time to complete the RFP processes and selection of new vendors. Extending these contracts as proposed will allow sufficient time for selection and implementation of new systems and avoid potential gaps in services.

III. Table 3. This table lists the technical solutions that provide support to the infrastructure and stability for the above systems. Extending these vendor solution contracts will allow additional time to complete the other RFP processes and determine whether an RFP to change technical directions is needed.

Fiscal Impact

The CalOptima Fiscal Year 2021–22 Operating Budget, approved by the Board on June 3, 2021 includes the annual fees for the listed contracted vendors related to CalOptima's core and supporting systems through June 30, 2022. Management will include expenses for the recommended contract extension periods on or after July 1, 2022, in future CalOptima operating budgets.

Rationale for Recommendation

Extension of the contracts for these systems will ensure there is no disruption to the services provided by each of the solutions and allows continuity of operations throughout the organization that impact CalOptima's member and provider community.

Concurrence

Gary Crockett, Chief Counsel

Rev 10/7/21: All contracts below extended for 3 years, except c. and d. were extended for 3.5 years.

Rev. 10/7/21: Option for one-year extensions exercisable at the Board's discretion.

Attachments

1. Tables of Proposed Contract Extensions
2. Entities Covered by this Recommended Board Action
3. Appendix: Summary of Contract History
4. Board Action dated June 3, 2021: Consider Approval of the CalOptima Fiscal Year 2021–22 Operating Budget
5. Board Action dated March 5, 2020: Consider Authorization of Expenditures in the CalOptima Fiscal Year 2019–20 Operating Budget for Claims Editing Solution and Recovery Services
6. Board Action dated December 6, 2018: Consider Extension of Contract Related to CalOptima's Core System, Facets
7. Board Action dated December 6, 2018: Consider Extension of Contracts Related to CalOptima's Key Operational and Human Resource Systems
8. Board Action dated September 1, 2016: Consider Extension of Contracts Related to CalOptima's Core Systems

/s/ Richard Sanchez — **Authorized Signature**

09/29/2021 — **Date**

Rev 10/7/21: All contracts below extended for 3 years, except c. and d. were extended for 3.5 years.

Rev. 10/7/21: Option for one-year extensions exercisable at the Board's discretion.

Tables — Proposed Contract Extensions

Table 1 — Solutions tightly integrated with the two core systems (Facets and/or Altruista)

Number from List, Vendor, Solution Name (if applicable)	Description of Service	Original Contract Start Date	Current Contract Expires	Recommend Contract Extension Through	Annual Cost Based on Fiscal Year 2021–22 Budget
a. Cognizant TriZetto Software Group, Inc.	Core business applications supporting membership, claims	2/22/2000	6/30/2022	6/30/2027	$1,915,000
b. Catalyst Solutions, LLC	Technical consultant support for Facets	4/21/2014	6/30/2022	6/30/2027	$28,000
c. Edifecs, Inc.	Electronic transaction standardization software	03/09/2011	12/31/2021	6/30/2027	$114,100
d. Imagenet, LLC	Archiving and document imaging services	11/21/2017	12/31/2021	6/30/2027	$350,000
e. Lexis Nexis Risk Solutions Fl Inc. and Enclarity, Inc.	Provider exclusion software	5/01/2015	10/31/2021	6/30//2027	$324,000

Table 2 — Solutions defined as essential systems with contracts that need extending to allow time for RFP selection and contract negotiation with implementation of the selected vendor to replace existing systems, and to assure there are no gaps in service.

Number from List, Vendor, Solution Name (if applicable)	Description of Service	Original Contract Start Date	Current Contract Expires	Recommend Contract Extension Through	Annual Cost Based on Fiscal Year 2021–22 Budget
f. Symplr	Credentialling system	11/29/2011	12/15/2021	12/31/2024	$119,000
g. Change Healthcare Technologies, LLC	Contract management software system	12/30/2016	12/30/2021	12/31/2024	$355,000
h. Ceridian Corporation	Employee payroll	6/29/2008	1/06/2022	1/06/2023	$384,000
i. Silk Road Technology, Inc.	HR recruitment tracking (Open Hire) and HR performance management (Wingspan)	06/19/2009	12/31/2021	12/31/2022	$81,000
j. Varis LLC	High dollar and forensic claims review	9/25/2017	9/24/2022	9/24/2023	$1,450,000
k. SmartComms, LLC	Letter generation software	12/31/2016	12/30/2021	12/30/2022	$145,000
l. InfoCrossing, A WIPRO Company	CMS enrollment/eligibility verification and CMS file reconciliation	05/01/2005	10/28/2021	12/31/2024	$24,000

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Rev. 10/7/21: Option for one-year extensions exercisable at the Board's discretion.

Table 3 — Technical solutions that maintain service level consistency.

Number from List, Vendor, Solution Name (if applicable)	Description of Service	Original Contract Start Date	Current Contract Expires	Recommend Contract Extension Through	Annual Cost Based on Fiscal Year 2021–22 Budget
m. Intuitive Technology Group, Inc.	Business intelligence software — Tableau	11/22/2017	11/28/2021	11/28/2024	$238,505
n. Lumen Technologies	Internet connectivity	02/15/2012	12/31/2021	12/31/2024	$984,000

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Cognizant Trizetto Software Group, Inc.	300 Frank W Burr Blvd.	Teaneck	NJ	07666
Catalyst Solutions, LLC	6400 S. Fiddlers Green Circle	Greenwood Village	CO	80111
Edifecs, Inc	1756 114th Ave. SE	Bellevue	WA	98004
Imagenet, LLC	5401 W. Kennedy Blvd.	Tampa	FL	33609
LexisNexis Risk Solutions FL Inc. and Enclarity, Inc.	1105 N Market St, Ste 501	Wilmington	DE	19801
Symplr	315 Capitol St., Suite 100	Houston	TX	77002
Change Healthcare Technologies, LLC	100 Airpark Center Dive East	Nashville	TN	37217
Ceridian Corporation	3311 E Old Shakopee Rd	Minneapolis	MN	55425
Silk Road Technology, Inc	100 S. Wacker Dr, Suite 425	Chicago	IL	60606
Varis, LLC	3915 Security Park Dr, Ste B	Rancho Cordova	CA	95742
SmartComms, LLC	250 Commercial Street	Manchester	NH	03101
InfoCrossing, A WIPRO Company	2 Tower Center	East Brunswick	NJ	08816
Intuitive Technology Group, Inc.	4530 W 77th Street, Suite 255	Edina	MN	55435
Lumen Technologies	100 CenturyLink Dr.	Monroe	LA	71203

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Rev 10/7/21: All contracts below extended for 3 years, except c. and d. were extended for 3.5 years.

Rev. 10/7/21: Option for one-year extensions exercisable at the Board's discretion.

APPENDIX TO AGENDA ITEM 16

Summary of Contract History

Vendor	Contract Number(s)	History of Contract Changes (Summary)	Last Approval
a. Cognizant TriZetto Software Group, Inc.	00-849-2197	There have been 48 amendments to the contract. These amendments have included time extensions, functional enhancements to support changes to regulatory and business requirements over the years, and administrative changes. Staff conducted multiple RFIs to survey the market for claims processing and customer service systems. Most recently, at the February 2020 meeting of the Finance and Audit Committee (FAC) of the Board, staff recommended to stay with our current core systems and to consider supplemental functions to fill the gap.	Board Approval December 6, 2018
b. Catalyst Solutions, LLC	14005	There have been 9 amendments to the contract. The amendments included date extensions along with technical support for system configuration changes required to meet regulatory and business requirements.	Board Approval December 6, 2018
c. Edifecs, Inc.	MC 01759	This contract has been extended 10 times. The extensions have included date extensions along with licensing modifications and technical support to accommodate changes to regulatory and business requirements.	Board Approval December 6, 2018
d. Imagenet, LLC	18-10184	There have been 7 amendments to the contract. The amendments include service additions to accommodate changes to regulatory and business requirements and the exercise of options to extend the contract that was included in the original contract.	Budget Approval June 3, 2021
e. Lexis Nexis Risk Solutions FL Inc. and Enclarity, Inc.	15-0964/ 15-0973	There have been 6 amendments to the contract. The amendments include date extensions, administrative changes and pricing updates.	Budget Approval June 3, 2021

Vendor	Contract Number(s)	History of Contract Changes (Summary)	Last Approval
f. Symplr	MC 01611	There have been 9 extensions to the contract. The extensions have included date extensions along with licensing modifications and technical support to accommodate changes to regulatory and business requirements.	Budget Approval June 3, 2021
g. Change Healthcare Technologies, LLC	17-10538	There have been 2 amendments to the contract. The amendments include technical support services related to the implementation and upgrade of the software.	Budget Approval June 3, 2021
h. Ceridian Corporation	MC 03232	There have been 12extensions to the contract. The extensions have included software license modifications and technical support services related to the implementation and upgrade required to meet regulatory and business requirements.	Board Approval December 6, 2018
i. Silk Road Technology, Inc.	MC 02042	There have been 10 extensions to the contract. The extensions have included technical support services related to the implementation and upgrade of the software.	Board Approval December 6, 2018
j. Varis, LLC	17-10537	There have been 2 amendments to the contract. The amendments were for date extensions.	Board Approval March 5, 2020
k. SmartComms, LLC	17-10511	There have been 2 amendments to the contract. The amendments include technical service additions to support implementation and the exercise of options to extend the contract that was included in the original contract.	Budget Approval June 3, 2021
l. InfoCrossing, A WIPRO Company	PO 06195	There have been 8 amendments to the contract. The amendments included date extensions along with service modifications required to meet CMS regulatory requirements.	Budget Approval June 3, 2021
m. Intuitive Technology Group, Inc.	18-10487	There have been 2 amendments to the contract. The amendments include additional licenses to support organizational growth and the exercise of options to extend the contract that was included in the original contract.	Budget Approval June 3, 2021

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 6, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

11. Consider Extension of Contracts Related to CalOptima's Key Operational and Human Resource Systems

Contact

Len Rosignoli, Chief Information Officer, (714) 246-8400
Ladan Khamseh, Chief Operating Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO) to:

1. Extend the contracts with the following vendors as listed below through the dates indicated in the attachment:
    a. Altruista Guiding Care
    b. Burgess Reimbursement System
    c. Edifecs XEngine
    d. Catalyst Solutions
    e. Medecision
    f. Star MTM
    g. Ansafone
    h. Ceridian Dayforce
    i. Silk Road Open Hire and Wingspan

2. Authorize payment of maintenance and support fees to these vendors through the dates and up to the amounts indicated in the attachment, Table 1.

Background

CalOptima contracts with many vendors that provide a variety of software solutions to support the overall business model. Two core systems are central to this infrastructure while many other supporting solutions surround the core.

Within the managed care industry, this is standard practice, as no commercially-available single solution meets the demands of the industry for all functions, especially when considering the varying lines of business, government regulations, and the uniqueness of each health plan. The trend over the past ten years or more has been to utilize this approach by using a core administrative processing system surrounded by specialty solutions. CalOptima, as well as the other 15 Local Health Plans of California, and virtually all health plans, use this approach.

The two core systems for CalOptima are:

1. Cognizant Facets – This solution handles the key functions of enrollment of members, health benefit configuration, claims processing and adjudication, provider contract reimbursement, and customer service.

2. Altruista Guiding Care – This solution handles the key functions of Care Management, including Case Management, Utilization Management, Authorizations/Referrals, Disease Management, as well as Appeals & Grievances.

The systems included in this staff recommendation are:

a. Altruista Guiding Care – As mentioned above, this is one of CalOptima's two core systems. CalOptima originally contracted with Altruista in April of 2014 for a term of seven total years, including an initial term and five one-year optional renewal terms extending to 4/6/2021. The system was live as of April 2015. There are two years remaining on the current contract, supporting the decision to recommend approval to extend for those two years, to 4/6/2021. Replacement of this core system was a substantial investment in money and time. It can take years for a core system of this type to fully stabilize. There are additional features yet to be explored, including the Population Health modules. No later than during Fiscal Year (FY) 2019-2020, a Request for Information (RFI) will be issued, primarily to remain informed and evaluate the marketplace for systems of this type, to help determine how long this system will remain or when it may be considered for replacement through a Request for Proposal (RFP) process.

b. Burgess Reimbursement System – This solution provides two key function. One - it enables continuous monitoring of the hundreds of claims reimbursement Medicare fee schedules maintained by the Federal Centers for Medicare and Medicaid Services (CMS) ensuring that CalOptima's Medicare fee schedules are up-to-date as soon as Medicare makes a change. Two - it uses sophisticated algorithms to calculate the reimbursement pricing for all CalOptima Medicare related claims. In the future, this solution will be expanded to perform the same functions for the Medi-Cal fee schedules and claims pricing. This system is very tightly integrated within the Facets core system software.

c. Edifecs – XEngine – This tool supports quality for the CalOptima Facets Claims process. XEngine is a tool that validates and ensures compliance with regulatory transaction standards and streamlines operational efficiency.

d. Catalyst Solutions – This vendor provides essential supplemental maintenance services and support of the Facets system based on their depth of knowledge of Facets and the inner workings of the software.

e. Medecision - Aerial Care Coordination - This solution is the current CalOptima provider portal – more commonly known to the CalOptima provider partners as CalOptima Link. This portal enables thousands of provider office users to verify eligibility, review claims status, view patient rosters, and submit service authorization requests. This will ultimately be replaced by the new CalOptima Provider Portal.

f. Star MTM – This vendor provides the system and services to support the Pharmacy Medication Therapy Management process required by The Centers for Medicare and Medicaid Services (CMS) for both the OneCare and OneCare Connect lines of business. This process is tightly integrated within the overall administration of CalOptima's pharmacy benefit. An RFP will be issued during FY 2020-2021 to re-evaluate this service.

g. Ansafone – This vendor provides critical services supporting both CalOptima's Customer Service function and the Medical Affairs function. Ansafone provides after-hours call center support for both general customer service calls as well as more specific medical affairs calls. Ansafone also periodically conducts designed member outreach calls, as needed. An RFP for this service will be issued during FY 2018-2019 to evaluate the marketplace and to determine if CalOptima will retain the existing vendor or consider other alternatives.

h. Ceridian Dayforce – This is the primary Human Resources (HR) system handling employee benefits and payroll.

i. Silk Road Open Hire and Wingspan – Open Hire is the current HR applicant tracking and recruitment system. Wingspan is the current performance management system where all CalOptima employee performance evaluations are stored.

   These three HR systems are tightly woven into the support and management of the CalOptima employees and are mission-critical for ongoing smooth operations. CalOptima has been on these systems for nearly ten years. During FY2019-20, CalOptima will issue an RFP for these functions to evaluate the marketplace to determine if a replacement is warranted, and if a single comprehensive HR solution can be procured rather than separate systems.

Discussion

The vendors listed in the attached table represent the solutions described above with contracts expiring in 2019 or sooner.

Many of these solutions are tightly embedded/integrated into either Facets and/or Guiding Care or are mission critical to the Human Resources function. Replacing any of these solutions would require a substantial additional investment, time commitment, and significant disruption to operations.

Fiscal Impact

The CalOptima FY 2018-19 Operating Budget includes the annual fees for the listed contracted vendors related to CalOptima's core and HR systems through June 30, 2019. Management will include expenses for the recommended contract extension periods on or after July 1, 2019, in future CalOptima Operating Budgets.

Rationale for Recommendation

Extension of the contracts for these systems will ensure there is no disruption to the services provided by each of the solutions and allow continuity of operations throughout the organization and with CalOptima's member and provider community, and its employees.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Proposed Contract Extensions – Table 1
2. Contracted Entities Covered by this Recommended Board Action

/s/ Michael Schrader — *11/28/2018*

Authorized Signature — **Date**

Attachment – Table 1 - Proposed Contract Extensions

Vendor – Solution Name	Description of Service	Original Contract Start Date	Current Contract Expires	Recommend Contract Extension Through	Comments	Annual Cost Based on Fiscal Year 2018-19 Fees
Altruista Health – Guiding Care	Core Care Management Solution	4/6/2014	4/6/2019	4/6/2021	2 years remaining on the original contract	$1,485,000
Burgess – Burgess Reimbursement System	Medicare/Medi-Cal Fee Schedules and Claims Pricing	1/1/2008	12/31/2019	6/30/2022	Tightly Integrated with Facets	$442,162
Edifecs – XEngine	Electronic transaction standardization tool	3/9/2011	12/31/2019	12/31/2021	Tightly Integrated with Facets	$90,000
Catalyst Solutions	Facets Support Services	4/21/2014	12/31/18	6/30/2022	Integral supplemental maintenance services for Facets	$35,000
Medecision – Aerial Care Coordination	Provider Portal (CalOptima Link)	3/23/2011	12/31/2019	12/31/2020	Eventually to be replaced with Provider Portal	$1,560,000
Star MTM	Pharmacy Medication Therapy Management Services	11/1/2014	3/21/2020	3/21/2022	Tightly Integrated into the Pharmacy process. Expect to issue RFP during Fiscal Year 2020-2021.	$156,000
Ephonamation.com, Inc., DBA Ansafone	After hours customer service call center; after hours medical affairs call center; member outreach.	9/1/2016	8/31/2019	8/31/2020	Tightly integrated within Customer Service and Medical Affairs. RFP to be issued during Fiscal Year 2018-2019.	$213,000
Ceridian - Dayforce	The main Human Resources System for Benefits and Payroll	6/29/2008	6/30/2019	12/31/2021	Plan to issue RFP during Fiscal Year 2019-2020	$254,000

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Vendor – Solution Name	Description of Service	Original Contract Start Date	Current Contract Expires	Recommend Contract Extension Through	Comments	Annual Cost Based on Fiscal Year 2018-19 Fees
Silk Road – Open Hire and Wingspan	Human Resources Support Systems – Performance Management, Applicant Tracking	6/19/2009	6/30/2019	12/31/2021	Plan to issue RFP during Fiscal Year 2019-2020	$58,500

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Altruista Health, Inc.	11800 Sunrise Valley Dr Suite 1000	Reston	VA	20191
Burgess Group, LLC	1701 Duke St	Alexandria	VA	22314
Edifecs, Inc.	1756 114th Ave SE	Bellevue	WA	98004
Catalyst Solutions, LLC	2353 S Broadway	Denver	CO	80210
Medecision, Inc.	550 E Swedesford Rd Building D, Suite 220	Wayne	PA	19087
Star MTM, LLC DBA Clinical Support Services	701 Seneca St	Buffalo	NY	14210
Ephonamation.com, Inc., DBA Ansafone Communications	145 E Columbine Ave	Santa Ana	CA	92707
Ceridian Corporation	3311 E Old Shakopee Rd	Minneapolis	MN	55425
SilkRoad Technology, Inc.	100 S Wacker Dr Suite 425	Chicago	IL	60606

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 4, 2022
Regular Meeting of the CalOptima Board of Directors

Report Item

19. Approve Actions Related to the Procurement of a Robotic Process Automation Software Solution

Contacts

Wael Younan, Chief Information Officer / Chief Information Security Officer, (657) 900-1154
Nora Onishi, Director, Information Technology Services, (714) 246-8630

Recommended Actions

1. Approve the scope of work (SOW) for the Robotic Process Automation (RPA) software solution.
2. Authorize the Chief Executive Officer to release the RPA request for proposal (RFP) with the approved SOW, and to negotiate and contract with the selected vendor.

Background

As part of CalOptima's Workplace Modernization and Digital Transformation Strategy, Information Technology Services will be evaluating and deploying multiple solutions. These solutions coincide with CalOptima's Cloud First strategy and take regulatory compliance and security measures into consideration. These initiatives will assist CalOptima in achieving its Vision Statement of removing barriers to achieve real-time claims payments and 24-hour treatment authorizations and doing annual assessments around social determinants of health by 2027. The projects and products that CalOptima implements will result in value-based care and improvements for member, provider, and employee experiences. These enhancements will provide CalOptima with the ability to be robust and agile, and to scale as a future-focused healthcare organization.

Discussion

Approving the SOW and issuing a RFP to procure a vendor solution with functionality that provides RPA coupled with artificial intelligence and machine learning enhances CalOptima's ability to move forward with its digital transformation. When software robots take on rules-based and repetitive tasks, it enables CalOptima staff to take on a more strategic role. RPA is scalable with growth of membership and additional programs or project requirements to support repetitive work, allowing staff to have time to focus on real decision work. Advantages of RPA are reduced turnaround time, resolution of errors, and quicker resolution to data input and workflow process. RPA can run "unattended" 24 hours a day with higher efficiency.

The attached SOW will support the request for approval to release - the RFP, which will support CalOptima's business requirement to enhance healthcare delivery and work toward real-time claims payments and 24-hour treatment authorizations. If approved, the RFP will be issued consistent with CalOptima's procurement process. Review of bids by a committee with a representation of stakeholders from multiple departments will take place to ensure collaboration and selection integrity by CalOptima staff. Based on the scoring from the bid review, CalOptima will request that vendors provide a demonstration for evaluation and functionality scoring to select a vendor.

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Fiscal Impact

The recommended action is a budgeted item. An estimated cost of $1.5 million for the capital project, "Enterprise Robotic Process Automation" under the "Applications Management" category was included in the Fiscal Year 2022-23 Digital Transformation Year One Capital Budget approved by the Board on June 2, 2022.

Rationale for Recommendation

This additional capability will help increase CalOptima's capacity and productivity, allowing CalOptima to do more with less while improving accuracy and lowering costs. RPA will be a key element as CalOptima works on achieving real-time claims payments and 24-hour treatment authorizations by allowing software robots to improve the manual processes that CalOptima staff does now. These processes can be done more efficiently with fewer errors and can run 24/7 unattended. This can save both processing time and labor costs by automating the workloads.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Proposed Robotic Process Automation Scope of Work.docx

/s/ Michael Hunn *07/28/2022*
Authorized Signature **Date**

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Robotic Process Automations with Artificial Intelligence and Machine Learning Scope of Work

OBJECTIVE

The purpose of this RFP is to solicit proposals from qualified robotic process automation (RPA) software vendors interested in contracting with CalOptima to perform these services. RPA will support automation of repetitive and decisive tasks to improve efficiency, ensure compliance, and to provide the time needed for the workforce to focus on decision support. RPA is a key function to support CalOptima's vision of Same-Day Treatment Authorizations and Real-Time Claims Payments.

CalOptima has the option to award contracts to a single or multiple supplier(s) as needed to ensure required coverage for its members. CalOptima has the option to retain any partial services in-house.

A. **RPA / AI / ML Functional Requirements:**

1. RPA Capabilities and Functionality:

A. Robotic Process Automation (RPA):

1. Streamline processes paving a path to digital transformation in a consistent repetitive workflow.

2. Automating repetitive tasks to simulate manual process.

3. Intelligent document processing. Full documentation of steps, process, entries, decision tree branching and outcomes.

a. Describe the functional capabilities to document screen shots to ensure the screen capture contains all necessary information.

4. Support automation of regression testing and validation of code or configuration changes. Consistent and structured process to avoid missed steps and capture of detail results.

5. Manage robotic process in multiple functional departments – with various system process updates. Examples of areas of focus process:

a. ITS – maintenance deployment and validation of updates to user PCs/ Laptops.

b. Customer Services call center data updates.

c. Claims processing / adjudication/ research / validation.

i. Ability to intake claims from the system on a nightly basis and triage for distribution of work.

1. Complete clean claims within guidelines and final disposition.

2. Route unclean or unmet guidelines to claims examiners queue.

ii. Claims Explanation of Benefits (EOB) documents – data translation and entry to support claims data completeness workflow.

1. Receive multiple document types from various primary payer EOB, which requires entry into the system to resolve the pended claims.

iii. Future State: Ability to intake on-line claims from the portal, complete real-time review, and process adjudication to complete clean claims to render payment and /or final determination.

1. Route unclean claims to claims examiner's queue.

2. Route non-payable decisions to claims examiner for review based on set guidelines.

d. Provider data sanction site validation

i. Provider data record updates from sanction findings.

ii. Data updates from inbound Health Network and provider attestation information.

iii. Conduct routine monthly, quarterly, or annual review of provider data and taxonomy updates from regulatory sites to maintain provider data integrity.

e. Utilization Management – Authorization entries, updates, procedure code and data field validations, ability to generate letters documentations for closure.

i. Ability to work with intake from faxes to create the authorization.

ii. Ability to process through work queue monitoring for inbound authorizations submitted via the portal – to drive automated decision based on clinical guidelines and/ or verification of code guidelines.

iii. Ability to complete notifications and update core systems to support completed authorizations process.

iv. Ability to route and distribute to appropriate staff work queues to enable medical decision process by clinical team.

f. Case Management – Clinical / Social analytics – outreach process

i. Reminder follow-up outreach campaigns.

ii. Health Risk Assessments – data entry into templates and analysis triggers to outreach.

g. Credentialing provider data collection, decision tree with captured data and documentation to support credentialed providers, leaving unverified providers for the workforce.

h. Finance / Accounting

i. Accounts Payable – invoice verification; Purchase Order funding; vendor and payroll pay cycle maintenance.

ii. Tax – 1099 provider address validation.

i. Etc.… (not limited to the examples above).

6. Reportable results: With each robotic function; capture data input/output performed and tracked to follow the rules and steps defined. All information captured are reportable and auditable to ensure compliance of defined process.

B. Intelligent Document Processing (IDP):

1. Document processing to convert unstructured document or images into accessible structured data. Leveraging Optical Character Recognition (OCR) and Intelligent Document Processing (IDP) to transform the information into accessible structured data.

a. Describe OCR/IDP software capability to handle different language and different types of text, such as handwritten, cursive, printed and mixed entries.

b. Ability to improve the image quality to extract data from low-resolution or distorted images.

c. Ability for OCR/IDP to assess confidence with accuracy rating of translation of documents.

d. OCR/IDP system must have a user interface to allow non-technical staff to set up and customize use cases, build new formats, and track metrics / results.

e. Describe the simplicity to set up OCR/IDP, configuration capabilities, and ability to manage the product with a scalable and stable API for integrations. To drive proper distribution of the data to the appropriate organizational structures – Emails, CRMs, ERPs, and other business applications.

f. Ability to leverage OCR/IDP document translation to discrete data and apply the data to RPA supporting end to end Process Automation.

C. Artificial Intelligence (AI) / Machine Learning (ML) / Natural Language Processing (NLP):

1. Leverage Machine Learning (ML), Natural Language Processing (NLP), Intelligent Optical Character Recognition (OCR), and Artificial Intelligence (AI) computer vision, so robots can read, see, and process more work.

a. To provide Intelligent Automation with RPA - must leverage ability to utilized cognitive technologies to expand the limitations of rules- based automation.

i. Machine / Deep Learning: Data analysis and analytical model building.

ii. Artificial Intelligence: Building knowledge with base foundation and analyzing each process and results to continue to build on the foundation. Ability to trend, forecast and apply insights.

iii. Natural Language Processing: Cognitive smart text recognition.

D. Hardware / Software, Technical requirements:

1. Define the simplicity of the infrastructure set up required to have functional RPA process set up.

a. Define hardware requirements and set up.

b. Define compatibility of RPA software with Microsoft and SQL.

c. Define ability to Integrate with enterprise applications; API connectors that can be orchestrated along with UI scrapers.

d. Simplify Low-code user experience (UX) for building UI front ends for bots.

e. Define requirements to develop process task mining and discovery to support and document procedures to enable RPA processing.

2. Support for real-time integration with multiple SOR systems, applications, and software through APIs.

E. System Function Configuration /Administration:

1. Orchestrate and administration capabilities, including configuration, monitoring, and security.

a. Define CalOptima's functional capabilities to administer Robotic Process Administration.

i. Define vendor set up to initiate RPA / AI / ML.

ii. Define CalOptima IT department functionality.

iii. Define End user (non-technical) capabilities to create their own robotic process.

b. Process/Task mining and discovery

i. Define requirement to set up robotic monitoring.

1. Define ability to leverage monitoring user steps with shadowing process.

2. Define ability to consider review of desk top procedures and provide level of automation based on DTP documentation.

c. Support for no-code/low-code development workflow automation to:

i. Service intake and processing.

ii. Rules-based approval and escalations.

iii. Time-based and/or rules-based notifications and alerts.

d. Ability to access workflow instances in a customizable dashboard for processing.

e. Define security administration controls.

i. For systems that require administrative security - describe ability to control robotic process to restrict access to task only.

f. Ability to trigger real-time alerts to management team – enable real-time interactions with Customer Service Staff.

F. Reporting, Analytics, and auditing functionality

1. Describe the level of data capture from RPA process through decision tree process to end results.

2. Define model or tool to assess ROI prior to leveraging process through RPA.

3. Define method to calculate Customer Success with RPA process.

4. Ability to report everything for audit purposes with tracked audit capture of adds/changes/ deletes within the record.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 4, 2022
Regular Meeting of the CalOptima Board of Directors

Report Item
20. Approve Modifications to CalOptima Administrative Policies

Contacts
Yunkyung Kim, Chief Operating Officer, (714) 246-8408
Nancy Huang, Chief Financial Officer, (657) 235-6935

Recommended Actions
Approve modifications to the following CalOptima policies:
1. AA.1217: Legal Claims and Judicial Review; and
2. GA.3202: Signature Authority.

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

Discussion
Staff request that the Board of Directors (Board) approve modifications to Policy AA.1217: Legal Claims and Judicial Review, and GA.3202: Signature Authority.

CalOptima Policy AA.1217: Legal Claims and Judicial Review was last revised on August 3, 2017. The policy describes the process for the presentation of legal claims and cases involving judicial review. Staff propose to amend the policy to align with the revisions to CalOptima's bylaws, as amended for the Board's consideration at this meeting. The proposed revision would increase the Chief Executive Officer's (CEO) authority to compromise any pending action against CalOptima from ≤$50,000 to ≤$300,000 and require the CEO to immediately report such actions to the Board.

Section	Proposed Change	Rationale
II.E., II.G.1.a.	Clarify that the CEO's designee may act not just "upon the CEO's unavailability"	Enhance efficiency in CalOptima's operations and governance
II.G.1.b.	Clarify that the amounts are "per individual claim"	Clarify reference point
II.G.2	Amends language to increase the authority of the CEO to compromise any pending action against CalOptima from ≤$50,000 to ≤$300,000 Added language to require CEO to immediately report such action to the Board	Align with CalOptima's amended bylaws and ensure transparency of the CEO's actions

CalOptima Policy GA.3202: CalOptima Signature Authority was last revised on October 3, 2019. The policy provides a delegation of authority for the execution of various types of documents binding

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CalOptima. The proposed revision would give the CEO authority to sign certain Department of Health Care Services (DHCS) or Centers for Medicare & Medicaid Services (CMS) contract amendments and CalOptima policies and procedures without separate Board approval. Specifically, the modified policy would delegate to the CEO authority to sign DHCS and CMS contracts that contain non-substantive changes or changes made only to comply with existing law. The Board shall approve any contracts that contain rate changes or have substantive policy or operational changes. Similarly, the modified policy delegates to the CEO authority to approve CalOptima policies and procedures that only contain non-substantive changes or changes made to comply with law. The CEO shall obtain legal advice in determining the nature of changes in contracts or policies and procedures.

Section	Proposed Change	Rationale
III.B	Added language "Except as specified in this policy"	Provide reference to exceptions allowed by policy
III.C	Added language to specify the types of DHCS and CMS contract amendments and CalOptima policies and procedures that the CEO is authorized to sign without Board approval	Enhance efficiency in CalOptima's operations and governance
III.D.2.b.ii and iii	Added language "CEO *or designee"* and "CFO *or designee"*	Enhance efficiency in CalOptima's operations and governance

In addition to the substantive modifications described above, staff also recommend non-substantive changes that are reflected in the redline (e.g., formatting, spelling, punctuation, capitalization, minor clarifying language, and/or grammatical changes).

Fiscal Impact
There is no fiscal impact.

Rationale for Recommendation
Updates to these administrative policies will enhance the efficiency of CalOptima's operations and governance.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. CalOptima Policy AA.1217: Legal Claims and Judicial Review
2. CalOptima Policy GA.3202: CalOptima Signature Authority

/s/ Michael Hunn *07/28/2022*
Authorized Signature **Date**

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Policy #: AA.1217
Title: **Legal Claims and Judicial Review**
Department: Administration
Section: Not Applicable

CEO Approval: Michael Schrader _____

Effective Date: 04/06/99
Last Review Date: 08/03/17
Last Revision Date: 08/03/17

Board Approved Policy

I. PURPOSE

To set forth the process for the presentation of Legal Claims to CalOptima in compliance with this Policy, Division 3.6 of Title 1 of the California Government Code, and all applicable statutes and regulations. Section 1094.6 of the California Code of Civil Procedure shall govern cases involving judicial review.

II. POLICY

A. General: As a public agency, CalOptima is subject to Division 3.6 of Title 1 of the California Government Code, pertaining to claims against public agencies. Any claims against CalOptima for money or damages, which are not governed by any other statutes or regulations expressly relating thereto, shall be presented in accordance with Title 1, Division 3.6, Part 3, Chapter 1 (commencing with Section 900) and Chapter 2 (commencing with Section 910) of the California Government Code, prior to initiating suit thereon.

B. Claims Presentation: Except as provided above in Section III.A, any action presented to CalOptima, which has the potential to be litigated, shall be handled in accordance with this Policy. Those actions include but are not limited to Verified Claims, Notice of Intent to Sue, Summons and Complaints, and all documents which have the potential to meet the criteria for a claim against a public entity as defined in Government Code Sections 910 and 910.2.

C. Excepted Claims: In accordance with the authority set forth in California Government Code Section 935, the claims procedures for those claims against CalOptima for money or damages, which are excepted from the claims presentation requirement by Government Code Section 905 and not governed by other statutes or regulations expressly relating thereto, are governed by the procedures set forth in this Policy. Notwithstanding any exceptions contained in Section 905 of the California Government Code, no action based on a claim or demand for money or damages shall be brought against CalOptima, or any of CalOptima's Board members, officers, employees, or agents, unless presented to, and acted upon by, the Board, as provided herein.

D. Timeliness: All claims shall be presented within the time limitations and in the manner prescribed by Sections 910 through 915.2 of the California Government Code. Such claims shall further be subject to the provisions of Section 945.4 of the California Government Code relating to the prohibition of suits in the absence of presentation of claims and action thereon by the Board.

E. Late and Insufficient Claims

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1. If the Chief Executive Officer (CEO), or their designee, determines that a claim fails to comply substantially with the presentation requirements of Government Code Sections 910 and 910.2, or with the requirements of a form provided under Government Code Section 910.4 if a claim is presented thereto, may give written notice of its insufficiency in accordance with Government Code Sections 910.8 and 915.4.

2. When a claim is not presented within the time limits prescribed in Government Code Section 911.2, the CEO, or their designee, is authorized to return the claim without further action, in accordance with Government Code Section 911.3 for claims required to be filed within six months, or reject the claim in accordance with Government Code Section 913 for all other claims.

F. Small Claims: In the cases of small claims actions brought against CalOptima which personally name an individual who has no personal knowledge of the claim (CEO, Chair of Board, etc.), it is permissible to substitute a representative with more personal knowledge for purposes of court appearances.

G. Delegated Functions of the Board and Settlement Authority

1. Claims Against CalOptima

a. The CEO, or their designee, is authorized to perform the functions of the Board which are specified in Part 3 of Division 3.6 of Title 1 of the California Government Code.

b. Such delegation includes the allowance, compromise, or settlement of any claims if the amount to be paid from CalOptima's treasury does not exceed $50,000 per individual claim. Notwithstanding the foregoing, any allowance, compromise, or settlement of any claim in which the amount to be paid from CalOptima's treasury exceeds $10,000 per individual claim shall be approved personally by the CEO, rather than his or her designee.

c. The CEO or his or her designee shall periodically report such actions to the Board of Directors.

2. Actions Against CalOptima: Consistent with Section 949 of Part 4 of Division 3.6 of Title 1 of the California Government Code:

a. The CEO, with the assistance of legal counsel, is authorized to compromise any pending action if the amount to be paid from CalOptima's treasury does not exceed $300,000. The CEO shall immediately report such action to the Board.

b. The Board may on a case-by-case basis authorize its CEO, with the assistance of legal counsel, to compromise any pending action where the amount to be paid from CalOptima's treasury exceeds $300,000. The CEO shall immediately report such action to the Board.

H. Judicial Review: In compliance with Section 1094.6 of the California Code of Civil Procedure, petitions for judicial review of any decision made by CalOptima must be filed within ninety (90) days after the action is final.

I. Claim Form: In accordance with California Government Code Section 910.4, CalOptima shall maintain and provide a claim form for the public's use, which form is attached hereto as Exhibit "A." All claims

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presented to CalOptima must be submitted on CalOptima's claim form pursuant to Government Code Section 910.4, or in a form that substantially complies with the claims requirements of California Government Code Sections 910 and 910.2. The CEO shall have the authority to revise the claim form from time to time as he or she deems necessary.

J. Exhaustion of Administrative Remedies: Nothing herein is intended to diminish, eliminate, or waive any legal or contractual obligation to exhaust CalOptima's administrative remedies prior to the presentation of a claim pursuant to this Policy.

III. PROCEDURE

Not Applicable

IV. ATTACHMENTS

A. CalOptima - Claim for Damage or Injury

V. REFERENCES

A. California Code of Civil Procedure, Section 1094.6
B. California Government Code, Title 1, Division 3.6, Sections 900-915.2, 935, 935.4, 945.4, and 949, and all applicable statutes and regulations.

VI. REGULATORY APPROVALS

None to Date

VII. BOARD ACTION

A. 05/05/22: Regular Meeting of the CalOptima Board of Directors
B. 08/03/17: Regular Meeting of the CalOptima Board of Directors
C. 12/04/14: Regular Meeting of the CalOptima Board of Directors
D. 08/05/03: Regular Meeting of the CalOptima Board of Directors
E. 06/04/02: Regular Meeting of the CalOptima Board of Directors
F. 04/06/99: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	04/06/1999	AA.1217	Legal Claims and Judicial Review	Administrative
Revised	06/04/2002	AA.1217	Legal Claims and Judicial Review	Administrative
Revised	08/05/2003	AA.1217	Legal Claims and Judicial Review	Administrative
Revised	01/01/2004	AA.1217	Legal Claims and Judicial Review	Administrative

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Revised	12/04/2014	AA.1217	Legal Claims and Judicial Review	Administrative
Reviewed	12/01/2015	AA.1217	Legal Claims and Judicial Review	Administrative
Revised	08/03/2017	AA.1217	Legal Claims and Judicial Review	Administrative

IX. GLOSSARY

Not Applicable

Policy:	GA.3202
Title:	**CalOptima Signature Authority**
Department:	CalOptima Administrative
Section:	Finance
Interim CEO Approval:	
Effective Date:	03/01/2012
Revised Date:	
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

I. PURPOSE

This policy sets forth the requirements for the execution of any document binding CalOptima in any manner.

II. POLICY

A. A CalOptima officer or employee may not expend any funds, or take any other action on behalf of CalOptima, unless the Board of Directors (Board) has approved such expenditure or action, or delegated its power to that officer or employee, subject to an articulated standard.

B. No document of any type whatsoever that binds CalOptima to undertake or refrain from undertaking any action, or to expend any CalOptima funds, shall be entered into except pursuant to this Policy.

C. In order for any document to bind CalOptima, the Board of Directors must have: (1) appropriated funds for the purpose identified in that document, (2) authorized the subject matter of the underlying action, and (3) the document must be executed by an authorized CalOptima representative, as identified in this Policy.

D. Amendments or other changes to any document binding CalOptima must be approved and executed in the same manner as the original document, except for minor price deviations, as provided within this Policy.

III. PROCEDURE

A. Board of Directors Appropriation: Except in emergency circumstances, as set forth CalOptima Policy GA.5002: Purchasing, no money may be expended for any purpose unless that money has been appropriated by the Board of Directors, through the operating or capital budget or individual Board action, and the subject matter of the expenditure has been approved by the Board of Directors, as set forth in this Policy.

B. Board of Directors Approval: Except as specified in this policy, no document binding CalOptima shall be entered into except pursuant to the approval of the CalOptima Board of Directors. In approving, the Board may delegate to a CalOptima officer the authority to enter into agreements

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that memorialize or are related to the approved action, subject to the assistance of legal counsel, rather than approving a specific binding document. Such approval must be through one of the following means:

1. Individual Board Action: To constitute an authorization though individual Board action, that action must either identify the subject matter of the authorization with reasonable specificity to allow the Board to make an informed decision and to allow staff to proceed without requiring any further fundamental policy decisions to be made, and must specify the nature and scope of that subject matter, such as amount, duration, reporting, or other limitations or requirements, as may be appropriate to the subject matter. Documents regarding arrangements in which the compensation is based in any part on monies recovered or costs avoided by the arrangement (contingency fee contracts) may only be entered into on the basis of a specific, individual Board action.

2. Operational or Capital Budget: To constitute an authorization through inclusion in CalOptima's operational or capital budget, expenditures must appear in a budget line item presented to the Board, be related to a Board-approved program or service, and meet the following requirements:

    a. Healthcare goods and services (for the direct provision of Covered Services*): The Board of Directors must approve, in the operating budget, an amount related to the healthcare or related service, and the expenditure must be pursuant to the criteria approved by the Board in an individual Board action, such as rates or rate methodologies, when adopted.

    b. Non-healthcare-related goods and non-professional services: To constitute an authorization through inclusion in the operating or capital budget, non-healthcare-related goods, non-professional services or other expenditure items must appear in a budget line item presented to the Board, specifying the following:

        i. The description of specific goods, services or other expenditure;

        ii. The number or duration of the goods, services or other expenditure items if available; and

        iii. The dollar amount of the expenditure.

    c. Non-medical professional services: Excluding those professional services contracts that must be authorized by direct Board action for legal or policy reasons, to constitute an authorization through inclusion in the operational or capital budget, non-medical professional services expenditure items must appear in a budget line item presented to the Board, specifying the following:

        i. The specific type of professional services to be obtained (e.g., actuarial, legal, management consulting, program evaluation, etc.), and the type of firm that would provide them (e.g., law firm, consultant, architect, engineer, etc.);

        ii. The objective of the professional services; and

        iii. The amount of the expenditure.

C. Board of Directors: The Board authorizes the CEO to enter into a document binding CalOptima under the following circumstances:

1. An amendment to a contract with the Department of Health Care Services (DHCS) or the Centers for Medicare & Medicaid Services (CMS) if that amendment:

    a. Contains only non-substantive changes, as determined by legal counsel;

    b. Contains only changes made to comply with existing law, as determined by legal counsel; and

    c. Does not contain rate changes.

2. A CalOptima Policy and Procedure (P&P) if that P&P:

    a. Contains only non-substantive changes, as determined by legal counsel; and

    b. Contains only changes made to comply with existing law, as determined by legal counsel.

D. Signature Authority: Documents executed pursuant to Board Authority, as identified in Section III.B of this Policy, may only be executed by the person expressly authorized to sign.

1. For authorizations that specify the signature authority in individual CalOptima Board Action Agenda Referral (COBAR), all related binding documents shall be executed by the person expressly authorized to sign.

2. For authorizations that do not specify the signature authority in individual COBAR, all related binding documents shall be executed as follows:

    a. Healthcare goods and services: For binding documents (such as contracts, amendments, consents to assignment, and Letters of Agreement (LOA)), including all those related to procurement of any goods and services that are Covered Services under any of CalOptima's lines of business, (e.g., those item budgeted under Section III.B.2.a):

        i. Except as provided in subsection ii of this Section, execution shall be by the Chief Executive Officer (CEO) or the Chief Operating Officer (COO).

        ii. For CalOptima Direct (COD) contracts that contain no changes from the standard boilerplate contract, and are for rates that do not exceed the Board of Director approved rates for the healthcare goods and services, execution may be by the CEO, COO, or the Executive Director, Network Operations.

    b. Budget and Vendor Management Department binding documents (such as contracts, amendments, consents to assignment, and purchase orders), for non-healthcare-related goods and services (e.g., those items budgeted under Sections III.B.2.b and III.B.2.c) shall be executed by the:

        i. CEO and the Chief Financial Officer (CFO), for documents involving an amount of two hundred fifty thousand dollars ($250,000) or more;

            1. For those contracts of two hundred fifty thousand dollars ($250,000) or more, the COO shall have delegated signature authority in the absence of either the CFO or the CEO.

ii. CEO or designee for documents for less than two hundred fifty thousand dollars ($250,000);

iii. CFO or designee for documents for one hundred thousand dollars ($100,000) or less;

iv. Controller or the Director of Budget and Procurement for documents for twenty-five thousand dollars ($25,000) or less; and

v. Purchasing Manager for documents for ten thousand dollars ($10,000) or less.

vi. Price term modifications in documents where payment is on a time and materials or per item basis, and that do not exceed ten percent (10%) of the original price term, either separately or cumulative, may be executed based on the price term increase amount. All other document modifications must be executed in the same manner as the original contract.

c. Emergency expenditure binding documents, related to emergency expenditures, as defined in CalOptima Policy GA.5002: Purchasing, shall be executed by the CEO or his or her Designee.

d. Government program contracts, documents that legally or by their terms require the signature of the governing body, and real property transaction documents (including leases) shall be executed by the Chair of the Board of Directors.

e. Employee reimbursements must be made, in accordance with the CalOptima Policy GA.5004: Travel Policy.

f. All Other binding documents (e.g., Memoranda of Understanding (MOU), Settlement Agreements, etc.) shall be executed by the CEO or Chair of the Board of Directors.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Policy GA.5002: Purchasing
B. CalOptima Policy GA.5004: Travel Policy

VI. REGULATORY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
03/01/2012	Regular Meeting of the CalOptima Board of Directors
09/19/2019	Regular Meeting of the CalOptima Finance & Audit Committee
10/03/2019	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	03/01/2012	GA.3202	CalOptima Signature Authority	Administrative
Revised	07/01/2012	GA.3202	CalOptima Signature Authority	Administrative
Revised	03/01/2013	GA.3202	CalOptima Signature Authority	Administrative
Revised	10/03/2019	GA.3202	CalOptima Signature Authority	Administrative
Revised	10/01/2020	GA.3202	CalOptima Signature Authority	Administrative

IX. GLOSSARY

Term	Definition
CalOptima Direct (COD)	A direct health care program operated by CalOptima that includes both COD-Administrative (COD-A) and CalOptima Community Network (CCN) and provides services to Members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment In/Eligibility with CalOptima Direct.
Covered Services	Medi-Cal: Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program, to the extent those services are included as Covered Services under CalOptima's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127), for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members notwithstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program. OneCare: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract. OneCare Connect: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the three-way agreement with the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS). PACE: Medical services, equipment, or supplies that CalOptima is obligated to provide to Participants under the provisions of Welfare & Institutions Code section 14132 and the CalOptima PACE Program Agreement, except those services specifically excluded under the Exhibit E, Attachment 1, Section 26 of the PACE Program Agreement.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Letter of Agreement (LOA)	An agreement with a specific Provider regarding the provision of a specific Covered Service to a Member in the absence of a Contract for the provision of such Covered Service.

Term	Definition
Memorandum of Understanding (MOU)	An agreement between CalOptima and an external agency, which delineates responsibilities for coordinating care for Members.

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 4, 2022
Regular Meeting of the CalOptima Board of Directors

Report Item
21. Authorize Modifications Related to the CalOptima Administrative Fellowship Program

Contacts
Yunkyung Kim, Chief Operating Officer, (714) 246-8408
Brigette Hoey, Chief Human Resources Officer, (714) 246-8405

Recommended Actions
1. Authorize the Chief Executive Officer to make modifications to the CalOptima Administrative Fellowship Program effective September 1, 2022; and
2. Authorize unbudgeted expenditures in an amount up to $94,000 from existing reserves for administrative expenses related to the appropriate pay grade.

Background
On June 2, 2022, to seek talented individuals and promote CalOptima as a desirable employer in Orange County, CalOptima management received the Board of Directors' approval to launch its first administrative fellowship program. Additionally, the administrative fellow's pay grade and position control number were discussed as a separate item during the June 2, 2022, Board of Directors' meeting. Staff later discovered that $94,000 more dollars than the allocated amount was needed to fund the positions at the appropriate pay grade for this program.

Discussion
To have a robust fellowship program, management believes that competitive pay and benefits should be offered to the administrative fellows. The program will be a great investment to enhance CalOptima's recruitment opportunities and empower the next generation of health care leaders.

Fiscal Impact
The Fiscal Year (FY) 2022-23 Operating Budget included $206,000 for the period of September 1, 2022, through June 30, 2023. An appropriation of up to $94,000 from existing reserves will fund the anticipated FY 2022-23 budget shortfall in administrative expenses for the CalOptima Administrative Fellowship Program.

Rationale for Recommendation
Adequate amount of funding for the administrative fellowship program will help CalOptima to select the best and brightest talent.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

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Attachments

1. Previous Board Action dated June 2, 2022; "Authorize the CalOptima Administrative Fellowship Program"

Board Action

Board Meeting Dates	Action	Term	Not to Exceed Amount
June 2, 2022	Authorize the CalOptima Administrative Fellowship Program	September 1, 2022, through Aug 31, 2023	$206,000

/s/ Michael Hunn *07/28/2022*
Authorized Signature **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item
19. Authorize the CalOptima Administrative Fellowship Program

Contacts
Yunkyung Kim, Chief Operating Officer, (714) 246-8408
Brigette Hoey, Chief Human Resources Officer, (714) 246-8405

Recommended Action
Authorize the Chief Executive Officer to launch the CalOptima Administrative Fellowship Program effective September 1, 2022.

Background
To seek talented individuals and promote CalOptima as a desirable employer in Orange County, CalOptima management requests the Board of Directors' approval to launch its first administrative fellowship program.

The program is intended for masters-trained individuals who are committed to making a difference in the health care system for Orange County's most vulnerable populations. This program will be designed for those who want to learn about practical health care operations and who want to develop their leadership potential in a public agency environment. This one-year limited fellowship program will provide opportunities to gain administrative experience in an integrated managed care setting.

Fellows will receive guidance and mentorship from senior leaders as they participate in CalOptima's important initiatives and projects. CalOptima will seek three (3) highly motivated, self-driven individuals who are interested in Health Care Management and Administration and have graduated from a relevant master's program within the past twenty-four (24) months.

Discussion
The administrative fellowship program concept is well tested. Other health plans, such as Kaiser Permanente and St. Joseph Health, have been offering administrative fellowship programs for several years. A competitive fellowship program will enhance CalOptima's recruitment opportunities and empower the next generation of health care leaders. This program will enable CalOptima to train motivated, educated, and thoughtful emerging leaders who can make a difference and continue CalOptima's mission.

Fiscal Impact
The annual fiscal impact for three (3) administrative fellows is $206,000. Funding for the period of September 1, 2022, through June 30, 2023, is a budgeted item in the proposed Fiscal Year (FY) 2022-23 Operating Budget. Management will include funding for the period of July 1, 2023, through August 31, 2023, in the FY 2023-24 Operating Budget.

Rationale for Recommendation
The administrative fellowship program will be beneficial to both CalOptima and fellows. The program will allow CalOptima to find talent and fellows to experience hands-on health plan operations.

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

Attachments
1. Fellowship/job description
2. Fellowship sample curriculum

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

Administrative Fellow (Draft)

Department(s): Medical Management
Reports to: Chief Medical Officer
FLSA status: Non-Exempt
Revised:

Job Summary

Under the direction of Executive Leadership (e.g., Chief Executive Officer, Chief Medical Officer, Chief Operating Officer, Chief Information Officer, Chief Financial Officer, etc.), the Administrative Fellow (Fellow) will work with key administrative personnel to gain knowledge and experience in the management of CalOptima, as well as the broader health care landscape. The Fellow will be assigned to select projects related to the business and operations of CalOptima. The Fellow will work directly with the primary preceptor to receive guidance and feedback on projects and opportunities. Over the course of the twelve (12) month fellowship, the Fellow will have the opportunity to formally meet with the CalOptima CalTeam senior leaders one-on-one and sit in on executive management meetings while tackling various inter-departmental projects. While working closely with the CalOptima CalTeam, the Fellow will need to use discretion and independent judgment, in assessing situations, considering alternatives, and determining appropriate courses of action. Throughout the fellowship, the Fellow will gain insight into the inner workings of a large complex health plan organization and how its work is realized in the surrounding community.

The Administrative Fellowship program is a twelve (12) month limited term appointment. The program is designed to provide fellows with an educational, interactive, and enriching experience that will contribute to their professional development, as well as to their understanding of CalOptima and health plan operations. In addition, the program will help create opportunities for fellows to enhance skills in project development, strategic implementation and operations management. Most fellows will experience a balance of project and operational work, with an emphasis on health plan operations. Learning opportunities can include but are not limited to the administrative aspects of the following specialized areas:

- Behavioral Health
- Case Management
- Claims Administration
- Financial Analysis
- Grievance and Appeals
- Information Technology Services
- Population Health
- Program for All-Inclusive Care of the Elderly (PACE)
- Project Management

- Quality Assurance
- Quality Improvement
- Special Programs
- Utilization Management

The following items are required for consideration:

- Completion of application and supplemental questions
- Resume
- A statement of interest on why you are interested in this Fellowship program (2 pages maximum)
- A writing sample from school or work (2 pages maximum)
- Two letters of recommendation (one academic and one professional)

Position Responsibilities

- Participates in a mission driven culture of high-quality performance, with a member focus on customer service, consistency, dignity, and accountability.
- Assists the team in carrying out department responsibilities and collaborates with others to support short and long-term goals/priorities for the department.
- Gathers, analyzes and interprets information relating to the synthesis of recommendations, reporting, and presenting development and delivery, and initiating process improvements.
- Works collaboratively with executive leadership to assist in projects related to CalOptima.
- Attends all related meetings and responds to other meetings and committees as required.
- Communicates outcomes appropriately.
- Maintains compliance with all state and federal legal requirements, such as the Occupational Safety and Health Administration (OSHA), Health Insurance Portability and Accountability Act (HIPPA), etc.
- Participates with executive leadership in the design, development, integration and implementation of strategic initiatives, health improvement, community outreach, mission integration, clinical research and other defined initiatives.
- Responds to the needs of others through effective communication, mutual respect, and consistent follow through in order to generate trust and enhance personal effectiveness.
- Participates on project related work teams, fosters shared problem solving and supports decisions of the work team.
- Other projects and duties as assigned.

Possesses the Ability to:

- Consistently demonstrate behaviors that aligns with the core values and mission statement of CalOptima.
- Initiate and follow-through on projects with supervision or guidance.
- Communicate clearly and concisely, both verbally and in writing, with all levels of management, staff, physicians, patients and public.
- Establish and maintain effective working relationships with CalOptima leadership and staff.

- Focus and be detail-oriented, handle sensitive and confidential situations and demonstrate an attitude of professionalism and cooperation throughout the fellowship.
- Consistently function in an environment that includes varying, unpredictable, or crisis circumstances while exercising appropriate interpersonal and critical thinking skills.
- Treat all information and data within the scope of the position with appropriate confidentiality and level of security.
- Have excellent time management and organizational skills.
- Have strong analytical, interpersonal, presentation, leadership, collaboration, and customer service skills.
- Work effectively in a flexible work environment with results-oriented approach.
- Be an innovative, practical and collaborative strategic problem solver.
- Understand health care delivery systems and economics.
- Plan and oversee the implementation of short-term, discrete projects.
- Utilize computer and appropriate software (e.g., Microsoft Office: Excel, Outlook, PowerPoint, Word) and job-specific applications/systems to produce correspondence, charts, spreadsheets, and/or other information applicable to the position assignment.

Experience & Education

- Degree in Master of Business Administration, Master of Healthcare Administration, Master of Public Health, Master of Science in Nursing, Master of Public Administration, or relevant field required.
- Master's degree received within the past twenty-four (24) months required.
- Candidates must be U.S. Citizens or permanent residents. CalOptima is unable to sponsor work visas.

Physical Demands and Work Environment

The physical demands and work environment characteristics described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

- *Physical demands:* Employee must be able to sit for extended periods of time, as well as work at the computer for long periods. Employee is required to use hands and fingers, especially for typing on the computer and using the mouse. Employee must be able to communicate, particularly for phone use and in meetings.

- *Work Environment:* Typical office environment with moderate noise levels in a cubicle environment and controlled office temperatures.

Disclaimer:

The Job duties, elements, responsibilities, skills, functions, experience, educational factors and the requirements and conditions listed in this job description are representative only and not exhaustive of the tasks that an employee may be required to perform. The Employer reserves the right to revise this job description at any time and to require employees to perform other tasks as circumstances or conditions of its business, competitive considerations, or work environment change.

CalOptima Administrative Fellowship Program Curriculum

Program Overview

This program is intended for masters-trained fellows who are passionate about making a difference in health care system for Orange County's most vulnerable population. Through this program, fellows will learn about practical health plan operations and have opportunities to develop their leadership potential in a public agency setting. This 18-month fellowship program provides a unique environment to gain valuable administrative experience in an integrated managed care setting.

Mentors

- Richard Pitts, DO, PhD – Chief Medical Officer
- Brigette Hoey, MPA, CLRM– Chief Human Resources Officer
- Yunkyung Kim – Chief Operations Officer
- Nancy Huang – Chief Financial Officer
- Additional Mentors to be determined

Resources:

- CalOptima Intranet (InfoNet)
    - Clerk of the Board SharePoint site
    - Policies & Procedures (Compliance 360)
    - Medical Management SharePoint site
    - Human Resources SharePoint Site
- Department of Health Care Services (DHCS) website: https://www.dhcs.ca.gov/
- Centers for Medicare and Medicaid Services (CMS) website: https://www.cms.gov/

Proposed Rotation Schedule 1: General
(Please note that these are proposed/tentative schedules; adjustments can be made.)

Quarter	Learning Area	Lead Executive/Mentor
Quarter 1	Medical Management	Dr. Richard Pitts
Quarter 2	Finance	Nancy Huang
Quarter 3	Operations	Yunkyung Kim
Quarter 4	Human Resources	Brigette Hoey

Proposed Rotation Schedule 2: Specialized

Quarter	Learning Area	Lead Executive/Mentor
Quarter 1	Finance	Chief Financial Officer
Quarter 2	Finance	Executive Director of Finance

Quarter	Learning Area	Lead Executive/Mentor
Quarter 3	Finance	Budget & Vendor Management
Quarter 4	Finance	Financial Analysis

Sample Quarterly Schedule

Quarter 1: Medical Management

During the 10-week course, the fellow will cover the following, including but not limited to:

- Clinical Operations
  - Case Management
  - Long Term Services and Support
  - Utilization Management
- Quality
  - Population Health Management
  - Quality Analytics
  - Quality Improvement
- Behavioral Health Integration
- Pharmacy Management
- Program of All-Inclusive Care for the Elderly (PACE)
- Project(s) using “Design Thinking and Innovation”

Quarter 2: Finance

10 weeks committed. To be determined by business area.

Quarter 3: Operations

10 weeks committed. To be determined by business area.

Quarter 4: Human Resources

Recruiting

Employee Relations

Worker’s Compensation and Leaves

10 weeks committed. To be determined by business area.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 4, 2022
Regular Meeting of the CalOptima Board of Directors

Report Item

22. Approve New Vendor Management Contract Templates and Authorize Template Use for New Contracts

Contact

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

Recommended Actions

1. Approve new vendor management contract templates, effective upon Board approval; and
2. Effective upon Board approval, authorize the Chief Executive Officer, with the assistance of legal counsel, to use the new vendor management contract templates to execute contracts with vendors within the parameters set forth in CalOptima Policy GA.5002: Purchasing Policy and CalOptima's Board-approved budget.

Background and Discussion

Staff, with assistance with legal counsel, reviewed existing vendor management contracts with the goal of streamlining the contracting process through the use of standardized templates. Base agreement templates were developed after current contract provisions and regulatory requirements were scrutinized, resulting in their deletion, revision, or inclusion in a separate exhibit to the contract template. The four (4) vendor management contract templates are:

- Public Works: Public Works contract with prevailing wage, bonding, and labor requirements;
- Software: Software and software with services contract for hosted and non-hosted software purchases;
- Broker: Non-medical services contract for insurance agent brokers; and
- Generic Vendor: Standard contract for all other services not listed above.

As such, the service descriptions, warranties, and exhibits specific to a type of contract will be found in these vendor-specific exhibits. These contract templates will serve as standard contract forms to provide consistent boilerplate language across vendor contracts by category. In the event substantive changes to these templates are necessary, Management will return to the Board with additional recommendations.

Upon Board approval, CalOptima will implement the applicable contract template for any new vendor contracts processed beginning August 5, 2022, within the parameters set forth in CalOptima Policy GA.5002: Purchasing Policy and CalOptima's Board-approved budget. For currently active contracts or contracts in various stages of negotiation prior to that date, Staff will continue to process them to completion on previous contract templates.

Fiscal Impact

The recommended action has no additional fiscal impact to the FY 2022-23 Operating Budget approved by the Board of June 2, 2022.

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Rationale for Recommendation

Approving the new vendor management contract templates will allow for greater administrative efficiencies in vendor contracting and management.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Public Works Contract Template
2. Software Contract Template
3. Broker Contract Template
4. Generic Vendor Contract Template

/s/ Michael Hunn *07/28/2022*

Authorized Signature **Date**

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CONTRACT NO. «Contract Number» ("**Contract**")
BETWEEN
ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY, dba
ORANGE PREVENTION & TREATMENT INTEGRATED MEDICAL ASSISTANCE, dba
CALOPTIMA ("**CalOptima**")
And
«Company Name»
("**CONTRACTOR**")

This Contract is made and entered into as of [insert date] ("**Effective Date**"), by and between the Orange County Health Authority, a public agency dba CalOptima, a public agency ("**CalOptima**") and «Company Name», a «Business Entity», hereinafter referred to as "**CONTRACTOR**." CalOptima and CONTRACTOR may be referred to herein collectively as the "**Parties**" or each individually as a "**Party**."

RECITALS

A. CalOptima desires to retain a contractor to provide «Description», as described in the Scope of Work in Exhibit A;

B. CONTRACTOR provides such services;

C. CONTRACTOR represents and warrants that it has the requisite personnel and experience and is capable of performing such services;

D. CONTRACTOR desires to perform these services for CalOptima; and

E. CalOptima and CONTRACTOR desire to enter into this Contract on the terms and conditions set forth herein below.

NOW, THEREFORE, in consideration of their mutual and respective promises, and subject to the terms and conditions hereinafter set forth, the Parties agree as follows:

1. Documents Constituting Contract. "**Contract Documents**" include the following documents in the order of descending precedence: (i) this Contract, inclusive of all its exhibits and addenda; (ii) CalOptima's Request for Proposal ("**RFP**"), if applicable, inclusive of any CalOptima revisions and addenda prior to the Effective Date; (iii) CONTRACTOR's best and final offer dated [Insert Date of Best and Final Offer], if applicable, and; (iv) CONTRACTOR's proposal dated [Insert Date CONTRACTOR's Response to RFP] ("**Proposal**"). Any new terms and conditions attached to CONTRACTOR's best and final offer, Proposal, invoices, or request for payment shall not be incorporated into the Contract Documents or be binding upon CalOptima unless expressly accepted by CalOptima in writing. All Contract Documents are incorporated into this Contract by this reference. Any changes to the Contract or the Contract Documents shall not be binding upon CalOptima except when specifically confirmed in writing by an authorized representative of CalOptima in accordance with Section 10, of this Contract. In the event of any conflict of provisions among the Contract and/or Contract Documents, the provisions shall prevail in the above-referenced descending order of precedence.

2. Scope of Work.

2.1. CONTRACTOR shall perform the work in accordance with (i) this Contract, including the Scope of Work in Exhibit A, (ii) the Contract Documents, (iii) the applicable standards and requirements of the Centers for Medicare and Medicaid Services ("**CMS**"), the California Department of Health Care Services ("**DHCS**"), and the California Department of Managed Health Care ("**DMHC**"), and (iv) all applicable laws.

3. Insurance.

3.1. At CONTRACTOR's sole expense and prior to undertaking performance of services under this Contract and at all times during performance hereunder, CONTRACTOR shall maintain insurance policies and amounts set forth in Exhibit A, which shall be full-coverage insurance not subject to self-insurance provisions, in accordance with applicable laws and industry standards. CONTRACTOR shall not of its own initiative cause such insurance to be canceled or materially changed during the Term.

3.2. Within five (5) days of the Effective Date and prior to commencing performance of any services or its receipt of any compensation under the Contract, CONTRACTOR shall furnish to CalOptima with additional insured endorsements broker-issued Certificate(s) of Insurance showing the required insurance coverages for CONTRACTOR. CONTRACTOR's Certificates of Insurance shall additionally comply with the following:

3.2.1. CalOptima's officers, officials, directors, employees, agents, and volunteers are to be covered as additional insureds with respect to liability arising out of work or operations performed by or on behalf of CONTRACTOR, including materials, parts, or equipment furnished in connection with such work or operations. This provision applies to CONTRACTOR's General Liability and Auto Liability policies, as applicable, and must be on ISO form CG 20 10 or equivalent.

3.2.2. For any claims related to this Contract, the CONTRACTOR's insurance coverage shall be primary insurance with respect to CalOptima, its officers, officials, directors, employees, agents, and volunteers. This provision applies to the CONTRACTOR's General Liability, Auto Liability and Workers' Compensation and Employers' Liability policies, as applicable.

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

3.2.4. Insurance is to be placed with insurers with a current A.M. Best rating of no less than A-VII, unless otherwise acceptable to CalOptima.

3.2.5. CONTRACTOR shall furnish CalOptima with original certificates and amendatory endorsements affecting coverage required by this Section 3.2 and Exhibit A. CalOptima reserves the right to require complete, certified copies of all required insurance policies, including endorsements affecting the coverage required by these specifications, at any time.

3.2.6. Any deductibles or self-insured retentions must be declared to and approved by CalOptima. CalOptima may require the CONTRACTOR to purchase coverage with a lower deductible or retention or provide proof of ability to pay losses and related investigations, claim administration, and defense expenses within the retention or deductible.

3.2.7. All deductibles and retentions that the aforementioned policies contain are the responsibility of the CONTRACTOR and in no way shall CalOptima be responsible for payment of the deductibles/retentions.

3.2.8. If CONTRACTOR maintains higher limits than the minimums required in this Contract, CalOptima requires and shall be entitled to coverage for the higher limits maintained by CONTRACTOR. Any available insurance proceeds in excess of the specified minimum limits of insurance and coverage shall be available to CalOptima.

3.2.9. Require the insurance carrier to provide thirty (30) days' prior written notice of cancellation to CalOptima.

3.3. If CONTRACTOR fails or refuses to maintain or produce proof of the insurance required by this Section 3 and Exhibit A, CalOptima may terminate this Contract upon written notice to CONTRACTOR. Such termination shall not affect CONTRACTOR'S right to be paid for its time and materials expended prior to notification of termination. CONTRACTOR waives the right to receive compensation and agrees to indemnify CalOptima for any work performed prior to approval of insurance by CalOptima

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

3.5. CONTRACTOR shall require each of its subcontractors who perform services related to this Contract, if any, to maintain insurance coverage that meets all of the requirements set forth in this Contract.

3.6. "**Occurrence**" means any event or related exposure to conditions that result in bodily injury or property damage.

4. Indemnification.

4.1. To the fullest extent permitted by law, CONTRACTOR shall defend, indemnify, and hold harmless CalOptima and its respective officers, directors, agents, volunteers, consultants and employees (individually and collectively referred to as "**Indemnified Parties**") against any and all [third-party] claims, losses, demands, damages, costs, expenses, or liability arising out CONTRACTOR's, or its officers, employees, subcontractors, agents, or representatives', breach of this Contract, negligence, recklessness, or intentional conduct, except to the extent any such loss was caused by the gross negligence, recklessness, or intentional misconduct of CalOptima. CONTRACTOR shall defend the Indemnified Parties in any claim or action based upon any such alleged acts or omissions at its sole expense, which shall include all costs and fees, including attorneys' fees, cost of investigation, defense, and settlement or awards. CalOptima may make all reasonable decisions with respect to its representation in any legal proceeding. CONTRACTOR's duty to defend herein is wholly independent of and separate from the duty to indemnify and such duty to defend shall exist regardless of any ultimate liability of CONTRACTOR, save and except claims arising through the sole negligence or sole willful misconduct of CalOptima.

[Mutual indemnity option]

Each Party (an "**Indemnifying Party**") shall defend, indemnify, and hold harmless the other Party and the other Party's respective officers, directors, agents, volunteers, consultants, and employees (individually and collectively referred to as "**Indemnified Parties**") from and against any third-party claims losses, demands, damages, costs, expenses, or liability arising out of the Indemnifying Party's breach of this Contract, negligence, recklessness, or intentional conduct, except to the extent any such loss was caused by the negligence, recklessness, or intentional conduct of the Indemnified Parties. The Indemnifying Party shall defend the Indemnified Parties in any claim or action at its sole expense, which shall include all costs and fees, including attorneys' fees, cost of investigation, defense, and settlement or awards. The Indemnified Party may make all reasonable decisions with respect to its representation in any legal proceeding.

4.2. CONTRACTOR's obligation to indemnify hereunder is in addition to any liability CONTRACTOR may have to CalOptima for a breach by CONTRACTOR of any of the provisions of this Contract. Under no circumstances shall the insurance requirements and limits set forth in this Contract be construed to limit CONTRACTOR's indemnification and duty to defend obligation or other liability hereunder

4.3. CONTRACTOR's indemnification and duty to defend obligations shall survive the expiration or earlier termination of this Contract until such time as any action against the Indemnified Parties for such a matter indemnified hereunder is fully and finally barred by the applicable statute of limitations, including those set forth under the California Government Claims Act (Cal. Gov. Code §900 *et seq*.).

4.4. In the event of any conflict between this Section 4 and the indemnification provisions set forth elsewhere in the Contract, including any business associate agreement ("**BAA**") between the Parties, the indemnification provision(s) in the BAA or elsewhere in the Contract shall be interpreted to relate only to matters within the scope of the BAA or those other Contract provisions.

4.5. The terms of this Section 4 shall survive the termination of this Contract.

5. Independent Contractor. CalOptima and CONTRACTOR agree that CONTRACTOR, which shall include for purposes of this Section 5 all subcontractors, agents, and employees of the CONTRACTOR, in performance of this Contract, shall act in an independent capacity, and not as officers or employees of CalOptima. CONTRACTOR's relationship with CalOptima in the performance of this Contract is that of an independent contractor and nothing in this Contract shall be construed as creating a partnership, joint venture, or agency. CONTRACTOR's personnel performing services under this Contract shall be at all times under CONTRACTOR's exclusive direction and control and shall be employees of CONTRACTOR and not employees of CalOptima. CONTRACTOR shall pay all wages, salaries and other amounts due its employees, agents, and/or subcontractors in connection with this Contract and shall be responsible for all reports and obligations respecting them, such as social security, state and federal income tax withholding, other payroll taxes, unemployment compensation, workers' compensation, and similar matters. CONTRACTOR shall file all required returns related to such taxes, contributions, and payroll deductions.

6. Personnel.

6.1. CONTRACTOR Staffing. CONTRACTOR shall ensure that only fully qualified CONTRACTOR personnel are assigned to perform the services under the Contract, and such CONTRACTOR personnel shall perform services diligently and in a timely manner, according to the applicable professional and technical standards.

6.2. CONTRACTOR Personnel Restrictions. When on CalOptima's premises, CONTRACTOR personnel shall comply with CalOptima policies and procedures, including CalOptima's identification requirements (e.g., name badges).

6.3. Any CalOptima property damaged by CONTRACTOR, its subcontractor(s), or by the personnel of either, will be subject to repair or replacement by CONTRACTOR at no cost to CalOptima.

[optional non-compete clause]

6.4. Neither Party shall actively solicit employees of the other Party for employment that directly or indirectly provided services under the Contract during the Term and for a period of one (1) year after termination.

7. Compensation.

7.1. CalOptima agrees to pay, and CONTRACTOR agrees to accept as full compensation for the faithful performance of this Contract, the rates, charges, and other payment terms identified in Exhibit B.

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

7.3. CONTRACTOR's requests for payments and reimbursements must comply with the requirements set forth in Exhibit B. CalOptima will not make payment for work that fails to meet the standards of performance set forth in the Contract and Exhibit A. **CALOPTIMA SHALL NOT PAY ANY FEES, EXPENSES, OR COSTS WHATSOEVER INCURRED BY CONTRACTOR IN RENDERING ADDITIONAL SERVICES NOT AUTHORIZED IN WRITING BY CALOPTIMA UNDER THIS CONTRACT.**

7.4. In no event shall the total compensation payable to CONTRACTOR for the services performed under this Contract exceed the maximum cumulative payment obligation, as set forth in Exhibit B, without the express prior written authorization of CalOptima. **CONTRACTOR ACKNOWLEDGES AND AGREES THAT CALOPTIMA SHALL NOT BE LIABLE FOR ANY FEES, EXPENSES OR COMPENSATION IN EXCESS OF THE MAXIMUM CUMULATIVE PAYMENT OBLIGATION.**

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

8. Confidential Material.

8.1. During the Term, either Party may have access to confidential material or information ("**Confidential Information**") belonging to the other Party or the other Party's customers, vendors, or partners. Confidential Information includes the disclosing Party's computer programs and codes, business plans, customer/member lists and information, financial records, partnership arrangements, projections, methodologies, data, reports, agreements, intellectual property, trade secrets, licensing plans, and other proprietary information, or other information, materials, records, writings or data that is marked confidential or that due to its character and nature, a reasonable person under like circumstances would treat as confidential. CalOptima's Confidential Information also includes all user information, patient information, and clinical data that comes into CalOptima's possession, custody or control. Confidential Information will be used only for the purposes of this Contract and related internal administrative purposes. Each Party agrees to protect the other's Confidential Information at all times and in the same manner as each protects the confidentiality of its own confidential materials, but in no event with less than a reasonable standard of care.

8.2. For the purposes of Section 8.1, Confidential Information does not include information which: (i) is already known to the other Party at the time of disclosure; (ii) is or becomes publicly known through no wrongful act or failure of the receiving Party; (iii) is independently developed without use or benefit of the other Party's Confidential Information or proprietary information; (iv) is lawfully received from a third party that is not under and does not thereby breach an obligation of confidentiality; or (v) is a public record, not exempt from disclosure, pursuant to California Public Records Act, Government Code Section 6250 *et seq*., applicable provisions of California Welfare

and Institutions Code, or other state or federal laws, regardless of whether such information is marked as confidential or proprietary.

8.3. Disclosure of the Confidential Information will be restricted to the receiving Party's employees, consultants, suppliers, or agents, who are bound by confidentiality obligations no less stringent than those in this Section 8, on a "need to know" basis in connection with the services performed under this Contract. The receiving Party may disclose Confidential Information pursuant to legal, judicial, or administrative proceeding or otherwise as required by law; provided, however, that the receiving Party gives reasonable prior notice, if not prohibited by applicable law, to the disclosing Party and assists the disclosing Party, at the disclosing Party's expense, to obtain protective or other appropriate confidentiality orders, and further provided that a required disclosure of Confidential Information or proprietary information to an agency or court does not relieve the receiving Party of its confidentiality obligations with respect to the other Party.

8.4. CONTRACTOR shall establish and maintain environmental, safety, and facility procedures, data security procedures and other safeguards against the unauthorized access, destruction, loss, or alteration of CalOptima's Confidential Information in the possession, custody, or control of CONTRACTOR. Those security procedures and other safeguards shall be no less rigorous than those maintained by CONTRACTOR for its own information of a similar nature.

8.5. Upon written request of the disclosing Party, the receiving Party shall promptly return to the disclosing Party or destroy all documents, notes, and other tangible materials representing the disclosing Party's Confidential Information and all copies thereof. This obligation to return materials or copies thereof does not extend to automatically generated computer backup or archival copies generated in the ordinary course of the receiving Party's information systems procedures, provided that the receiving Party shall make no further use of such copies.

8.6. If a breach of the obligations under this Section 8 occurs, the injured Party may be entitled to such injunctive relief and any and all other remedies available at law or in equity. This Section 8 in no way limits the liability or damages that may be assessed against a Party if another Party breaches any of the provisions of this Section 8.

8.7. This Contract does not require or permit CONTRACTOR to create, receive, maintain, use, or transmit protected health information ("**PHI**"). As such, no BAA is required for this Contract; provided, however, that if CONTRACTOR or its employees, agents, or subcontractors access or receive, whether intentionally or unintentionally, PHI regarding CalOptima members during the Term, CONRACTOR and its employees, agents, and subcontractors shall immediately notify CalOptima, protect such PHI from any additional disclosure, not use or disclose that PHI in any way that would violate a federal or state privacy or security law, its implementing regulations, or any other state or federal law, and execute a BAA with CalOptima, as necessary and requested by CalOptima.

9. California Public Records Act. As a local public agency, CalOptima is subject to the California Public Records Act (California Government Code Sections 6250 *et seq*.) (the "**PRA**"). CONTRACTOR hereby acknowledges that any materials, documents, data, or similar items are subject to disclosure upon public request, unless exempt from disclosure under the provisions of the PRA. CalOptima may be required to reveal certain information believed to be proprietary or confidential by CONTRACTOR pursuant to the PRA. If CONTRACTOR discloses information that it believes to be proprietary or confidential to CalOptima, it shall mark such information as "Confidential," "Proprietary," or "Restricted" or other similar marking. Unless CONTRACTOR marks its materials as "Confidential," "Proprietary," or "Restricted," and also notifies CalOptima in writing that CONTRACTOR has so marked each piece of material, then CalOptima will not be responsible to take any actions to protect any CONTRACTOR's materials under the PRA that are not so marked. If CalOptima receives a request under the PRA that potentially encompasses CONTRACTOR materials that have been properly marked, CalOptima will provide CONTRACTOR with notice thereof to allow CONTRACTOR to take actions it deems appropriate to prevent disclosure of the marked material. Within five (5) days from receipt of CalOptima's notice, CONTRACTOR shall notify

CalOptima if it intends to object to production of CONTRACTOR's information; otherwise CalOptima will respond to the PRA request according to the requirements of the PRA. CONTRACTOR agrees to defend, indemnify, and hold harmless CalOptima, its officers, agents, employees, members, subsidiaries, joint venture partners, and predecessors and successors in interest from and against any claim, action, proceeding, liability, loss, damage, cost, or expense, including attorneys' fees, and any costs awarded to the person or entity that sought CONTRACTOR's marked material, arising out of or related to CalOptima's failure to produce or provide the CONTRACTOR-marked material (collectively referred to for purposes of this Section 9 as "**Public Records Act Claim(s)**"). CONTRACTOR shall pay to CalOptima any expenses or charges relating to or arising from any such Public Record Act Claim(s) as they are incurred by CalOptima.

10. Modifications. CalOptima may modify the Contract upon written notice to CONTRACTOR at any time should such modification be required by CMS, DHCS, the DMHC, or applicable law or regulation ("**Regulatory Amendment**"). Any other modifications of the Contract that are not Regulatory Amendments shall be executed only by a written amendment to the Contract, signed by CalOptima and CONTRACTOR. Execution of amendments shall be contingent upon CONTRACTOR's notification to CalOptima, and CalOptima's approval, of any increase or decrease in the price of this Contract or in the time required for CONTRACTOR's performance.

11. Assignments.

11.1. CONTRACTOR may not assign, transfer, or delegate any interest herein, either in whole or in part, without the prior written consent of CalOptima, which consent may be withheld in its sole discretion. If CalOptima provides such prior written consent, CONTRACTOR acknowledges and agrees that such assignment, transfer, or delegation may additionally be subject to the prior written approval of DHCS. Any assignment, transfer, or delegation made without CalOptima's express written consent shall be void.

11.2. For purposes of this Section 11, an assignment is: (1) the change of more than fifty percent (50%) of the ownership or equity interest in CONTRACTOR (whether in a single transaction or in a series of transactions); (2) the change of more than fifty percent (50%) of the directors or trustees of CONTRACTOR (whether in a single transaction or in a series of transactions); (3) the merger, reorganization, or consolidation of CONTRACTOR with another entity with respect to which CONTRACTOR is not the surviving entity; and/or (4) a change in the management of CONTRACTOR from management by persons appointed, elected or otherwise selected by the governing body of CONTRACTOR (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

12. Subcontracts. CONTRACTOR may not subcontract or delegate its obligations or the performance of services under this Contract without CalOptima's prior written consent, which CalOptima may exercise in its sole discretion. CalOptima-approved subcontractors are listed in Addendum 1 to Exhibit A.

13. Term. This Contract shall commence on the Effective Date and shall continue in full force and effect through «Current Expiration» ("**Initial Term**"), unless earlier terminated as provided in this Contract. At the end of the Initial Term, CalOptima may, at its option, extend this Contract for up to «Extended Term spelled» («Extended Term») additional consecutive one (1)-year terms ("**Extended Terms**"), provided that if CalOptima does not exercise its option to extend at the end of the Initial Term, or any Extended Term, the remaining option(s) shall automatically lapse. The Initial Term together with any Extended Terms constitute the "**Term**" of this Contract.

[optional term for fixed term agreements]

Term. This Contract shall commence on the Effective Date and shall continue in full force and effect through «CurrentExpiration» ("**Term**"), unless earlier terminated, as provided in this Contract.

14. Termination.

14.1. Termination without Cause. CalOptima may terminate this Contract at any time, in whole or in part, for its convenience and without cause, by giving CONTRACTOR thirty (30) days' prior written notice. Upon termination, CalOptima shall pay CONTRACTOR all fees and other charges due and payable for services satisfactorily performed and accepted by CalOptima as of the termination date. Thereafter, CONTRACTOR shall have no further claims against CalOptima under this Contract.

[optional mutual without cause termination]

Termination without Cause: Either Party may terminate this Contract at any time, in whole or in part, for its convenience and without cause, by giving the other Party sixty (60) days' prior written notice. Upon termination, CalOptima shall pay CONTRACTOR all fees and other charges due and payable for services satisfactorily performed and accepted by CalOptima as of the termination date.

14.2. Termination for Unavailability of Funds. In recognition that CalOptima is a governmental entity and its operations and budgets are determined on an annual basis, CalOptima shall have the right to terminate this Contract as follows:

14.2.1. CalOptima may terminate this Contract if it does not receive funding from the State of California or the federal government, as applicable, for any fiscal year.

14.2.2. In the event of termination under Section 14.2.1, CalOptima agrees to promptly pay CONTRACTOR all fees and other charges due and payable for services satisfactorily performed and accepted by CalOptima as of the termination date. CONTRACTOR shall not be entitled to payment for any other items, including lost or anticipated profit on work not performed, administrative costs, attorneys' fees, or consultants' fees.

14.3. Termination for Default. CalOptima may immediately terminate this Contract upon notice to CONTRACTOR for (i) CONTRACTOR's default, (ii) if a federal or state proceeding for the relief of debtors is undertaken by or against CONTRACTOR; or (iii) if CONTRACTOR makes an assignment, as defined in Section 11, for the benefit of creditors ("**Termination for Default**").

14.4. Termination for Breach. Either Party may at its option, terminate this Contract by notice to the other Party if the other Party breaches one of its obligations under this Contract and fails to cure that breach or default within thirty (30) days after receiving notice identifying that breach. The rights described in this Section 14.4 to terminate this Contract shall be in addition to any other remedy available to the non-breaching Party, whether under this Contract or in law or equity, on account of that breach.

14.5. Notwithstanding the foregoing, CalOptima may terminate this Contract immediately upon CONTRACTOR's breach of Section 3 (Insurance) or Section 8 (Confidential Material).

14.6. Effect of Termination. Upon expiration or receipt of a termination notice under this Section 14:

14.6.1. CONTRACTOR shall promptly discontinue all services (unless CalOptima's notice directs otherwise) and deliver or otherwise make available to CALOPTIMA all documents, reports, software programs, and any other products, data and such other materials, equipment, and information, including Confidential Information, or equipment provided by CalOptima, as may have been accumulated by CONTRACTOR in performing this Contract, whether completed or in process. If CONTRACTOR personnel were granted access to CalOptima's premises and issued a badge or access card, such badge or access card shall be returned prior to departure.

14.6.2. CalOptima may take over the services and may award another party a contract to complete the services under this Contract.

15. Dispute Resolution

15.1. Meet and Confer. If either Party has a dispute arising under or related to this Contract, the Parties shall informally meet and confer to try and resolve the dispute. The Parties shall meet and confer within thirty (30) days of a written request submitted by either Party in an effort to settle any dispute. At each meet-and-confer meeting, each Party shall be represented by persons with final authority to settle the dispute. If either Party fails to meet within the thirty (30)-day period, that Party shall be deemed to have waived the meet-and-confer requirement, and at the other Party's option, the dispute may proceed immediately to arbitration under Section 15.2.

15.2. Subject to the California Government Claims Act (Cal. Gov. Code §900 *et seq*.) governing claims against public entities, either Party may submit the dispute for resolution exclusively through confidential, binding arbitration, instead of through trial by court or jury, in Orange County, California. The Parties may agree in writing prior to commencing the arbitration on the dispute resolution rules and arbitration service that will be used to resolve the dispute. If the Parties cannot reach such an agreement, the arbitration will be conducted by Judicial Arbitration and Mediation Services ("**JAMS**") in accordance with the commercial dispute rules then in effect for JAMS; provided, however, that this Contract shall control in instances where it conflicts with JAMS's (or the applicable arbitration service's) rules. The arbitration shall be conducted on an expedited basis by a single arbitrator. The Parties prefer that the arbitrator be a retired judge of the California Superior, Appellate, or Supreme Court or of a United States court sitting in California. If no such retired judge is available, the arbitrator may be an attorney with at least fifteen (15) years of experience, including at least five (5) years in managed health care. If the Parties are unable to agree on the arbitrator within thirty (30) days of the date that the arbitration service accepts the arbitration, the arbitrator shall be selected by the arbitration service from a list of four potential arbitrators (all of whom shall be on arbitration services' panel of arbitrators) submitted by the Parties, two from each side; provided, however, that nothing stated in this section shall prevent a Party from disqualifying an arbitrator based on a conflict of interest. In making decisions about discovery and case management, it is the Parties' express agreement and intent that the arbitrator at all times promote efficiency without denying either Party the ability to present relevant evidence. In reaching and issuing decisions, the arbitrator shall have no jurisdiction to make errors of law and/or legal reasoning. The Parties shall share the costs of arbitration equally, and each Party shall bear its own attorneys' fees and costs.

15.3. Exclusive Remedy. With the exception of any dispute that under applicable laws may not be settled through arbitration, arbitration under Section 15.2 is the exclusive method to resolve a dispute between the Parties arising out of or relating to this Contract that is not resolved through the meet-and-confer processes.

15.4. Waiver. By agreeing to binding arbitration as set forth in Section 15.2, the Parties acknowledge that they are waiving certain substantial rights and protections which otherwise may be available if a dispute between them was determined by litigation in a court, including the right to a jury trial, attorneys' fees, and certain rights of appeal.

16. General Provisions.

16.1. Non-Exclusive Relationship. This is a non-exclusive relationship between CalOptima and CONTRACTOR. CalOptima shall have the right to have any of the services that are the subject of this Contract performed by CalOptima personnel or enter into contractual arrangements with one or more contractors who can provide CalOptima with similar or like services.

16.2. Compliance with Applicable Law and Policies. CONTRACTOR warrants that, in the performance of this Contract, it shall, at its own expense, observe and comply with all applicable federal, state,

and local laws, and CalOptima vendor policies relating to services under the Contract that are in effect when this Contract is signed or that come into effect during the Term and are available to CONTRACTOR on CalOptima's website.

16.3. Names and Marks. Neither Party shall use the name, logo or other proprietary mark of the other Party in any press release, advertising, promotional, marketing or similar publicly disseminated material without obtaining the other Party's express written approval of the material and consent to such use.

16.4. Time is of the Essence. Time is of the essence in performance of this Contract.

16.5. Choice of Law. This Contract shall be governed by and construed in accordance with all laws of the State of California. If any Party institutes legal proceedings to enforce or interpret this Contract, venue and jurisdiction shall be in the County of Orange, California.

16.6. Force Majeure. When satisfactory evidence of a cause beyond a Party's control is presented to the other Party, and nonperformance is unforeseeable, beyond the control, and not due to the fault of the Party not performing, a Party shall be excused from performing its obligations under this Contract during the time and to the extent that it is prevented from performing by such cause, including any incidence of fire, flood, acts of God, commandeering of material, products, plants or facilities by the federal, state or local governments, or a material act or omission by the other Party. A Party invoking this clause shall provide the other Party with prompt written notice of any delay or failure to perform that occurs by reason of force majeure. If the force majeure event continues for a period of XX (XX) days, the Party unaffected by the force majeure event may terminate this Contract upon notice to the other Party.

16.7. Notices. All notices required or permitted under this Contract shall be in writing and shall be sent by registered or certified mail, postage prepaid, return receipt requested, or by any other overnight delivery service which delivers to the noticed destination and provides proof of delivery to the sender. All notices shall be effective when first received at the following addresses set forth below. Any notice not related to termination of this Contract may be submitted electronically to the address set forth below. Any Party whose address changes shall notify the other Party in writing.

To CONTRACTOR:	**To CalOptima:**
	CalOptima
	505 City Parkway West
	Orange, CA 92868
	Attention:
	Email:

16.8. Notice of Labor Disputes. Whenever CONTRACTOR has knowledge that any actual or potential labor dispute may delay this Contract, CONTRACTOR shall immediately notify and submit all relevant information to CalOptima.

16.9. No Liability of County of Orange. As required under Ordinance No. 3896 of the County of Orange, State of California, as amended, the Parties agree that the obligations of CalOptima under this Contract are solely the obligations of CalOptima, and the County of Orange, State of California, shall have no obligation or liability related to this Contract. [County of Orange Ordinance No 3896, codified in Orange County Municipal Code Section 4-11-7(a)]

16.10. Entire Agreement. This Contract, including all exhibits, addenda, and Contract Documents, contains the entire agreement between CONTRACTOR and CalOptima with respect to the subject matter of this Contract, and it supersedes all prior written or oral and all or contemporaneous oral agreements, representations, understandings, discussions, negotiations, and commitments between

CONTRACTOR and CalOptima, whether express or implied, with respect to the subject matter of this Contract.

16.11. Waiver. Any failure of a Party to insist upon strict compliance with any provision of this Contract shall not be deemed a waiver of such provision or any other provision of this Contract. To be effective, a waiver must be in a writing that is signed and dated by the Parties. A waiver by either of the Parties of a breach of any of the covenants, conditions, or agreements to be performed by the other Party shall not be construed to be a waiver of any succeeding breach of the Contract or of any other covenant or condition of the Contract. Any information delivered, exchanged, or otherwise provided hereunder shall be delivered, exchanged, or otherwise provided in a manner that does not constitute a waiver of immunity or privilege under applicable law.

16.12. Survival. The following provisions of this Contract shall survive termination or expiration of this Contract: Sections 4 (Indemnification), 5 (Independent Contractor), 8 (Confidential Material), 9 (California Public Records Act), 14.6 (Effect of Termination), 15 (Dispute Resolution), 16.3 (Names and Marks), 16.5 (Choice of Law), 16.9 (No Liability of County of Orange), this Section 16.12, 16.14 (Interpretation), 16.15 (Third-Party Beneficiaries), 16.16 (Successors and Assigns) and any other Contract provisions that by their nature are intended to survive termination or expiration of this Contract.

16.13. Severability. If any section, subsection or provision of this Contract, or the application of such section, subsection or provision, is held invalid or unenforceable by any court of competent jurisdiction, the remainder of this Contract, other than that to which it is held invalid, shall remain in effect.

16.14. Interpretation. The terms of this Contract are the result of negotiation between the Parties. Accordingly, any rule of construction of contracts (including California Civil Code Section 1654) that ambiguities are to be construed against the drafting party shall not be employed in the interpretation of this Contract.

16.15. Third Party Beneficiaries. There are no intended third-party beneficiaries of this Contract. Nothing in this Contract shall be construed as conferring any rights on any other persons.

16.16. Successors and Assigns. Except as otherwise expressly provided in this Contract, this Contract will be binding on, and will inure to the benefit of, the successors and permitted assigns of the Parties. Nothing in this Contract is intended to confer upon any party other than the Parties or their respective successors and permitted assigns any rights or obligations under or by reason of this Contract, except as expressly provided in this Contract.

16.17. Without Limitation. Any reference in the Contract to “include(s)” or “including” means inclusion without limitation, unless otherwise distinguished within the text.

16.18. Authority to Execute. The persons executing this Contract on behalf of the Parties warrant that they are duly authorized to execute this Contract and that by executing this Contract the Parties are formally bound.

16.19. Counterparts. This Contract may be executed and delivered in one or more counterparts, each of which shall be deemed an original, but all of which together will constitute one and the same instrument.

16.20. Recitals and Exhibits. The recitals, exhibits, and addenda attached to this Contract are made a part of the Contract by this reference.

[*Signatures on following page*]

IN WITNESS WHEREOF, these Parties have, by their duly authorized representatives, executed this Contract No. «Internal Number» on the day and year last shown below.

«Company Name»	CalOptima
By:	By:
Print Name:	Print Name:
Title: Date:	Title: Date:

By:	By:
Print Name:	Print Name:
Title: Date:	Title: Date:

EXHIBIT A
Scope of Work

1. **Description of Work**

[add for each RFP]

2. **Standard of Performance; Warranties**.

2.1 CONTRACTOR agrees to perform all work under this Contract with the requisite skill and diligence consistent with professional standards for the industry and type of work performed under this Contract, and pursuant to the governing rules and regulations of the industry.

2.2 If CONTRACTOR may subcontract for services under this Contract, then CONTRACTOR represents and warrants that any individual or entity acting as a subcontractor to this Contract has the appropriate skill and expertise to perform the subcontracted work and will comply with all applicable provisions of this Contract.

2.3 CONTRACTOR expressly warrants that all material and work will conform to applicable specifications, drawings, description and samples, including CalOptima's designs, drawings, and specifications, and will be merchantable, of good workmanship and material, and free from defect. CONTRACTOR further warrants that all material covered by this Contract, if any, which is the product of CONTRACTOR will be new and unused unless otherwise specified and shall be fit and sufficient for the purpose intended by CalOptima, as disclosed to CONTRACTOR. CONTRACTOR shall promptly make whatever adjustments or corrections that may be necessary to cure any defects, including repairs of any damage resulting from such defects. CalOptima shall give notice to CONTRACTOR of any observed defects. If CONTRACTOR fails to adjust, repair, correct, or perform other work made necessary by such defects, CalOptima may make such adjustments, repairs, and/or corrections and charge CONTRACTOR the costs incurred.

2.4 CONTRACTOR's warranties, together with its service guarantees, must run to CalOptima and its customers or users of the material and services, and must not be deemed exclusive. CalOptima's inspection, approval, acceptance, use of and payment for all or any part of the material and services must in no way affect its warranty rights whether or not a breach of warranty had become evident in time.

2.5 CONTRACTOR's obligations under this Section 2 are in addition to CONTRACTOR's other express or implied warranties and other obligations under this Contract or state law, and in no way diminish any other rights that CalOptima may have against CONTRACTOR for faulty materials, equipment or work. CalOptima rejects any disclaimer by CONTRACTOR of any warranty, standard, implied or express, unless specifically agreed to in writing by both Parties.

2.6 Any CalOptima property damaged by CONTRACTOR, its subcontractor(s), or by the personnel of either, will be subject to repair or replacement by CONTRACTOR at no cost to CalOptima.

3. **Record Ownership and Retention**.

3.1 The originals of all letters, documents, reports, and any other products and data prepared or generated for the purposes of this Contract shall be delivered to and become the property of CalOptima at no cost to CalOptima and in a form accessible for CalOptima's use. Copies may be made for CONTRACTOR's records but shall not be furnished to others without written authorization from CalOptima. Such deliverables shall become the sole property of CalOptima and all rights in copyright therein shall be retained by CalOptima. CalOptima's ownership of these documents includes use of, reproduction or reuse of, and all incidental rights. CONTRACTOR shall provide all deliverables within a reasonable amount of time upon CalOptima's request, but in no event shall such time exceed thirty (30) calendar days unless otherwise specified by CalOptima.

3.2 CONTRACTOR hereby assigns to CalOptima all of its rights in all materials prepared by or on behalf of CalOptima under this Contract ("**Works**"), and this Contract shall be deemed a transfer to CalOptima of the sole and exclusive copyright of any copyrightable subject matter CONTRACTOR created in these Works. CONTRACTOR agrees to cause its agents and employees to execute any documents necessary to secure or perfect CalOptima's legal rights and worldwide ownership in such materials, including documents relating to patent, trademark and copyright applications. Upon CalOptima's request, CONTRACTOR will return or transfer all property and materials, including the Works, in CONTRACTOR's possession or control belonging to CalOptima.

4 Required Insurance

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

4.1.1 Per occurrence: $1,000,000

4.1.2 Personal Advertising Injury: $1,000,000

4.1.3 Products Completed Operations: $2,000,000

4.1.4 General Aggregate: $2,000,000

4.2 If Contractor or subcontractors are on CalOptima's premises or transporting CalOptima members or employees, Commercial Automobile Liability covering any auto, whether owned, lease, hired, or rented, on an ISO form CA 0001 or equivalent in the amount of $1,000,000 combined single limit for bodily injury or property damage.

4.3 Worker's Compensation and Employer's Liability Policy written in accordance with applicable laws and providing coverage for all of CONTRACTOR's employees:

4.3.1 The policy must provide statutory coverage for Worker's Compensation.

4.3.2 The policy must also provide coverage for $1,000,000 Employers' Liability for each employee, each accident, and in the general aggregate.

4.4 Professional Liability insurance covering the CONTRACTOR's professional errors and omissions with $1,000,000 per occurrence and $2,000,000 general aggregate. [Only applicable if the contract is for professional services]

4.5 Commercial crime policy covering employee theft and dishonesty, forgery and alteration, money orders and counterfeit currency, credit card fraud, wire transfer fraud, and them of client property with $1,000,000 limits per occurrence.

EXHIBIT A
Addendum 1

The following is a list of subcontractors approved to perform Services under this Contract:

Subcontractor Name	Functions

EXHIBIT B
Payment

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

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

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

4. Notwithstanding any provisions of this Contract to the contrary, CalOptima and CONTRACTOR mutually agree that CalOptima's maximum cumulative payment obligation hereunder for work performed and/or products received on Exhibit A of this Contract shall not exceed [Insert Maximum Cumulative Payment Amount, Written] Dollars ($[Insert Maximum Cumulative Payment Amount, Number]), including all amounts payable to CONTRACTOR for its direct labor and expenses, overhead costs, fixed fee, subcontracts, leases, materials, and costs arising from or due to termination of this Contract.

   [different compensation options]

5. CONTRACTOR's hourly billable rate shall be «Hourly billable spelled» Dollars ($«Hourly Billable») per hour. This rate is fixed for the duration of the Contract. CONTRACTOR agrees to extend this rate to CalOptima for a period of one (1) year after Contract termination. CalOptima shall not pay CONTRACTOR for time spent traveling.

5. CONTRACTOR's fees for the goods and/or services provided under Exhibit A, Scope of Work, will be billed based upon completion of the milestones as set forth in the schedule(s) in Exhibit B-1. These fees are fixed for the duration of the Contract. CONTRACTOR agrees to extend these fees to CalOptima for a period of one (1) year after Contract termination. CalOptima shall not pay CONTRACTOR for time spent traveling.

5. CONTRACTOR's fees for the goods and/or services provided under Exhibit A, Scope of Work, will be billed on a time and materials basis. Each CONTRACTOR employee will have an associated hourly rate, which CONTRACTOR will extend by the hours of service performed in order to determine the amount of fees to invoice. The CONTRACTOR's employees who will participate in this Contract, their titles/labor category and the [hourly/daily] rates associated with this Contract are set forth in Exhibit B-1. These fees and rates are fixed for the duration of the Contract. CONTRACTOR agrees to extend these fees and rates to CalOptima for a period of one (1) year after Contract termination. CalOptima shall not pay CONTRACTOR for time spent traveling.

5. CONTRACTOR's fees for the goods and/or services provided under Exhibit A, Scope of Work, will be billed based upon completion of the milestones as set forth in the schedule(s) in Exhibit B-1. For any additional work beyond that specified in Exhibit A, Scope of Work, that is authorized by CalOptima in a written amendment or change order, CONTRACTOR shall be paid at the hourly billable rate of «Hourly Billable Spelled» Dollars

($«Hourly Rate») per hour. These fees and rates are fixed for the duration of the Contract. CONTRACTOR agrees to extend these fees and rates to CalOptima for a period of one (1) year after Contract termination. CalOptima shall not pay CONTRACTOR for time spent traveling.

5. CONTRACTOR's fees for the goods and/or services provided under Exhibit A, Scope of Work, will be billed at the rates set forth in Exhibit B-1. These fees are fixed for the duration of the Contract. CONTRACTOR agrees to extend these fees to CalOptima for a period of one (1) year after Contract termination. CalOptima shall not pay CONTRACTOR for time spent traveling.

6. If CONTRACTOR incurs travel-related expenses under this Contract, CalOptima will only reimburse such expenses if CalOptima provides prior written approval of such expenses and those expenses are incurred and submitted in accordance with CalOptima Travel Policy (G.A.5004), as amended, which is incorporated into this Contract by this reference. CalOptima will make CalOptima Travel Policy (G.A.5004) available to CONTRACTOR upon written request.

EXHIBIT B-1
Payment Schedule

Milestone	Completion Date	Fee
_____	_____	_____
_____	_____	_____
_____	_____	_____
TOTAL		

Name	Title/Labor Category	Rate
_____	_____	_____
_____	_____	_____
_____	_____	_____

EXHIBIT C
Regulatory Requirements

CalOptima is a public agency and is licensed by the DMHC. In addition, CalOptima arranges for the provision of Medi-Cal services to Medi-Cal beneficiaries under a contract with DHCS ("**DHCS Contract**") and Medicare Advantage ("**MA**") services to Medicare beneficiaries under a contract CMS ("**CMS Contract**"). This Exhibit C sets forth the statutory, regulatory, and contractual requirements that CalOptima must incorporate into the Contract as a public agency and DMHC-licensed health care service plan with MA and Medi-Cal products.

1. **Medi-Cal Requirements**.

1.1. Compliance with Medi-Cal Standards. CONTRACTOR agrees that the Contract shall be governed by and construed in accordance with all laws and applicable regulations governing the DHCS Contract. CONTRACTOR shall comply with all applicable requirements of the Medi-Cal program and comply with all monitoring of the DHCS Contract and any other monitoring requests by DHCS.

1.2. Disclosure of Officers, Owners, Stockholders and Creditors. Pursuant to Exhibit E, Attachment 2, Section 33 (a) of the DHCS Contract and 42 C.F.R. Section 455.104, upon the Effective Date, on an annual basis, and within thirty (30) days of any changes, CONTRACTOR shall identify the names of the following persons by listing them on Exhibit D of this Contract and submitting the form to CalOptima:

1.2.1. All officers and owners who own greater than five percent (5%) of the CONTRACTOR;

1.2.2. All stockholders owning greater than five percent (5%) of any stock issued by CONTRACTOR; and

1.2.3. All creditors of CONTRACTOR's business if such interest is over five percent (5%).

1.3. Compliance with Employment and Labor Laws. Each Party shall, at its own expense, comply with all applicable laws in performing their respective obligations under the Contract, including, but not limited to, the National Labor Relations Act, the Americans With Disabilities Act, all applicable employment discrimination laws, overtime laws, tax laws, immigration laws, workers' compensation laws, occupational safety and health laws, and unemployment insurance laws and any regulations related thereto. CONTRACTOR acknowledges and agrees that:

1.3.1. CONTRACTOR and its subcontractors will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. CONTRACTOR and its subcontractors will take affirmative action to ensure that qualified applicants are employed and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age, or status as a disabled veteran or veteran of the Vietnam era. Such action shall include the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. CONTRACTOR and its subcontractors agree to post in conspicuous places, available to employees and applicants for employment, notices 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 shall state CONTRACTOR and its subcontractors' obligation 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. [DHCS Contract, Exhibit D(F), Provision 1, Section A]

1.3.2. CONTRACTOR and its subcontractors will, in all solicitations or advancements for employees placed by or on behalf of CONTRACTOR and its subcontractors, state that all qualified applicants

will receive consideration for employment without regard to race, color, religion, sex, national origin, physical or mental handicap, disability, age, or status as a disabled veteran or veteran of the Vietnam era. [DHCS Contract, Exhibit D(F), Provision 1, Section B]

1.3.3. CONTRACTOR and its subcontractors will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the federal government or the State of California, advising the labor union or workers' representative of CONTRACTOR and its subcontractors' commitments under this Section 1.3 and shall post copies of the notice in conspicuous places available to employees and applicants for employment. [DHCS Contract, Exhibit D(F), Provision 1, Section C]

1.3.4. CONTRACTOR and its subcontractors will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212), and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity", and as supplemented by regulation at 41 C.F.R. 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. [DHCS Contract, Exhibit D(F), Provision 1, Section D]

1.3.5. CONTRACTOR and its subcontractors will furnish all information and reports required by Federal Executive Order No. 11246, as amended, including by Executive Order 11375, "Amending Executive Order No. 11246, Relating to Equal Employment Opportunity", and as supplemented by regulation at 41 C.F.R. 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. [DHCS Contract, Exhibit D(F), Provision 1, Section E]

1.3.6. If CONTRACTOR and its subcontractors' do not comply with the requirements of this Section 1.3 or with any federal rules, regulations, or orders referenced herein, this Contract may be cancelled, terminated, or suspended in whole or in part, and CONTRACTOR and its subcontractors may be declared ineligible for further federal and state contracts, in accordance with procedures authorized in Federal Executive Order No. 11246, as amended, and such other sanctions may be imposed and remedies invoked as provided in Federal Executive Order No. 11246, as amended, including by Executive Order 11375, "Amending Executive Order No. 11246 Relating to Equal Employment Opportunity", and as supplemented by regulation at 41 C.F.R. 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. [DHCS Contract, Exhibit D(F), Provision 1, Section F]

1.3.7. CONTRACTOR and its subcontractors will include the provisions of this Section 1.3 in every subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor, issued pursuant to Federal Executive Order No. 11246, as amended, including by Executive Order 11375, "Amending Executive Order No. 11246 Relating to Equal Employment Opportunity", and as supplemented by regulation at 41 C.F.R. 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. CONTRACTOR and its subcontractors will take such action with respect to any subcontract or purchase order as the Director of the Office of Federal Contract Compliance Programs or DHCS may direct as a means of enforcing such provisions, including sanctions for noncompliance; provided, however, that if CONTRACTOR and its subcontractors become involved in, or are threatened with litigation by a subcontractor as a result of such direction by DHCS, CONTRACTOR and its subcontractors may request in writing to DHCS, which, in turn, may request the United States to enter into such litigation

to protect the interests of the State of California and of the United States. [DHCS Contract, Exhibit D(F), Provision 1.G]

1.4. Debarment and Suspension Certification.

1.4.1. By signing this Contract, the CONTRACTOR agrees to comply with any and all applicable federal suspension and debarment regulations, including, as applicable, 7 C.F.R. 3017, 45 C.F.R. 76, 40 C.F.R. 32, or 34 C.F.R. 85. [DHCS Contract, Exhibit D(F), Provision 19, Section A]

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

1.4.2.1. Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any state or federal department or agency; [DHCS Contract, Exhibit D(F), Provision 19, Section B.1]

1.4.2.2. Have not within a three (3)-year period preceding this Contract been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, state or local) transaction or contract under a public transaction; violation of federal or state anti-trust statutes; or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property; [DHCS Contract, Exhibit D(F), Provision 19, Section B.2]

1.4.2.3. Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (federal, state or local) with commission of any of the offenses enumerated in Section 1.4.2.2 of this Exhibit C; [DHCS Contract, Exhibit D(F), Provision 19, Section B.3]

1.4.2.4. Have not within a three (3)-year period preceding the Effective Date of this Contract had one or more public transactions (federal, state or local) terminated for cause or default; [DHCS Contract, Exhibit D(F), Provision 19, Section B.4]

1.4.2.5. Have not and shall not knowingly enter into any lower-tier covered transaction with a person who is proposed for debarment under federal regulations (i.e., 48 C.F.R. 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State of California; and [DHCS Contract, Exhibit D(F), Provision 19, Section B.5]

1.4.2.6. Will include a clause entitled, "Debarment and Suspension Certification" that sets forth the provisions herein in all lower-tier covered transactions and in all solicitations for lower-tier covered transactions. [DHCS Contract, Exhibit D(F), Provision 19, Section B.6]

1.4.3. If the CONTRACTOR is unable to certify to any of the statements in this certification, the CONTRACTOR shall submit an explanation to CalOptima. [DHCS Contract, Exhibit D(F), Provision 19, Section C]

1.4.4. The terms and definitions herein have the meanings set out in the Definitions and Coverage sections of the rules implementing Federal Executive Order 12549. [DHCS Contract, Exhibit D(F), Provision 19, Section D]

1.4.5. If the CONTRACTOR knowingly violates this certification, in addition to other remedies available to the federal government, CalOptima may terminate this Contract for cause or default. [DHCS Contract, Exhibit D(F), Provision 19, Section E]

1.5. Lobbying Restrictions and Disclosure Certification.

1.5.1. *Certification and Disclosure Requirements*.

1.5.1.1. If Contract is subject to 31 U.S.C. § 1352 and exceeds $100,000 at any tier, CONTRACTOR and its subcontractors, as applicable, shall file a certification (in the form set forth in Exhibit E, consisting of one page, entitled "Certification Regarding Lobbying") that CONTRACTOR and its subcontractors, as applicable, have not made, and will not make, any payment prohibited by Section 1.5.2 below. [DHCS Contract, Exhibit D(F), Provision 31, Section A.1; 31 U.S.C. § 1352]

1.5.1.2. CONTRACTOR and its subcontractors, as applicable, shall file a disclosure (in the form set forth in Exhibit E, entitled "Certification Regarding Lobbying") if CONTRACTOR and its subcontractors, as applicable, have made or agreed to make any payment using non-appropriated funds (to include profits from any covered federal action) in connection with the Contract or a subcontract thereunder that would be prohibited under Section 1.5.2 below if paid for with appropriated funds. [DHCS Contract, Exhibit D(F), Provision 31, Section A.2]

1.5.1.3. CONTRACTOR and its subcontractors, as applicable, shall file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affect the accuracy of the information contained in any disclosure form previously filed by CONTRACTOR and its subcontractors, as applicable, under this Section 1.5.1. An event that materially affects the accuracy of the information reported includes: [DHCS Contract, Exhibit D(F), Provision 31, Section A.3]

1.5.1.3.1. A cumulative increase of $25,000 or more in the amount paid or expected to be paid for influencing or attempting to influence a covered federal action; [DHCS Contract, Exhibit D(F), Provision 31, Section A.3.a]

1.5.1.3.2. A change in the person(s) or individuals(s) influencing or attempting to influence a covered federal action; or [DHCS Contract, Exhibit D(F), Provision 31, Section A.3.b]

1.5.1.3.3. A change in the officer(s), employee(s), or member(s) contacted for the purpose of influencing or attempting to influence a covered federal action. [DHCS Contract, Exhibit D(F), Provision 31, Section A.3.c]

1.5.1.3.4. As applicable and required by this Section 1.5, CONTRACTOR's subcontractors shall file a certification and a disclosure form, if required, to the next tier above. [DHCS Contract, Exhibit D(F), Provision 31, Section A.4]

1.5.1.3.5. All disclosure forms (but not certifications) shall be forwarded from tier to tier until received by CONTRACTOR. CONTRACTOR shall forward all disclosure forms to CalOptima. [DHCS Contract, Exhibit D(F), Provision 31, Section A.5]

1.5.2. *Prohibition*. 31 U.S.C. § 1352 provides in part that no appropriated funds may be expended by the recipient of a federal contract, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with any of the following covered federal actions: the awarding of any federal contract, the making of any federal grant, the making of any federal loan, entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement. [DHCS Contract, Exhibit D(F), Provision 31, Section B]

1.6. Verification of CalOptima Costs by Government. Until the expiration of ten (10) years after the later of furnishing of any service pursuant to this Contract or completion of any audit, or longer as required by applicable regulations, CONTRACTOR will make available, upon written request of CalOptima, the Secretary of Health and Human Services Office of Inspector General, the Comptroller General of the United States, the U.S. Department of Justice, DHCS, the DMHC, the Bureau of Medical Fraud, or any of their duly authorized representatives copies of this Contract and any financial statements, books, documents, records, patient care documentation, and other records or data of CONTRACTOR that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under this Contract, or as are otherwise necessary to certify the nature and extent of costs incurred by CalOptima for such services. This provision shall also apply to any agreement with a CONTRACTOR subcontractor or an organization related to a CONTRACTOR subcontractor by control or common ownership. CONTRACTOR further agrees that regulating entities have the right to inspect, evaluate and audit any pertinent information and to facilitate the review of the items referenced herein, to make available its premises, physical facilities and equipment, records related to Medicare enrollees, and any additional relevant information that regulating entities may require. CONTRACTOR further agrees and acknowledges that this provision will be included in any and all agreements with CONTRACTOR's subcontractors. [DHCS Contract, Exhibit E, Attachment 2, Provision 20]

1.7. Confidentiality of Member Information.

1.7.1. If CONTRACTOR and its employees, agents, or subcontractors access or receive, whether intentionally or unintentionally, personally identifying information during the Term, CONRACTOR and its employees, agents, and subcontractors shall protect from unauthorized disclosure, the names and other identifying information concerning persons either receiving services pursuant to this Contract, or persons whose names or identifying information become available or are disclosed to CONTRACTOR, its employees, agents, or subcontractors as a result of services performed under this Contract, except for statistical information not identifying any such person. CONTRACTOR and its employees, agents, or subcontractors shall not use such identifying information for any purpose other than carrying out the express terms of and CONTRACTOR's obligations under this Contract. CONTRACTOR and its employees, agents, or subcontractors shall promptly transmit to CalOptima all requests for disclosure of such identifying information, except requests for medical records in accordance with applicable law, not emanating from the CalOptima member. CONTRACTOR shall not disclose, except as otherwise specifically permitted by this Contract or authorized by the CalOptima member, any such identifying information to anyone other than DHCS or CalOptima without prior written authorization from CalOptima specifying that the information is releasable under Title 42 C.F.R. Section 431.300 *et seq*., Section 14100.2, Welfare and Institutions Code, and regulations adopted there under. For purposes of this Section 1.7, identity shall include name, identifying number, symbol, or other identifying detail assigned to the individual, such as finger or voice print or a photograph. [DHCS Contract, Exhibit D(F), Provision 12, Exhibit E, Attachment 2, Provision 22, Section B]

1.7.2. Names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with Title 42 C.F.R. Section 431.300 *et seq*., Section 14100.2, Welfare and Institutions Code, and regulations adopted thereunder. For the purpose of this Contract, all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to CalOptima members shall be protected by CONTRACTOR from unauthorized disclosure. CONTRACTOR may release Medical Records in accordance with applicable law pertaining to the release of this type of information. CONTRACTOR is not required to report requests for Medical Records made in accordance with applicable law. With respect to any identifiable information concerning a CalOptima member under this Contract that is obtained by CONTRACTOR or its subcontractors, CONTRACTOR will, at the termination of this Contract, return all such information to CalOptima or maintain such information according to written procedures sent to the CONTRACTOR by CalOptima for this purpose. [DHCS Contract, Exhibit E, Attachment 2, Provision 22]

1.8. Member Hold Harmless. To the extent CONTRACTOR provides services or supplies to CalOptima members, CONTRACTOR hereby agrees that in no event, including nonpayment by CalOptima, the insolvency of CalOptima, or breach of the Contract, shall CONTRACTOR bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against CalOptima members, persons acting on their behalf, or DHCS. CONTRACTOR further agrees that this hold harmless provision shall survive the termination of the Contract regardless of the cause giving rise to the termination, shall be construed to be for the benefit of CalOptima members, and that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between CalOptima or CONTRACTOR and a CalOptima member or persons acting on their behalf that relates to liability for payment for services under the Contract. [DHCS Contract, Exhibit A, Attachment 6, Provision 13, Section B.15; CMS Medicare Managed Care Manual Chapter 11, Section 100.4]

1.9. Air and Water Pollution Requirements. If this Contract or any subcontract thereunder is in excess of one hundred thousand dollars ($100,000), CONTRACTOR agrees to comply with all applicable standards, orders, or requirements issued under the Clean Air Act (42 USC § 7401 *et seq*.), as amended, and the Federal Water Pollution Control Act (33 USC § 1251 *et seq*.), as amended. [DHCS Contract, Exhibit D(F), Provision 11]

2. **Medicare Requirements**.

2.1. CONTRACTOR expressly warrants that CONTRACTOR and CONTRACTOR's subcontractors, if any, shall comply with all applicable Medicare laws, regulations, and CMS instructions. CONTRACTOR further agrees and acknowledges that this provision will be included in all agreements with CONTRACTOR's subcontractors.

2.2. For any medical records or other health and enrollment information CONTRACTOR maintains with respect to Medicare enrollees, CONTRACTOR shall establish procedures to:

2.2.1. Abide by all federal and state laws regarding confidentiality and disclosure of medical records and other health and enrollment information. CONTRACTOR shall safeguard the privacy of any information that identifies a particular enrollee and shall have procedures that specify: (a) the purposes for which the information will be used within CONTRACTOR's organization; and (b) to whom and for what purposes CONTRACTOR will disclose the information.

2.2.2. Ensure that the medical information is used and released only in accordance with applicable federal or state law, or pursuant to court orders or subpoenas.

2.2.3. Maintain the records and information in an accurate and timely manner.

2.3. CONTRACTOR shall comply with the reporting requirements provided in 42 C.F.R. § 422.516, as well as the encounter data submission requirements in 42 C.F.R. § 422.257.

2.4. For all contracts in the amount of $100,000 or more, CONTRACTOR and CONTRACTOR's subcontractors, if any, shall comply with 41 C.F.R. 60-300.5(a) and 41 C.F.R. 60-741.5(a) as follows:

2.4.1. CONTRACTOR and Subcontractor shall abide by the requirements of 41 C.F.R. § 60-300.5(a). This regulation prohibits discrimination against qualified protected veterans and requires affirmative action by covered prime contractors and subcontractors to employ and advance in employment qualified protected veterans. [41 C.F.R. § 60-300.5(d)]

2.4.2. CONTRACTOR and subcontractor shall abide by the requirements of 41 C.F.R. § 60-741.5(a). This regulation prohibits discrimination against qualified individuals on the basis of disability and requires affirmative action by covered prime contractors and subcontractors to employ and advance in employment qualified individuals with disabilities. [41 C.F.R. § 60-741.5(d)]

2.5. In addition to the termination provisions of Section 14 of the Contract, CalOptima may terminate the Contract if CMS or CalOptima determines that CONTRACTOR has not satisfactorily performed its obligations under the Contract. Under such circumstances, CalOptima may pay CONTRACTOR its allowable costs incurred to the date of termination. Thereafter, CONTRACTOR shall have no further claims against CalOptima for matters pertaining to this Contract.

2.6. While CalOptima maintains ultimate responsibility for adhering to and complying with all terms and conditions of the CMS Contract, CONTRACTOR shall comply with all such applicable requirements in the CMS Contract, at the direction of CalOptima.

2.7. CONTRACTOR shall ensure that the persons it employs or contracts with for the provision of services pursuant to the Contract are in good standing and not on the preclusion list, defined in 42 C.F.R. § 422.2. CONTRACTOR shall promptly disclose to CalOptima any exclusion or other event that makes a CONTRACTOR employee or subcontractor ineligible to perform work related to federal health care programs. CONTRACTOR agrees to be bound by the provisions set forth at 2 C.F.R. Part 376. [42 C.F.R. § 422.752(a)(8)]

2.8. FDR Compliance. Upon execution of this Contract, CONTRACTOR agrees to execute and abide by the terms of the "FDR Compliance Attestation" in Exhibit F and shall submit an executed FDR Compliance Attestation no less than annually thereafter. [Delete if CONTRACTOR is not a FDR.]

3. **Offshore Performance**.

3.1. Due to security and identity protection concerns, direct services under this Contract shall not be performed by offshore subcontractors, unless otherwise authorized in writing by CalOptima prior to the provision of those services.

3.2. CONTRACTOR shall complete, sign, and return Exhibit G, "Attestation Concerning the Use of Offshore Subcontractors" as of the Effective Date and shall submit an executed Offshore Subcontractor Attestation to CalOptima no less than annually thereafter. CONTRACTOR represents and warrants that it has disclosed in Exhibit G any and all such offshore subcontractors and that it has obtained CalOptima's written approval to use such offshore subcontractors prior to the Effective Date.

3.3. Any subcontract with an offshore entity under which the offshore entity will have access to any confidential CalOptima member or other protected health information must be approved in writing by CalOptima prior to execution of the subcontract. CONTRACTOR is required to submit future Offshore Contractor Attestations to CalOptima within thirty (30) calendar days after it has signed a contract with any subcontractor that may be using an offshore subcontractor to perform any related work.

3.4. Unless specifically stated otherwise in this Contract, the restrictions of this Section 3 do not apply to indirect or "overhead" services, or services that are incidental to the performance of the Contract.

3.5. The provisions of this Section 3 apply to work performed by subcontractors at all tiers.

4. **Prohibited Interest**.

4.1. CONTRACTOR shall comply with all applicable federal, state, and local laws and regulations pertaining to conflict-of-interest laws, including CalOptima's Conflict of Interest Code, the California Political Reform Act (California Government Code § 81000 *et seq*.) and California Government Code § 1090 *et seq*. (collectively, the "**Conflict of Interest Laws**").

4.2. CONTRACTOR covenants that, to the best of its knowledge during the Term, no director, officer, or employee of CalOptima during his or her tenure has any interest, direct or indirect, in this Contract or the proceeds thereof. CONTRACTOR further covenants that, for the Term, and consistent with the provisions of 22 C.C.R. § 53600(f), no state officer or state employee shall be employed in a management or

contractor position by CONTRACTOR within one (1) year after the state office or state employee has terminated state employment.

4.3. CONTRACTOR, and any person designated by CONTRACTOR to make or participate in making a governmental decision on behalf of CalOptima, is considered a "**Consultant**" pursuant to CalOptima's Conflict of Interest Code and shall be required to file a statement of economic interests (Fair Political Practices Commission Form 700) with CalOptima annually. [2 C.C.R. Section 18734]

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

4.5. If CONTRACTOR becomes aware of any facts that might reasonably be expected to either create a conflict of interest under the Conflict of Interest Laws or violate the provisions of this Section 4, CONTRACTOR shall immediately make full written disclosure of such acts to CalOptima. Full written disclosure shall include identification of all persons, entities, and businesses implicated and a complete description of all relevant circumstances.

5. **State Auditor Audit Disclosure**. Pursuant to California Government Code § 8546.7, if this Contract is more than ten thousand dollars ($10,000), it is subject to examination and audit of the California State Auditor, at the request of CalOptima or as part of any audit of CalOptima for a period of three (3) years after final payment under this Contract. In addition to and notwithstanding any other right of access or inspection that may be otherwise set forth in this Contract, CONTRACTOR agrees that during the Term and for a period of three (3) years after its termination, CalOptima shall have access to and the right to examine any directly pertinent books, documents, invoices, and records of CONTRACTOR relating to services provided under this Contract. Where another right of access or inspection in this Contract provides for a period of greater than three (3) years, nothing herein shall be construed to shorten that time period. [Gov't Code § 8546.7]

6. **Prevailing Wage**. To the extent required by state law, CONTRACTOR agrees that CONTRACTOR and any of its subcontractors shall comply with the requirements under California Labor Code § 1720, *et seq*. and shall pay not less than the prevailing wage rates for services performed in the execution of this Contract as required under California Labor Code § 1774. It is CONTRACTOR's responsibility to interpret and implement any prevailing wage requirements, and CONTRACTOR agrees to pay any penalty or civil damages resulting from a violation of the prevailing wage laws. In accordance with California Labor Code § 1773.2, copies of the prevailing rate of per diem wages are available upon request from CalOptima's Purchasing Department or the website for State of California Prevailing Wage Determinations at www.dir.ca.gov/OPRL/PWD. If applicable, a copy of the prevailing rate of per diem wages must be posted at the job.

7. **Surety Bonds**. If the Contract Documents change, the CONTRACTOR shall ensure that the amounts of the bond(s) required under this Section 7 are adjusted to reflect one hundred percent (100%) of the Contract price. This Contract shall not become effective until such bond(s) required under this Section 7 are provided to, and approved by, CalOptima.

7.1. Payment Bond. CONTRACTOR shall, prior to beginning any work pursuant to this Contract, furnish a bond in the amount of one hundred percent (100%) of the Contract price to guarantee payment of all claims for labor and materials furnished and the faithful performance of the work. [Cal. Civ. Code § 9550]

8. **Labor Code Compliance**. To the extent required by state law, the compensation under this Contract includes funds sufficient to allow CONTRACTOR to comply with all applicable local, state, and federal laws or regulations governing the work to be performed under this Contract, including any such laws or regulations requiring CONTRACTOR to pay prevailing wages. CONTRACTOR will fully comply with all such laws and regulations. By its signature, CONTRACTOR acknowledges that CalOptima has requested CONTRACTOR to provide CalOptima with all accurate and updated information required to comply with the provisions of

California Labor Code § 2810(d). CONTRACTOR agrees to provide CalOptima with all such information, including the information to be inserted in Exhibit H to this Contract.

EXHIBIT D
Medi-Cal Disclosure Form

Contractor Officer, Owner, Shareholder, and Creditor Information

Contractor's Business Name: _____

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

Business Address: _____

City:_____ State:_____ Zip:_____
Business Phone:_____ Email: :_____
President: _____ Contact Person:_____

Person(s) Signing Contract & Title: :_____

*Please provide names of owners, officers, stockholders, and creditors of Contractor's business if such interest is over 5%.

Name	Officer Title or Ownership/Creditorship %
_____	_____
_____	_____
_____	_____
_____	_____

BY SIGNING BELOW, THE UNDERSIGNED HEREBY CERTIFIES THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF HIS OR HER KNOWLEDGE AND BELIEF.

_____ _____
Authorized Signature Date

_____
Name and Title

EXHIBIT E

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES
CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the making, awarding or entering into of this federal contract, federal grant, or cooperative agreement, and the extension, continuation, renewal, amendment, or modification of this federal contract, grant, or cooperative agreement.

(2) If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency of the United States Government, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, or cooperative agreement, the undersigned shall complete and submit Standard Form LLL, "Disclosure of Lobbying Activities"' in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontractors, subgrants, and contracts under grants and cooperative agreements) of $100,000 or more, and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S.C., any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

_____	_____
Name of Contractor	Printed Name of Person Signing for Contractor
_____	_____
Contract/Grant Number	Signature of Person Signing for Contractor
_____	_____
Date	Title

After execution by or on behalf of Contractor, please return to:

Department of Health Care Services
Medi-Cal Managed Care Division
MS 4415, 1501 Capitol Avenue, Suite 71.4001
P.O. Box 997413
Sacramento, CA 95899-7413

CERTIFICATION REGARDING LOBBYING

Approved by OMB 0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure)

1. Type of Federal Action: ☐a. contract ☐b. grant ☐c. cooperative agreement ☐d. loan ☐e. loan guarantee ☐f. loan insurance	2. Status of Federal Action: ☐a. bid/offer/application ☐b. initial award ☐c. post-award	3. Report Type: ☐a. initial filing ☐b. material change **For Material Change Only:** Year _____ quarter_____ date of last report _____

4. Name and Address of Reporting Entity: ☐ Prime ☐ Subawardee Tier ____, *if known*: Congressional District, *if known*:	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime: Congressional District, *if known*:
6. Federal Department/Agency:	7. Federal Program Name/Description: CDFA Number, *if applicable*:
8. Federal Action Number, *if known*:	9. Award Amount, *if known*: $_____
10. a. Name and Address of Lobbying Entity (*If individual, last name, first name, MI*): (*attach Continuation Sheet(s) SF-LLLA, if necessary*)	b. Name and Address of Lobbying Entity (If individual, last name, first name, MI):
11. Amount of Payment (check all that apply): $_____ ☐actual ☐planned 12. Form of Payment (check all that apply): ☐ a. cash ☐ b. in-kind, specify: Nature _____ Value_____	13. Type of Payment ☐ a. retainer ☐ b. one-time fee ☐ c. commission ☐ d. contingent fee ☐ e. deferred ☐ f. other, specify: _____
14. Brief Description of Services Performed or to be Performed and Dates(s) of Service, including Officer(s), Employee(s), or Member(s) Contracted for Payment indicated in item 11: *(Attach Continuation Sheet(s) SF-LLL-A, If necessary)*	
15. Continuation Sheet(s) SF-LLL-A Attached: ☐Yes ☐No	
16. Information requested through this form is authorized by Title 31, U.S.C., Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to Title 31, U.S.C., Section 1352. This information will be reported to the Congress semiannually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.	Signature: Print Name: Title: Telephone No.: Date:
Federal Use Only	Authorized for Local Reproduction Standard Form-LLL

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime federal recipients at the initiation or receipt of a covered federal action, or a material change to a previous filing, pursuant to Title 31, U.S.C., Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered federal action. Use the SF - LLL- A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered federal action.

2. Identify the status of the covered federal action.

3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered federal action.

4. Enter the full name, address, city, state, and ZIP code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants, and contract awards under grants.

5. If the organization filing the report in Item 4 checks "Subawardee," then enter the full name, address, city, state, and ZIP code of the prime federal recipient. Include Congressional District, if known.

6. Enter the name of the federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation United States Coast Guard.

7. Enter the federal program name or description for the covered federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CDFA) number for grants, cooperative agreements, loans, and loan commitments.

8. Enter the most appropriate federal identifying number available for the federal action identified in Item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract grant, or loan award number; the application/proposal control number assigned by the federal agency). Include prefixes, e.g., "RFP-DE-90401."

9. For a covered federal action where there has been an award or loan commitment by the federal agency, enter the federal amount of the award/loan commitment for the prime entity identified in Item 4 or 5.

10. (a) Enter the full name, address, city, state, and ZIP code of the lobbying entity engaged by the reporting entity identified in Item 4 to influence the covered federal action.

    (b) Enter the full names of the Individual(s) performing services and include full address if different from 10.(a). Enter last name, first name, and middle initial (MI).

11. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (Item 4) to the lobbying entity (Item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

12. Check the appropriate box(es). Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.

13. Check the appropriate box(es). Check all boxes that apply. If other, specify nature.

14. Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with federal officials. Identify the federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.

15. Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.

16. The certifying official shall sign and date the form, print his/her name, title, and telephone number.

EXHIBIT F
FDR Attestation

FDR COMPLIANCE ATTESTATION

Please complete and execute this attestation and return it to CalOptima's Office of Compliance via email Compliance@caloptima.org , or mail: CalOptima, Office of Compliance, Attn: Annie Phillips 505 City Parkway West, Orange, CA 92868, within thirty (30) calendar days for (existing FDRs) or sixty (60) calendar days for (new FDRs) of this notice.

Which CalOptima program(s) does this form pertain to? Select all that apply:	☐OneCare Connect ☐OneCare HMO SNP	☐Medi Cal ☐PACE

I hereby attest that [_____ (the "Organization")], and all its downstream entities, if any, that are involved in the provision of health or administrative services for any of the CalOptima programs identified above:

I. **General and HIPAA Compliance and FWA Training.** Provide effective Fraud, Waste and Abuse training, General Compliance training, General HIPAA training to all Organization and downstream entity board members, officers, employees, temporary employees, and volunteers, within ninety (90) calendar days of appointment, hire or contracting, as applicable, and at least annually thereafter as a condition of appointment, employment or contracting. The Organization and its downstream entities currently use (Select all that apply):

- ☐ CMS's Fraud, Waste, and Abuse training, General Compliance training, and General HIPAA training module. (The Organization shall maintain records per CMS retention requirement)
- ☐ An internal training program that meets CMS's Fraud, Waste, and Abuse training, General Compliance training, and HIPAA training module requirements. (The Organization shall maintain records per CMS retention requirement)

Note: If selecting an internal training program that meets CMS's FWA, HIPAA, and General Compliance, please submit a copy of your organization's trainings to CalOptima's Office of Compliance for review, and to ensure they meet CMS's requirements.

II. Administer specialized compliance training to Organization and downstream entity board members, employees, temporary employees, and volunteers: (i) based on their job function within the first ninety (90) days of hire and at least annually thereafter as a condition of appointment, employment or contracting, (ii) when requirements change: (iii) when such persons work in an area previously found to be non- compliant with program requirements or implicated in past misconduct.

III. **Compliance Plan and Code of Conduct Requirements.** Have established and publicized compliance policies and procedures, standards of conduct, and compliance reference material that meet the requirements outlined in 42 CFR § 422.503(b)(4)(vi)(A) and 42 CFR § 423.504(b)(4)(vi)(A) which information, and any updates thereto, are distributed to all Organization and downstream entity board members, officers, employees, temporary employees, and volunteers within ninety (90) days of appointment, hire or contracting, as applicable, and at least annually thereafter. Evidence of receipt of such compliance by such persons is obtained and retained by the Organization. (Select which applies to your organization):

- ☐ Organization has adopted, implemented, and distributed CalOptima's Compliance Plan and Code of Conduct
- ☐ Organization has distributed a comparable Compliance Plan and Code of Conduct

Note: If selecting a comparable Compliance Plan and Code of Conduct, please submit a copy of your organization's Compliance Plan and Code of Conduct to CalOptima's Office of Compliance for review, and to ensure they meet CMS's requirements

IV. **Exclusion Monitoring**. Review all Organization and downstream entity board members, officers, potential and actual employees, temporary employees, and volunteers against the (Suspended and Ineligible Provider List) S & I Medi-Cal, (Health and Human Services) HHS, (Office of Inspector General) OIG List of Excluded Individuals & Entities list, (System for Award Management) SAM/(General Services Administration) GSA Debarment list, Centers for Medicare & Medicaid Services (CMS) Preclusion List (as applicable), (here after "Lists") upon appointment, hire or contracting, as applicable, and monthly thereafter. Further, in the event that the Organization or downstream entity becomes aware that any of the foregoing persons or entities are included on these Lists, the Organization will notify CalOptima within five (5) calendar days, the relationship with the listed person/entity will be terminated as it relates to CalOptima, and appropriate corrective action will be taken.

V. **Conflict of Interest**. Screen the Organization and its subcontractors' governing bodies for conflicts of interest as defined in state and federal law and CalOptima policies and procedures upon hire or contracting and annually thereafter.

VI. **Reporting of FWA/Non-Compliance**. Will report suspected fraud, waste, and abuse, as well as all other forms of non- compliance, as it relates to CalOptima, confidentially and anonymously.

VII. **Disciplinary Action**. Understand that any violation of any laws, regulations, or CalOptima policies and procedures are grounds for disciplinary action, up to and including termination of Organization's contractual status.

VIII **Non-Retaliation**. Are aware that persons reporting suspected fraud, waste, and abuse, and other non- compliance are protected from retaliation under the False Claims Act and other applicable laws prohibiting retaliation.

IX. **Records Management**. Retain documented evidence of compliance with the above, including training and exclusion screening (i.e. sign-in sheets, certificates, attestations, OIG and GSA search results, etc.) for at least ten (10) years, and provide such documentation to CalOptima upon request.

The individual signing below is knowledgeable about and authorized to attest to the foregoing matters on behalf of the Organization.

_____	_____
Signature	Date
_____	_____
Name (Print)	Organization
_____	
Email (Print)	

EXHIBIT G

Attestation Concerning the Use of Offshore Subcontractors

If Organization offshores any protected health information (PHI) it must notify CalOptima prior to entering into or amending any agreement with an Offshore Subcontractor, and Contractor must complete the Offshore Subcontracting Attestation.

Which CalOptima program(s) does this form pertain to? Select all that apply.	☐ OneCare Connect ☐ PACE ☐ OneCare ☐ Medi-Cal

Please check one of the following:

☐ Our Organization does not offshore any protected health information.
Please skip to Part V below

☐ Our Organization does offshore protected health information.
Please complete Offshore Subcontractor Attestation (Part I through Part V) below

Part I — Offshore Subcontractor Information	
Attestation	**Response**
Our Organization uses an offshore subcontractor or offshore staff to perform functions that support our contract with CalOptima	☐ Yes ☐ No
Offshore Subcontractor name:	
Offshore Subcontractor country:	
Offshore Subcontractor address:	
Describe offshore subcontractor functions:	
Proposed or actual effective date for offshore subcontractor (MM/DD/Year):	

Part II — Precautions for Protected Health Information (PHI)	
Question	**Response**
1. Describe the PHI that will be provided to the offshore subcontractor	
2. Explain why providing PHI is necessary to accomplish the offshore subcontractor's objectives:	
3. Describe alternatives considered to avoid providing PHI, and why each alternative was rejected:	

Part III — Attestation of Safeguards to Protect Beneficiary Information in the Offshore Subcontract	
Attestation	**Response**
A. Offshore subcontracting arrangement has policies and procedures in place to ensure that Medicare beneficiary protected health information (PHI) and other personal information remains secure.	☐ Yes ☐ No*
B. Offshore subcontracting arrangement prohibits subcontractor's access to Medicare data not associated with CalOptima's contract with the offshore subcontractor.	☐ Yes ☐ No*
C. Offshore subcontracting arrangement has policies and procedures in place that allow for immediate termination of the subcontract upon discovery of a significant security breach.	☐ Yes ☐ No*
D. Offshore subcontracting arrangement includes all required Medicare Part C and D language (e.g., record retention requirements, compliance with all Medicare Part C and D requirements, etc.)	☐ Yes ☐ No*

Part IV — Attestation of Audit Requirements to Ensure Protection of PHI	
Attestation	**Response**
A. Our Organization will conduct an annual audit of the offshore subcontractor/employee.	☐ Yes ☐ No*
B. Audit results will be used by our Organization to evaluate the continuation of its relationship with the offshore subcontractor/employee.	☐ Yes ☐ No*
C. Our Organization agrees to share offshore subcontractor's/employee's audit results with CalOptima or CMS upon request.	☐ Yes ☐ No*

***Explanation required for all "no" responses to Part III and Part IV above:**

Part V — Organization Information	
By signing below, I hereby attest that the information contained herein is true, correct and complete.	
Printed name of authorized person:	Title:
Email:	Phone #:
Signature:	Date:

Note: CalOptima's policies and procedures, CMS training module instructions for FWA, General Compliance, General HIPAA, CalOptima's Code of Conduct, CalOptima's Compliance Plan can be accessed at https://www.caloptima.org/en/About/GeneralCompliance.aspx

EXHIBIT H

ADDITIONAL INFORMATION TO BE PROVIDED BY CONTRACTOR

PURSUANT TO CALIFORNIA LABOR CODE SECTION 2810

Workers compensation insurance policy number: _____

Name of insurance carrier: _____

Address of insurance carrier: _____

Telephone number of insurance carrier: _____

List of vehicles owned, by vehicle identification number: _____

Vehicle liability insurance policy number: _____

Name of insurance carrier: _____

Address of insurance carrier: _____

Telephone number of insurance carrier: _____

Provide address of any real property in which you intend to house any of your workers in connection with the project (or write "None" if no property willbe used to house workers): _____

Total number of workers to be employed: *_____

Total amount of all wages to be paid: *_____

Date(s) when wages will be paid: *_____

Total number of independent contractors/subcontractors: *_____

List by name each independent contractor/subcontractor and provide the contractor's license number for each: *_____

_____

_____

_____

_____

_____

_____

*May be estimated if unknown at the time this Contract is signed. CONTRACTOR must provide CalOptima with actual figures when known.

EXHIBIT I
Faithful Performance Bond

Bond No. _____
Premium _____

KNOW ALL PERSONS BY THE PRESENTS: That we, _____,

as Principal, and _____, as Surety, are held and firmly bound unto the Orange County Health Authority, dba CalOptima, a California Public Agency, ("CalOptima") in the sum of One Hundred Percent (100%) of the Contract Price pursuant to the agreement between Principal and CalOptima made and entered into on **[DATE]** for **[INSERT CONTRACT DESCRIPTION HERE]**, for the payment of which we hereby bind ourselves, our successor, heirs, executors and administrators, jointly and severally, firmly by these presents.

That the Surety's office is located at _____, telephone number _____, and the Surety is licensed to do business in the State of California, and that the California Insurance Agent's License Number, address and telephone number are as follows:

License Number: _____

Address: _____

_____

Telephone Number: _____

That the following clause may be completed if in fact a non-resident agent for the Surety is a party to the transaction:

Name of non-resident agent: _____

Non-Resident agent's office address: _____

_____

Non-resident agent's telephone number: _____

THE CONDITION OF THE FOREGOING OBLIGATION IS SUCH THAT:

1. The principal has entered into a contract, attached hereto, dated the _____ day of _____, 20__, with CalOptima for **[INSERT CONTRACT DESCRIPTION HERE]**.

2. If the Principal shall well and truly perform, or cause to be performed, each and all of the requirements and obligations of the contract to be performed by the Principal, as set forth in the contract, then this bond shall be null and void; otherwise, it shall remain in full force and effect. In the event that suit is instituted to recover on this bond, the Surety will pay reasonable attorney's fees.

3. As a condition precedent to the satisfactory completion of the contract, the above obligation in the said amount shall remain in effect for a period of one (1) year after the completion and acceptance by CalOptima of the work undertaken pursuant to the contract during which time if the Principal, his or its heirs, executors, administrators, successors, or assigns shall fail to make full, complete, and satisfactory repair and replacements or totally protect CalOptima from loss due to damage made evident during said period of one (1) year from the date of acceptance of the work, and resulting from or caused by defective materials, equipment and/or faulty workmanship in the prosecution of the work done, the above obligation in the said amount shall remain in full force and effect. However, notwithstanding anything in this paragraph to the contrary, the obligation of the Surety hereunder shall continue in effect so long as any obligation of the Principal remains.

4. Further, the Surety, for value received, hereby stipulates and agrees that no change, extension of time, alteration or modification of the Contract Documents or of work performed shall in any way affect its obligation on this bond, and it does hereby waive notice of any change, extension of time, alteration or modification of the Contract Documents or the work to be performed. The Surety hereby waives the provisions of Sections 2819 and 2845 of the Civil Code of the State of California.

WITNESS OUR HANDS AND SEALS THIS _____ day of _____, 20___.

_____

Principal

BY: _____

_____

Surety

BY: _____

Attorney-in-Fact

_____

California Resident Agent

By: _____

Non-Resident Agent/Attorney-in-Fact

STATE OF CALIFORNIA
COUNTY OF (_____)

On _____, 20___ before me, _____, Notary Public, personally appeared _____, who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY of PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature _____ (Seal)

Acknowledgment by Surety, as a Non-Resident Agent, as Attorney-in-Fact MUST be attached hereto)

STATE OF CALIFORNIA) ss
COUNTY OF _____)

On _____, 20___ before me, _____, Notary Public, personally appeared _____, who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY of PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature _____ (Seal)

EXHIBIT J
Labor and Material Payment Bond

Bond No. _____
Premium _____

KNOW ALL PERSONS BY THE PRESENTS:

That we, _____,

as Principal, and _____, as Surety, are held and firmly bound unto the Orange County Health Authority, dba CalOptima, a California Public Agency, ("CalOptima") in the sum of One Hundred Percent (100%) of the Contract Price pursuant to the agreement between Principal and CalOptima made and entered into on «Effective_Date» for «Project_Description» for the payment of which we hereby bind ourselves, our successor, heirs, executors and administrators, jointly and severally, firmly by these presents.

That the Surety's office is located at _____, telephone number _____, and the Surety is licensed to do business in the State of California, and that the California Insurance Agent's License Number, address and telephone number are as follows:

License Number: _____

Address: _____

_____

Telephone Number: _____

That the following clause may be completed if in fact a non-resident agent for the Surety is a party to the transaction:

Name of non-resident agent: _____

Non-Resident agent's office address: _____

_____

Non-resident agent's telephone number: _____

THE CONDITION OF THE FOREGOING OBLIGATION IS SUCH THAT:

1. The principal has entered into a contract, attached hereto, dated the _____ day of _____, 20__, with CalOptima for «Project_Description».

2. If the Principal, its heirs, executors, administrators, successors or assigns, or subcontractors, shall fail to pay (1) any of the persons named in Section 9100 of the California Civil Code, (2) amounts due under the Unemployment Insurance Code with respect to work or labor performed under the contract, or (3) for amounts required to be deducted, withheld, and paid over to the Employment Development Department from the wages of employees of the contractor or subcontractors pursuant to Section 13020 of the Unemployment Insurance Code with respect to the work and labor, the Surety or Sureties will pay for same in the amount not exceeding the sum specified in this bond. In the event that suit is instituted to recover on this bond, the Surety will pay reasonable attorney's fees and costs of CalOptima as shall be fixed by the court.

3. Further, the Surety, for value received, hereby stipulates and agrees that no change, extension of time, alteration or modification of the Contract Documents or of work performed shall in any way affect its obligation on this bond, and it does hereby waive notice of any change, extension of time, alteration or modification of the Contract Documents or the work to be performed. The Surety hereby waives the provisions of Sections 2819 and 2845 of the Civil Code of the State of California.

4. This bond shall inure to the benefit of any and all persons, companies, and corporations entitled to claims under California Civil Code Section 9100, so as to give a right of action to them or their assignees in any suit brought upon this bond.

WITNESS OUR HANDS AND SEALS THIS _____ day of _____, 20___.

_____
Principal
BY: _____

_____
Surety
BY: _____
Attorney-in-Fact

_____
California Resident Agent

BY: _____
Non-Resident Agent/Attorney-in-Fact

CONTRACT NO. «Contract Number» ("**Contract**")
BETWEEN
ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY, dba
ORANGE PREVENTION & TREATMENT INTEGRATED MEDICAL ASSISTANCE, dba
CALOPTIMA ("**CalOptima**")
And
«Company Name»
("**CONTRACTOR**")

This Contract is made and entered into as of [insert date] ("**Effective Date**"), by and between the Orange County Health Authority, a public agency dba CalOptima, a public agency ("**CalOptima**") and «Company Name», a «Business Entity», hereinafter referred to as "**CONTRACTOR**." CalOptima and CONTRACTOR may be referred to herein collectively as the "**Parties**" or each individually as a "**Party**."

RECITALS

A. CalOptima desires to retain a contractor to provide «Description», as described in the Scope of Work in Exhibit A;

B. CONTRACTOR provides such services;

C. CONTRACTOR represents and warrants that it has the requisite personnel and experience and is capable of performing such services;

D. CONTRACTOR desires to perform these services for CalOptima; and

E. CalOptima and CONTRACTOR desire to enter into this Contract on the terms and conditions set forth herein below.

NOW, THEREFORE, in consideration of their mutual and respective promises, and subject to the terms and conditions hereinafter set forth, the Parties agree as follows:

1. Documents Constituting Contract. "**Contract Documents**" include the following documents in the order of descending precedence: (i) this Contract, inclusive of all its exhibits and addenda; (ii) CalOptima's Request for Proposal ("**RFP**"), if applicable, inclusive of any CalOptima revisions and addenda prior to the Effective Date; (iii) CONTRACTOR's best and final offer dated [Insert Date of Best and Final Offer], if applicable, and; (iv) CONTRACTOR's proposal dated [Insert Date CONTRACTOR's Response to RFP] ("**Proposal**"). Any new terms and conditions attached to CONTRACTOR's best and final offer, Proposal, invoices, or request for payment shall not be incorporated into the Contract Documents or be binding upon CalOptima unless expressly accepted by CalOptima in writing. All Contract Documents are incorporated into this Contract by this reference. Any changes to the Contract or the Contract Documents shall not be binding upon CalOptima except when specifically confirmed in writing by an authorized representative of CalOptima in accordance with Section 10, of this Contract. In the event of any conflict of provisions among the Contract and/or Contract Documents, the provisions shall prevail in the above-referenced descending order of precedence.

2. Scope of Work.

2.1 CONTRACTOR shall perform the work in accordance with (i) this Contract, including the Scope of Work in Exhibit A, (ii) the Contract Documents, (iii) the applicable standards and requirements of the Centers for Medicare and Medicaid Services ("**CMS**"), the California Department of Health Care Services ("**DHCS**"), and the California Department of Managed Health Care ("**DMHC**"), and (iv) all applicable laws.

3. Insurance.

3.1 At CONTRACTOR's sole expense and prior to undertaking performance of services under this Contract and at all times during performance hereunder, CONTRACTOR shall maintain insurance policies and amounts set forth in Exhibit A, which shall be full-coverage insurance not subject to self-insurance provisions, in accordance with applicable laws and industry standards. CONTRACTOR shall not of its own initiative cause such insurance to be canceled or materially changed during the Term.

3.2 Within five (5) days of the Effective Date and prior to commencing performance of any services or its receipt of any compensation under the Contract, CONTRACTOR shall furnish to CalOptima with additional insured endorsements broker-issued Certificate(s) of Insurance showing the required insurance coverages for CONTRACTOR. CONTRACTOR's Certificates of Insurance shall additionally comply with the following:

3.2.1 CalOptima's officers, officials, directors, employees, agents, and volunteers are to be covered as additional insureds with respect to liability arising out of work or operations performed by or on behalf of CONTRACTOR, including materials, parts, or equipment furnished in connection with such work or operations. This provision applies to CONTRACTOR's General Liability policy, as applicable, and must be on ISO form CG 20 10 or equivalent.

3.2.2 For any claims related to this Contract, the CONTRACTOR's insurance coverage shall be primary insurance with respect to CalOptima, its officers, officials, directors, employees, agents, and volunteers. This provision applies to the CONTRACTOR's General Liability and Workers' Compensation and Employers' Liability policies, as applicable.

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

3.2.4 Insurance is to be placed with insurers with a current A.M. Best rating of no less than A-VII, unless otherwise acceptable to CalOptima.

3.2.5 CONTRACTOR shall furnish CalOptima with original certificates and amendatory endorsements affecting coverage required by this Section 3.2 and Exhibit A. CalOptima reserves the right to require complete, certified copies of all required insurance policies, including endorsements affecting the coverage required by these specifications, at any time.

3.2.6 Any deductibles or self-insured retentions must be declared to and approved by CalOptima. CalOptima may require the CONTRACTOR to purchase coverage with a lower deductible or retention or provide proof of ability to pay losses and related investigations, claim administration, and defense expenses within the retention or deductible.

3.2.7 All deductibles and retentions that the aforementioned policies contain are the responsibility of the CONTRACTOR and in no way shall CalOptima be responsible for payment of the deductibles/retentions.

3.2.8 If CONTRACTOR maintains higher limits than the minimums required in this Contract, CalOptima requires and shall be entitled to coverage for the higher limits maintained by CONTRACTOR. Any available insurance proceeds in excess of the specified minimum limits of insurance and coverage shall be available to CalOptima.

3.2.9 Require the insurance carrier to provide thirty (30) days' prior written notice of cancellation to CalOptima.

3.3 If CONTRACTOR fails or refuses to maintain or produce proof of the insurance required by this Section 3 and Exhibit A, CalOptima may terminate this Contract upon written notice to CONTRACTOR. Such termination shall not affect CONTRACTOR'S right to be paid for its time and materials expended prior to notification of termination. CONTRACTOR waives the right to receive compensation and agrees to indemnify CalOptima for any work performed prior to approval of insurance by CalOptima

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

3.5 CONTRACTOR shall require each of its subcontractors who perform services related to this Contract, if any, to maintain insurance coverage that meets all of the requirements set forth in this Contract.

3.6 "**Occurrence**" means any event or related exposure to conditions that result in bodily injury or property damage.

4. Indemnification.

4.1 To the fullest extent permitted by law, CONTRACTOR shall defend, indemnify, and hold harmless CalOptima and its respective officers, directors, agents, volunteers, consultants and employees (individually and collectively referred to as "**Indemnified Parties**") against any and all [third-party] claims, losses, demands, damages, costs, expenses, or liability arising out CONTRACTOR's, or its officers, employees, subcontractors, agents, or representatives', breach of this Contract, negligence, recklessness, or intentional conduct, except to the extent any such loss was caused by the gross negligence, recklessness, or intentional misconduct of CalOptima. CONTRACTOR shall defend the Indemnified Parties in any claim or action based upon any such alleged acts or omissions at its sole expense, which shall include all costs and fees, including attorneys' fees, cost of investigation, defense, and settlement or awards. CalOptima may make all reasonable decisions with respect to its representation in any legal proceeding. CONTRACTOR's duty to defend herein is wholly independent of and separate from the duty to indemnify and such duty to defend shall exist regardless of any ultimate liability of CONTRACTOR, save and except claims arising through the sole negligence or sole willful misconduct of CalOptima.

[Mutual indemnity option]

Each Party (an "**Indemnifying Party**") shall defend, indemnify, and hold harmless the other Party and the other Party's respective officers, directors, agents, volunteers, consultants, and employees (individually and collectively referred to as "**Indemnified Parties**") from and against any third-party claims losses, demands, damages, costs, expenses, or liability arising out of the Indemnifying Party's breach of this Contract, negligence, recklessness, or intentional conduct, except to the extent any such loss was caused by the negligence, recklessness, or intentional conduct of the Indemnified Parties. The Indemnifying Party shall defend the Indemnified Parties in any claim or action at its sole expense, which shall include all costs and fees, including attorneys' fees, cost of investigation, defense, and settlement or awards. The Indemnified Party may make all reasonable decisions with respect to its representation in any legal proceeding.

4.2 CONTRACTOR's obligation to indemnify hereunder is in addition to any liability CONTRACTOR may have to CalOptima for a breach by CONTRACTOR of any of the provisions of this Contract. Under no circumstances shall the insurance requirements and limits set forth in this Contract be construed to limit CONTRACTOR's indemnification and duty to defend obligation or other liability hereunder

4.3 CONTRACTOR's indemnification and duty to defend obligations shall survive the expiration or earlier termination of this Contract until such time as any action against the Indemnified Parties for such a matter indemnified hereunder is fully and finally barred by the applicable statute of limitations, including those set forth under the California Government Claims Act (Cal. Gov. Code §900 *et seq*.).

4.4 In the event of any conflict between this Section 4 and the indemnification provisions set forth elsewhere in the Contract, including any business associate agreement ("**BAA**") between the Parties, the indemnification provision(s) in the BAA or elsewhere in the Contract shall be interpreted to relate only to matters within the scope of the BAA or those other Contract provisions.

4.5 The terms of this Section 4 shall survive the termination of this Contract.

5. Independent Contractor. CalOptima and CONTRACTOR agree that CONTRACTOR, which shall include for purposes of this Section 5 all subcontractors, agents, and employees of the CONTRACTOR, in performance of this Contract, shall act in an independent capacity, and not as officers or employees of CalOptima. CONTRACTOR's relationship with CalOptima in the performance of this Contract is that of an independent contractor and nothing in this Contract shall be construed as creating a partnership, joint venture, or agency. CONTRACTOR's personnel performing services under this Contract shall be at all times under CONTRACTOR's exclusive direction and control and shall be employees of CONTRACTOR and not employees of CalOptima. CONTRACTOR shall pay all wages, salaries and other amounts due its employees, agents, and/or subcontractors in connection with this Contract and shall be responsible for all reports and obligations respecting them, such as social security, state and federal income tax withholding, other payroll taxes, unemployment compensation, workers' compensation, and similar matters. CONTRACTOR shall file all required returns related to such taxes, contributions, and payroll deductions.

6. Personnel.

6.1 CONTRACTOR Staffing. CONTRACTOR shall ensure that only fully qualified CONTRACTOR personnel are assigned to perform the services under the Contract, and such CONTRACTOR personnel shall perform services diligently and in a timely manner, according to the applicable professional and technical standards.

6.2 CONTRACTOR Personnel Restrictions. When on CalOptima's premises, CONTRACTOR personnel shall comply with CalOptima policies and procedures, including CalOptima's identification requirements (e.g., name badges).

6.3 Any CalOptima property damaged by CONTRACTOR, its subcontractor(s), or by the personnel of either, will be subject to repair or replacement by CONTRACTOR at no cost to CalOptima.

[optional non-compete clause]

6.4 Neither Party shall actively solicit employees of the other Party for employment that directly or indirectly provided services under the Contract during the Term and for a period of one (1) year after termination.

7. Compensation.

7.1 CalOptima agrees to pay, and CONTRACTOR agrees to accept as full compensation for the faithful performance of this Contract, the rates, charges, and other payment terms identified in Exhibit B.

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

7.3 CONTRACTOR's requests for payments and reimbursements must comply with the requirements set forth in Exhibit B. CalOptima will not make payment for work that fails to meet the standards of performance set forth in the Contract and Exhibit A. **CALOPTIMA SHALL NOT PAY ANY FEES, EXPENSES, OR COSTS WHATSOEVER INCURRED BY CONTRACTOR IN RENDERING ADDITIONAL SERVICES NOT AUTHORIZED IN WRITING BY CALOPTIMA UNDER THIS CONTRACT.**

7.4 In no event shall the total compensation payable to CONTRACTOR for the services performed under this Contract exceed the maximum cumulative payment obligation, as set forth in Exhibit B, without the express prior written authorization of CalOptima. **CONTRACTOR ACKNOWLEDGES AND AGREES THAT CALOPTIMA SHALL NOT BE LIABLE FOR ANY FEES, EXPENSES OR COMPENSATION IN EXCESS OF THE MAXIMUM CUMULATIVE PAYMENT OBLIGATION.**

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

8. Confidential Material.

8.1 During the Term, either Party may have access to confidential material or information ("**Confidential Information**") belonging to the other Party or the other Party's customers, vendors, or partners. Confidential Information includes the disclosing Party's computer programs and codes, business plans, customer/member lists and information, financial records, partnership arrangements, projections, methodologies, data, reports, agreements, intellectual property, trade secrets, licensing plans, and other proprietary information, or other information, materials, records, writings or data that is marked confidential or that due to its character and nature, a reasonable person under like circumstances would treat as confidential. CalOptima's Confidential Information also includes all user information, patient information, and clinical data that comes into CalOptima's possession, custody or control. Confidential Information will be used only for the purposes of this Contract and related internal administrative purposes. Each Party agrees to protect the other's Confidential Information at all times and in the same manner as each protects the confidentiality of its own confidential materials, but in no event with less than a reasonable standard of care.

8.2 For the purposes of Section 8.1, Confidential Information does not include information which: (i) is already known to the other Party at the time of disclosure; (ii) is or becomes publicly known through no wrongful act or failure of the receiving Party; (iii) is independently developed without use or benefit of the other Party's Confidential Information or proprietary information; (iv) is lawfully received from a third party that is not under and does not thereby breach an obligation of confidentiality; or (v) is a public record, not exempt from disclosure, pursuant to California Public Records Act, Government Code Section 6250 *et seq*., applicable provisions of California Welfare

and Institutions Code, or other state or federal laws, regardless of whether such information is marked as confidential or proprietary.

8.3 Disclosure of the Confidential Information will be restricted to the receiving Party's employees, consultants, suppliers, or agents, who are bound by confidentiality obligations no less stringent than those in this Section 8, on a "need to know" basis in connection with the services performed under this Contract. The receiving Party may disclose Confidential Information pursuant to legal, judicial, or administrative proceeding or otherwise as required by law; provided, however, that the receiving Party gives reasonable prior notice, if not prohibited by applicable law, to the disclosing Party and assists the disclosing Party, at the disclosing Party's expense, to obtain protective or other appropriate confidentiality orders, and further provided that a required disclosure of Confidential Information or proprietary information to an agency or court does not relieve the receiving Party of its confidentiality obligations with respect to the other Party.

8.4 CONTRACTOR shall establish and maintain environmental, safety, and facility procedures, data security procedures and other safeguards against the unauthorized access, destruction, loss, or alteration of CalOptima's Confidential Information in the possession, custody, or control of CONTRACTOR. Those security procedures and other safeguards shall be no less rigorous than those maintained by CONTRACTOR for its own information of a similar nature.

8.5 Upon written request of the disclosing Party, the receiving Party shall promptly return to the disclosing Party or destroy all documents, notes, and other tangible materials representing the disclosing Party's Confidential Information and all copies thereof. This obligation to return materials or copies thereof does not extend to automatically generated computer backup or archival copies generated in the ordinary course of the receiving Party's information systems procedures, provided that the receiving Party shall make no further use of such copies.

8.6 If a breach of the obligations under this Section 8 occurs, the injured Party may be entitled to such injunctive relief and any and all other remedies available at law or in equity. This Section 8 in no way limits the liability or damages that may be assessed against a Party if another Party breaches any of the provisions of this Section 8.

8.7 For the purposes of Section 8.6 only, Confidential Information does not include protected health information ("**PHI**") or individually identifiable information, as defined by the Health Insurance Portability and Accountability Act of 1996 ("**HIPAA**") and other privacy statutes or regulations. The access use and disclosure of PHI shall be governed by a BAA, which is Exhibit H to this Contract.

[alternative provision if no PHI involved]

This Contract does not require or permit CONTRACTOR to create, receive, maintain, use, or transmit protected health information ("**PHI**"). As such, no BAA is required for this Contract; provided, however, that if CONTRACTOR or its employees, agents, or subcontractors access or receive, whether intentionally or unintentionally, PHI regarding CalOptima members during the Term, CONRACTOR and its employees, agents, and subcontractors shall immediately notify CalOptima, protect such PHI from any additional disclosure, not use or disclose that PHI in any way that would violate a federal or state privacy or security law, its implementing regulations, or any other state or federal law, and execute a BAA with CalOptima, as necessary and requested by CalOptima.

9. California Public Records Act. As a local public agency, CalOptima is subject to the California Public Records Act (California Government Code Sections 6250 *et seq*.) (the "**PRA**"). CONTRACTOR hereby acknowledges that any materials, documents, data, or similar items are subject to disclosure upon public request, unless exempt from disclosure under the provisions of the PRA. CalOptima may be required to reveal certain information believed to be proprietary or confidential by CONTRACTOR pursuant to the PRA. If CONTRACTOR discloses information that it believes to be proprietary or confidential to

CalOptima, it shall mark such information as "Confidential," "Proprietary," or "Restricted" or other similar marking. Unless CONTRACTOR marks its materials as "Confidential," "Proprietary," or "Restricted," and also notifies CalOptima in writing that CONTRACTOR has so marked each piece of material, then CalOptima will not be responsible to take any actions to protect any CONTRACTOR's materials under the PRA that are not so marked. If CalOptima receives a request under the PRA that potentially encompasses CONTRACTOR materials that have been properly marked, CalOptima will provide CONTRACTOR with notice thereof to allow CONTRACTOR to take actions it deems appropriate to prevent disclosure of the marked material. Within five (5) days from receipt of CalOptima's notice, CONTRACTOR shall notify CalOptima if it intends to object to production of CONTRACTOR's information; otherwise CalOptima will respond to the PRA request according to the requirements of the PRA. CONTRACTOR agrees to defend, indemnify, and hold harmless CalOptima, its officers, agents, employees, members, subsidiaries, joint venture partners, and predecessors and successors in interest from and against any claim, action, proceeding, liability, loss, damage, cost, or expense, including attorneys' fees, and any costs awarded to the person or entity that sought CONTRACTOR's marked material, arising out of or related to CalOptima's failure to produce or provide the CONTRACTOR-marked material (collectively referred to for purposes of this Section 9 as "**Public Records Act Claim(s)**"). CONTRACTOR shall pay to CalOptima any expenses or charges relating to or arising from any such Public Record Act Claim(s) as they are incurred by CalOptima.

10. Modifications. CalOptima may modify the Contract upon written notice to CONTRACTOR at any time should such modification be required by CMS, DHCS, the DMHC, or applicable law or regulation ("**Regulatory Amendment**"). Any other modifications of the Contract that are not Regulatory Amendments shall be executed only by a written amendment to the Contract, signed by CalOptima and CONTRACTOR. Execution of amendments shall be contingent upon CONTRACTOR's notification to CalOptima, and CalOptima's approval, of any increase or decrease in the price of this Contract or in the time required for CONTRACTOR's performance.

11. Assignments.

    11.1 CONTRACTOR may not assign, transfer, or delegate any interest herein, either in whole or in part, without the prior written consent of CalOptima, which consent may be withheld in its sole discretion. If CalOptima provides such prior written consent, CONTRACTOR acknowledges and agrees that such assignment, transfer, or delegation may additionally be subject to the prior written approval of DHCS. Any assignment, transfer, or delegation made without CalOptima's express written consent shall be void.

    11.2 For purposes of this Section 11, an assignment is: (1) the change of more than fifty percent (50%) of the ownership or equity interest in CONTRACTOR (whether in a single transaction or in a series of transactions); (2) the change of more than fifty percent (50%) of the directors or trustees of CONTRACTOR (whether in a single transaction or in a series of transactions); (3) the merger, reorganization, or consolidation of CONTRACTOR with another entity with respect to which CONTRACTOR is not the surviving entity; and/or (4) a change in the management of CONTRACTOR from management by persons appointed, elected or otherwise selected by the governing body of CONTRACTOR (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

12. Subcontracts. CONTRACTOR may not subcontract or delegate its obligations or the performance of services under this Contract without CalOptima's prior written consent, which CalOptima may exercise in its sole discretion. CalOptima-approved subcontractors are listed in Addendum 2 to Exhibit A.

13. Term. This Contract shall commence on the Effective Date and shall continue in full force and effect through «Current Expiration» ("**Initial Term**"), unless earlier terminated as provided in this Contract. At the end of the Initial Term, CalOptima may, at its option, extend this Contract for up to «Extended Term spelled» («Extended Term») additional consecutive one (1)-year terms ("**Extended Terms**"), provided that if CalOptima does not exercise its option to extend at the end of the Initial Term, or any Extended Term,

the remaining option(s) shall automatically lapse. The Initial Term together with any Extended Terms constitute the "**Term**" of this Contract.

[optional term for fixed term agreements]

Term. This Contract shall commence on the Effective Date and shall continue in full force and effect through «CurrentExpiration» ("**Term**"), unless earlier terminated, as provided in this Contract.

14. Termination.

14.1 Termination without Cause. CalOptima may terminate this Contract at any time, in whole or in part, for its convenience and without cause, by giving CONTRACTOR thirty (30) days' prior written notice. Upon termination, CalOptima shall pay CONTRACTOR all fees and other charges due and payable for services satisfactorily performed and accepted by CalOptima as of the termination date. Thereafter, CONTRACTOR shall have no further claims against CalOptima under this Contract.

[optional mutual without cause termination]

Termination without Cause: Either Party may terminate this Contract at any time, in whole or in part, for its convenience and without cause, by giving the other Party sixty (60) days' prior written notice. Upon termination, CalOptima shall pay CONTRACTOR all fees and other charges due and payable for services satisfactorily performed and accepted by CalOptima as of the termination date.

14.2 Termination for Unavailability of Funds. In recognition that CalOptima is a governmental entity and its operations and budgets are determined on an annual basis, CalOptima shall have the right to terminate this Contract as follows:

14.2.1 CalOptima may terminate this Contract if it does not receive funding from the State of California or the federal government, as applicable, for any fiscal year.

14.2.2 In the event of termination under Section 14.2.1, CalOptima agrees to promptly pay CONTRACTOR all fees and other charges due and payable for services satisfactorily performed and accepted by CalOptima as of the termination date. CONTRACTOR shall not be entitled to payment for any other items, including lost or anticipated profit on work not performed, administrative costs, attorneys' fees, or consultants' fees.

14.3 Termination for Default. CalOptima may immediately terminate this Contract upon notice to CONTRACTOR for (i) CONTRACTOR's default, (ii) if a federal or state proceeding for the relief of debtors is undertaken by or against CONTRACTOR; or (iii) if CONTRACTOR makes an assignment, as defined in Section 11, for the benefit of creditors ("**Termination for Default**").

14.4 Termination for Breach. Either Party may at its option, terminate this Contract by notice to the other Party if the other Party breaches one of its obligations under this Contract and fails to cure that breach or default within thirty (30) days after receiving notice identifying that breach. The rights described in this Section 14.4 to terminate this Contract shall be in addition to any other remedy available to the non-breaching Party, whether under this Contract or in law or equity, on account of that breach.

14.5 Notwithstanding the foregoing, CalOptima may terminate this Contract immediately upon CONTRACTOR's breach of Section 3 (Insurance) or Section 8 (Confidential Material).

14.6 Effect of Termination. Upon expiration or receipt of a termination notice under this Section 14:

14.6.1 CONTRACTOR shall promptly discontinue all services (unless CalOptima's notice directs otherwise) and deliver or otherwise make available to CALOPTIMA all documents, reports, software programs, and any other products, data and such other materials, equipment, and information, including Confidential Information, or equipment provided by CalOptima, as may have been accumulated by CONTRACTOR in performing this Contract, whether completed or in process. If CONTRACTOR personnel were granted access to CalOptima's premises and issued a badge or access card, such badge or access card shall be returned prior to departure.

14.6.2 CalOptima may take over the services and may award another party a contract to complete the services under this Contract.

15. Dispute Resolution

15.1 Meet and Confer. If either Party has a dispute arising under or related to this Contract, the Parties shall informally meet and confer to try and resolve the dispute. The Parties shall meet and confer within thirty (30) days of a written request submitted by either Party in an effort to settle any dispute. At each meet-and-confer meeting, each Party shall be represented by persons with final authority to settle the dispute. If either Party fails to meet within the thirty (30)-day period, that Party shall be deemed to have waived the meet-and-confer requirement, and at the other Party's option, the dispute may proceed immediately to arbitration under Section 15.2.

15.2 Subject to the California Government Claims Act (Cal. Gov. Code §900 *et seq*.) governing claims against public entities, either Party may submit the dispute for resolution exclusively through confidential, binding arbitration, instead of through trial by court or jury, in Orange County, California. The Parties may agree in writing prior to commencing the arbitration on the dispute resolution rules and arbitration service that will be used to resolve the dispute. If the Parties cannot reach such an agreement, the arbitration will be conducted by Judicial Arbitration and Mediation Services ("**JAMS**") in accordance with the commercial dispute rules then in effect for JAMS; provided, however, that this Contract shall control in instances where it conflicts with JAMS's (or the applicable arbitration service's) rules. The arbitration shall be conducted on an expedited basis by a single arbitrator. The Parties prefer that the arbitrator be a retired judge of the California Superior, Appellate, or Supreme Court or of a United States court sitting in California. If no such retired judge is available, the arbitrator may be an attorney with at least fifteen (15) years of experience, including at least five (5) years in managed health care. If the Parties are unable to agree on the arbitrator within thirty (30) days of the date that the arbitration service accepts the arbitration, the arbitrator shall be selected by the arbitration service from a list of four potential arbitrators (all of whom shall be on arbitration services' panel of arbitrators) submitted by the Parties, two from each side; provided, however, that nothing stated in this section shall prevent a Party from disqualifying an arbitrator based on a conflict of interest. In making decisions about discovery and case management, it is the Parties' express agreement and intent that the arbitrator at all times promote efficiency without denying either Party the ability to present relevant evidence. In reaching and issuing decisions, the arbitrator shall have no jurisdiction to make errors of law and/or legal reasoning. The Parties shall share the costs of arbitration equally, and each Party shall bear its own attorneys' fees and costs.

15.3 Exclusive Remedy. With the exception of any dispute that under applicable laws may not be settled through arbitration, arbitration under Section 15.2 is the exclusive method to resolve a dispute between the Parties arising out of or relating to this Contract that is not resolved through the meet-and-confer processes.

15.4 Waiver. By agreeing to binding arbitration as set forth in Section 15.2, the Parties acknowledge that they are waiving certain substantial rights and protections which otherwise may be available if a dispute between them was determined by litigation in a court, including the right to a jury trial, attorneys' fees, and certain rights of appeal.

16. General Provisions.

16.1 Non-Exclusive Relationship. This is a non-exclusive relationship between CalOptima and CONTRACTOR. CalOptima shall have the right to have any of the services that are the subject of this Contract performed by CalOptima personnel or enter into contractual arrangements with one or more contractors who can provide CalOptima with similar or like services.

16.2 Compliance with Applicable Law and Policies. CONTRACTOR warrants that, in the performance of this Contract, it shall, at its own expense, observe and comply with all applicable federal, state, and local laws, and CalOptima vendor policies relating to services under the Contract that are in effect when this Contract is signed or that come into effect during the Term and are available to CONTRACTOR on CalOptima's website.

16.3 Names and Marks. Neither Party shall use the name, logo or other proprietary mark of the other Party in any press release, advertising, promotional, marketing or similar publicly disseminated material without obtaining the other Party's express written approval of the material and consent to such use.

16.4 Time is of the Essence. Time is of the essence in performance of this Contract.

16.5 Choice of Law. This Contract shall be governed by and construed in accordance with all laws of the State of California. If any Party institutes legal proceedings to enforce or interpret this Contract, venue and jurisdiction shall be in the County of Orange, California.

16.6 Force Majeure. When satisfactory evidence of a cause beyond a Party's control is presented to the other Party, and nonperformance is unforeseeable, beyond the control, and not due to the fault of the Party not performing, a Party shall be excused from performing its obligations under this Contract during the time and to the extent that it is prevented from performing by such cause, including any incidence of fire, flood, acts of God, commandeering of material, products, plants or facilities by the federal, state or local governments, or a material act or omission by the other Party. A Party invoking this clause shall provide the other Party with prompt written notice of any delay or failure to perform that occurs by reason of force majeure. If the force majeure event continues for a period of XX (XX) days, the Party unaffected by the force majeure event may terminate this Contract upon notice to the other Party.

16.7 Notices. All notices required or permitted under this Contract shall be in writing and shall be sent by registered or certified mail, postage prepaid, return receipt requested, or by any other overnight delivery service which delivers to the noticed destination and provides proof of delivery to the sender. All notices shall be effective when first received at the following addresses set forth below. Any notice not related to termination of this Contract may be submitted electronically to the address set forth below. Any Party whose address changes shall notify the other Party in writing.

To CONTRACTOR:	To CalOptima:
	CalOptima
	505 City Parkway West
	Orange, CA 92868
	Attention:
	Email:

16.8 Notice of Labor Disputes. Whenever CONTRACTOR has knowledge that any actual or potential labor dispute may delay this Contract, CONTRACTOR shall immediately notify and submit all relevant information to CalOptima.

16.9 No Liability of County of Orange. As required under Ordinance No. 3896 of the County of Orange, State of California, as amended, the Parties agree that the obligations of CalOptima under this Contract are solely the obligations of CalOptima, and the County of Orange, State of California, shall have no obligation or liability related to this Contract. [County of Orange Ordinance No 3896, codified in Orange County Municipal Code Section 4-11-7(a)]

16.10 Entire Agreement. This Contract, including all exhibits, addenda, and Contract Documents, contains the entire agreement between CONTRACTOR and CalOptima with respect to the subject matter of this Contract, and it supersedes all prior written or oral and all or contemporaneous oral agreements, representations, understandings, discussions, negotiations, and commitments between CONTRACTOR and CalOptima, whether express or implied, with respect to the subject matter of this Contract.

16.11 Waiver. Any failure of a Party to insist upon strict compliance with any provision of this Contract shall not be deemed a waiver of such provision or any other provision of this Contract. To be effective, a waiver must be in a writing that is signed and dated by the Parties. A waiver by either of the Parties of a breach of any of the covenants, conditions, or agreements to be performed by the other Party shall not be construed to be a waiver of any succeeding breach of the Contract or of any other covenant or condition of the Contract. Any information delivered, exchanged, or otherwise provided hereunder shall be delivered, exchanged, or otherwise provided in a manner that does not constitute a waiver of immunity or privilege under applicable law.

16.12 Survival. The following provisions of this Contract shall survive termination or expiration of this Contract: Sections 4 (Indemnification), 5 (Independent Contractor), 8 (Confidential Material), 9 (California Public Records Act), 14.6 (Effect of Termination), 15 (Dispute Resolution), 16.3 (Names and Marks), 16.5 (Choice of Law), 16.9 (No Liability of County of Orange), this Section 16.12, 16.14 (Interpretation), 16.15 (Third-Party Beneficiaries), 16.16 (Successors and Assigns) and any other Contract provisions that by their nature are intended to survive termination or expiration of this Contract.

16.13 Severability. If any section, subsection or provision of this Contract, or the application of such section, subsection or provision, is held invalid or unenforceable by any court of competent jurisdiction, the remainder of this Contract, other than that to which it is held invalid, shall remain in effect.

16.14 Interpretation. The terms of this Contract are the result of negotiation between the Parties. Accordingly, any rule of construction of contracts (including California Civil Code Section 1654) that ambiguities are to be construed against the drafting party shall not be employed in the interpretation of this Contract.

16.15 Third Party Beneficiaries. There are no intended third-party beneficiaries of this Contract. Nothing in this Contract shall be construed as conferring any rights on any other persons.

16.16 Successors and Assigns. Except as otherwise expressly provided in this Contract, this Contract will be binding on, and will inure to the benefit of, the successors and permitted assigns of the Parties. Nothing in this Contract is intended to confer upon any party other than the Parties or their respective successors and permitted assigns any rights or obligations under or by reason of this Contract, except as expressly provided in this Contract.

16.17 Without Limitation. Any reference in the Contract to “include(s)” or “including” means inclusion without limitation, unless otherwise distinguished within the text.

16.18 Authority to Execute. The persons executing this Contract on behalf of the Parties warrant that they are duly authorized to execute this Contract and that by executing this Contract the Parties are formally bound.

16.19 Counterparts. This Contract may be executed and delivered in one or more counterparts, each of which shall be deemed an original, but all of which together will constitute one and the same instrument.

16.20 Recitals and Exhibits. The recitals, exhibits, and addenda attached to this Contract are made a part of the Contract by this reference.

[*Signatures on following page*]

IN WITNESS WHEREOF, these Parties have, by their duly authorized representatives, executed this Contract No. «Internal Number» on the day and year last shown below.

«Company Name»	CalOptima
By:	By:
Print Name:	Print Name:
Title: Date:	Title: Date:

By:	By:
Print Name:	Print Name:
Title: Date:	Title: Date:

EXHIBIT A
Scope of Work

This Exhibit A, including Addendum 1, describes the services that CONTRACTOR provides under the Contract. If there is any conflict or inconsistency between the other provisions of the Contract and this Exhibit A, this Exhibit A shall control.

1. **Definitions**.

1.1. "**CalOptima Content**" means all information and materials provided by CalOptima, its agents or employees (regardless of form) to CONTRACTOR under this Contract, including User information, patient information control (excluding patient information, if any, that is solely owned by the patient as provided by law) , clinical data, as well as CalOptima trade secrets or proprietary information and any and all updates or modifications thereto and/or derivatives thereof made by CONTRACTOR for CalOptima.

1.2. "**Deliverable(s)**" means all the materials/services that CONTRACTOR provides under this Contract and that are designated as "Deliverable" under the Addendum 1 to Exhibit A.

1.3. "**Documentation**" means all operations and user manuals (operational, educational, and otherwise) made available by CONTRACTOR to CalOptima, any report, specification or other written work product produced by CONTRACTOR for or at the request of CalOptima, and all other written materials related to the Software or any of the Services, provided, that Documentation shall not include written materials relating to the source code (and not the binary code) of the Software.

1.4. "**Intellectual Property**" means patents, copyrights, trademarks, trade secrets, and other proprietary information.

1.5. "**Software**" means the software described in the Documentation and Contract Documents, including Addendum 1 to this Exhibit A, the RFP and CONTRACTOR's best and final offer, that meets all of CalOptima's business and clinical requirements set forth in the Contract Documents, including the RFP.

1.6. "**Software Updates**" means all error corrections, maintenance releases, updates, upgrades, revisions, modifications, and enhancements of the Software that CONTRACTOR makes generally available to its licensees and their authorized end users.

1.7. "**User**" means any authorized employee or contractor of CalOptima who use(s) the Software in connection with the authorized business and clinical activities of CalOptima under the Contract.

2. **Services.**

2.1. Services. CONTRACTOR shall provide the services set forth in this Exhibit A ("**Services**"). Services shall include Implementation Services, Hosting Services, Maintenance Services, and Support Services, as those terms are defined in this Section 2. CalOptima shall use Services and Software in compliance with the Contract, including the Contract Documents.

2.2. Cooperation. CONTRACTOR and CalOptima shall work together to implement the Services and Software. CalOptima will cooperate with CONTRACTOR and execute and deliver all documents, forms, or instruments reasonably necessary for CONTRACTOR to implement and render the Services and Software.

2.3. Hosting Services. CONTRACTOR shall provide hosting services for the Software to meet CalOptima's business and clinical objectives in accordance with this Section 2.3, as well as the Contract Documents ("**Hosting Services**"). CalOptima's authorized Users' access to and use of the Software may be through an Internet website or through some other mutually agreed upon method of access.

2.3.1. User IDs and Passwords. CONTRACTOR shall provide Users with unique identification numbers and passwords upon CalOptima's request or enable CalOptima to create such User identification numbers and passwords within CalOptima's authorized use of the Software. Upon receipt of CalOptima's proper written notice to CONTRACTOR, CONTRACTOR shall immediately make all additions, changes, and deletions to the User identification numbers and passwords assigned to approved CalOptima personnel.

2.3.2. CalOptima Network Access. To the extent CONTRACTOR receives access to CalOptima's network, CONTRACTOR shall use such access solely to meet its obligations under the Contract.

2.3.3. URL Ownership. Each Party shall retain exclusive ownership of its respective URLs and Hyperlinks.

2.3.4. Safeguards and Security Backup. CONTRACTOR has established and will maintain an information security program containing appropriate administrative, technical and physical measures, including industry-standard Internet firewall technology, to protect CalOptima data against accidental or unlawful destruction, alteration, unauthorized disclosure, or access consistent with applicable laws. In addition, CONTRACTOR has established and shall maintain a commercially reasonable business continuity and disaster recovery plan and will follow such plan, including maintaining procedures for the reconstruction of lost CalOptima Content received or processed under this Contract and correcting, at CalOptima's request, any destruction, loss or alteration of any CalOptima Content caused by CONTRACTOR. CONTRACTOR shall employ an appropriate level of physical security at its data center, including fire and intruder alarms and avoidance systems, and other physical security appropriate for secure data processing. At a minimum, CONTRACTOR shall employ the following additional security methods and procedures:

2.3.4.1. *Access Controls*. CONTRACTOR shall only permit access to CalOptima Content in accordance with the terms of the Contract or as otherwise agreed by the Parties in writing.

2.3.4.2. *Patch Management / Anti-Virus Software*. CONTRACTOR shall appropriately manage its use of software patches in accordance with TRUSTe's Security Guidelines, as updated during the Term. In addition, CONTRACTOR shall employ the latest industry-standard anti-virus software at all times during the Term and as long as it maintains or otherwise possesses CalOptima Content.

2.3.4.3. *Data Isolation*. CalOptima Content shall be logically isolated from other of CONTRACTOR customers' data to further restrict unauthorized access using methods and procedures mutually agreed upon by CONTRACTOR and CalOptima.

2.3.4.4. *Network Isolation*. CONTRACTOR's data center shall have appropriate network segmenting of CONTRACTOR and CalOptima Content and CalOptima's systems at the data center.

2.3.4.5. *Restricted Access*. CONTRACTOR shall not access CalOptima Content except as necessary to comply with its obligations under the Contract or as may be required by law. All printed copies (if authorized) of CalOptima Content shall be kept to a minimum and shall be shredded at earliest convenience after they are no longer needed for the purpose for which they were authorized.

2.3.4.6. *Resource and System Monitoring*. CONTRACTOR shall provide a comprehensive system monitoring procedure to include server, network, and test PC monitoring, as appropriate.

2.3.4.7. *Disaster Recovery*. Each Party shall make commercially reasonable efforts to prepare for and otherwise recover from a natural disaster such that CalOptima is able to promptly restore normal business operations as rapidly as practical after a natural disaster to the

extent such a disaster impacts CONTRACTOR's ability to perform its obligations under the Contract.

2.4. Implementation Services. CONTRACTOR shall provide all services necessary to configure and implement the Software in order to enable CalOptima and all of its authorized Users to access and use the Software for all of CalOptima's business and clinical requirements ("**Implementation Services**"). CONTRACTOR shall cooperate and communicate with CalOptima's designated technical contact in connection with the Implementation Services.

2.5. Scheduling. CONTRACTOR shall commence providing Hosting Services and Implementation Services as soon as practicable after the Effective Date, and in no event later than [XX] days from the Effective Date. CONTRACTOR shall complete Implementation Services within [XX] days of the Effective Date. Failure to meet any of these deadlines is a material breach of the Contract.

2.6. Service Organization Control Reports. Following completion of Implementation Services, CONTRACTOR will, at CalOptima's request and at no charge, provide CalOptima with copies of any routine Service Organization Control 1 reports ("**SOC 1 Reports**") (or any successor reports) directly related to the Software and already released to CONTRACTOR by the public accounting firm producing the report. SOC 1 Reports are CONTRACTOR's Confidential Information, and CalOptima will not distribute or allow any third party (other than its independent auditors) to use any such report without the prior written consent of CONTRACTOR. CalOptima will instruct its independent auditors or other approved third parties to keep such reports confidential.

2.7. Training. CONTRACTOR shall timely provide the training services necessary to train all Users and other personnel designated by CalOptima to enable such Users and personnel to be reasonably proficient in the use of the Software for all of CalOptima's business and clinical requirements.

2.8. Acceptance Testing. CalOptima shall use the Software for at least [XX] days ("**Acceptance Period**") to determine if it meets CalOptima's business and clinical requirements. If CalOptima determines that the Software does not meet its business and clinical requirements during the Acceptance Period, CONTRACTOR shall have thirty (30) days from the date of receipt of such notification to rectify or resolve the issue. If CONTRACTOR corrects the issue within the thirty (30)-day period, CONTRACTOR shall resubmit the Software to CalOptima for continued acceptance testing to determine if it will meet CalOptima's business and clinical requirements. The Acceptance Period will extend by [XX] days from the date the CONTRACTOR resubmits the Software for continued acceptance testing. If the Software operates through the Acceptance Period without a material issue, then the Software will be deemed accepted, and CalOptima shall provide CONTRACTOR with a notice of final acceptance. Otherwise, CalOptima may finally reject the Software and return any applicable materials to CONTRACTOR. Within thirty (30) days of such final rejection, CONTRACTOR shall refund all fees paid by CalOptima under the Contract and shall cooperate with CalOptima in connection with the necessary acts required when the Contract is terminated.

2.9. Maintenance Services. CONTRACTOR shall provide during the Term, without additional charge to CalOptima, those technical support and software maintenance services necessary for the Software to operate, and for CalOptima and Users to access and use the Software in accordance with CalOptima's business and clinical requirements ("**Maintenance Services**"). Maintenance Services include CONTRACTOR's obligation to provide to CalOptima error corrections, maintenance releases, updates, upgrades, and new versions of the Software that CONTRACTOR makes commercially available for the Software during the Term. CONTRACTOR neither promises nor warrants that a certain number of releases (or any release) will be made available during any particular time period.

2.10. Technical Support. CONTRACTOR shall provide CalOptima with access to sufficient numbers of CONTRACTOR's technical support personnel available [XX] by telephone, instant chat, and e-mail to enable CalOptima and its authorized Users to obtain assistance with the operation and proper functioning of the Software whenever any issues, problems, or defects arise ("**Support Services**"). In addition, CalOptima shall have, at no additional charge, online access to CONTRACTOR's customer information

network, if any, for online information and questions during the Term. The provision of such access shall in no way reduce CONTRACTOR's obligation to comply with any of its other support and maintenance obligations in this Exhibit A. CONTRACTOR shall provide to CalOptima telephone numbers and website addresses for the purpose of CalOptima accessing CONTRACTOR's non-public informational network. CalOptima shall not be charged an additional fee to access such network or website, but CalOptima shall be responsible for any connect-time charges to CalOptima's public telecommunications carrier.

2.11. Update Services. Within ten (10) days of general commercial availability or such shorter period if the Software Update relates to a critical fix or functionality, CONTRACTOR shall notify CalOptima of all material Software Updates, describe in reasonable detail the effect of such Software Updates on the use or functionality of the updated Software, and provide the Software Updates to the Software at no additional cost to CalOptima. At the request of CalOptima, and when reasonably possible, CONTRACTOR shall perform a Software Update after CalOptima's standard business hours at no additional charge to CalOptima.

2.12. Design of the Services. CONTRACTOR will design the Services and Software, including the functions and processes applicable to the performance of the Services and Software, to assist the CalOptima in complying with its legal and regulatory requirements applicable to the Contract. CONTRACTOR will be responsible for the accuracy of such design. CalOptima shall be responsible for (i) how it uses the Software to comply with its legal and regulatory requirements and (ii) the consequences of any instructions that it gives or fails to give to CONTRACTOR, including as part of the implementation of the Software, provided CONTRACTOR follows such instructions.

2.13. Service Levels. CONTRACTOR shall perform all of its obligations related to Services at levels in accordance with the service levels set forth in Addendum 1 to this Exhibit A ("**Service Levels**"). CONTRACTOR shall measure and report (electronically) its performance each month against the Service Levels by no later than the last day of the following month. CONTRACTOR may fulfill the obligations under this Section 2.13 by providing CalOptima with access to such data and reports.

3. License.

3.1. License Grant. Subject to the terms and conditions of the Contract, CONTRACTOR hereby grants to CalOptima, and CalOptima hereby accepts from CONTRACTOR, a nontransferable, nonexclusive, terminable, perpetual license ("**Software License**") during the Term to use the Software and Documentation solely for CalOptima's business and clinical use. The Software may only be used by CalOptima and its Users. The license to CalOptima granted herein entitles CalOptima to grant sublicenses to Users, and CalOptima is responsible for such Users' compliance with the terms of the Contract.

3.2. Reservation of Rights. The Software is and will remain the sole and exclusive property of CONTRACTOR and those third parties from which any portion of the Software is licensed by CONTRACTOR, as applicable. Neither CalOptima nor any Users will acquire any title or ownership of the Software under or by reason of the Contract.

4. Intellectual Property.

4.1. CalOptima Intellectual Property Rights. All rights, title, and interests in and to CalOptima Content and Deliverables, including all Intellectual Property rights inherent therein and pertaining thereto, are owned exclusively by CalOptima or its licensors. CalOptima hereby grants to CONTRACTOR for the Term a non-exclusive, worldwide, non-transferable, royalty-free license to use, edit, modify, adapt, translate, exhibit, publish, reproduce, copy, and display the CalOptima Content for the sole purpose of providing the services under the Contract.

4.2. CONTRACTOR Intellectual Property Rights. Except for the rights expressly granted to CalOptima in this Contract, all rights, title, and interest in and to CONTRACTOR's software provided under the Contract, including all Intellectual Property rights inherent therein and pertaining thereto, are owned exclusively by

CONTRACTOR or its licensors. CONTRACTOR grants to CalOptima for the Term a personal, non-exclusive, non-transferable, royalty-free license to use and access CONTRACTOR software for the purposes set forth in this Contract. CalOptima will not obscure, alter or remove any copyright, trademark, service mark or proprietary rights notices on any materials provided by CONTRACTOR in connection with the Contract and will not copy, decompile, recompile, disassemble, reverse engineer, or make or distribute any other form of, or any derivative work from such CONTRACTOR materials.

4.3. Ownership of Reports. CalOptima will retain ownership of the content of reports and other materials that include CalOptima Content produced and delivered by CONTRACTOR under this Contract; provided, however, that CONTRACTOR will be the owner of the format of such reports. To the extent any such reports or other materials incorporate any CONTRACTOR proprietary information, CONTRACTOR (i) retains sole ownership of such proprietary information and (ii) provides the CalOptima a fully paid up, irrevocable, perpetual, royalty-free license to access and use same for the purposes set forth in this Contract.

5. Standard of Performance; Warranties.

5.1. CONTRACTOR agrees to perform all work under this Contract with the requisite skill and diligence consistent with professional standards for the industry and type of work performed under this Contract and pursuant to the governing laws, rules, and regulations of the industry.

5.2. If CONTRACTOR may subcontract for services under this Contract, then CONTRACTOR represents and warrants that any individual or entity acting as a subcontractor to this Contract has the appropriate skill and expertise to perform the subcontracted work and will comply with all applicable provisions of this Contract.

5.3. CONTRACTOR represents and warrants to CalOptima that all Documentation provided by CONTRACTOR shall be materially accurate and complete and shall be revised by CONTRACTOR on a timely basis at no cost to CalOptima to reflect such changes and updates to the Documentation.

5.4. CONTRACTOR represents and warrants that CalOptima shall receive free, good, and clear licensing rights to the Software and Documentation and that CONTRACTOR has full power and authority and has acquired all rights and licenses as necessary to license Software to CalOptima.

5.5. CONTRACTOR warrants that the software licensed, sold, and delivered to CalOptima conforms in all material respects with all applicable contractual commitments, including the Contract Documents and Documentation, and all express and implied warranties. CONTRACTOR warrants that any Software will operate free from defects and uninterrupted during the Term and the Software shall be capable of operating fully and correctly with the combination of the computer hardware, telecommunications equipment, and operating systems used by CONTRACTOR and CalOptima. CONTRACTOR shall at its own expense replace the Software or correct any error in the Software, provided that the Software has been properly installed and has not been modified by CalOptima without the permission of CONTRACTOR.

5.6. CONTRACTOR warrants that any items furnished to CalOptima under this Contract, including any Software licensed, sold, and delivered to CalOptima or the normal use or sale thereof, does not infringe on any United States letters patent, patent, trademark, copyright, or other intellectual property right. CONTRACTOR shall indemnify, hold harmless and defend, at its expense, any suit against CalOptima arising from or related to a breach of this Section 5.6 and shall pay costs and damages finally awarded in any such suit, provided that CONTRACTOR is notified in writing of the suit and given authority, information, and assistance at CONTRACTOR's expense for the defense of the suit. CONTRACTOR, at no expense to CalOptima, shall obtain for CalOptima the right to use and sell said item or software, or shall substitute an equivalent item or software acceptable to CalOptima and extend this patent indemnity thereto.

5.7. CONTRACTOR acknowledges and agrees that CalOptima and its authorized Users must have continued access to Software in order to provide health care payments and/or health care services in real time up to twenty-four (24) hours per day, seven (7) days per week, three hundred sixty five (365) days per year. Accordingly, CONTRACTOR represents and warrants that CONTRACTOR will maintain sufficient backup servers and other computer hardware, backup application software, and database backups to enable CONTRACTOR to provide continuous, uninterrupted access to and use and operation of the Software.

5.8. CONTRACTOR represents and warrants that any and all Services shall only be provided by CONTRACTOR's employees working and residing within the United States of America.

5.9. CONTRACTOR represents and warrants that, as of the Effective Date, there is no action, suit, claim, investigation, arbitration, or legal proceeding of any kind that is pending, or to the best of CONTRACTOR's knowledge threatened against, by, or affecting CONTRACTOR, that if adversely determined could materially adversely affect the Software or restrict CONTRACTOR's ability to fully perform all of its obligations under the Contract. CONTRACTOR also knows of no basis for any such action, suit, claim, investigation or proceeding.

5.10. All of the representations, warranties and covenants of this Section 5 that are applicable to the Software shall be deemed to be made with respect to any modification, Software Updates, replacements, substitutes, or additional Software provided by CONTRACTOR to CalOptima under the Contract, including maintenance releases.

5.11. CONTRACTOR's warranties, together with its service guarantees, must run to CalOptima and its customers or users of the Software and Services, and must not be deemed exclusive. CalOptima's inspection, approval, acceptance, use of and payment for all or any part of the Software and Services must in no way affect its warranty rights whether or not a breach of warranty had become evident in time.

5.12. CONTRACTOR's obligations under this Section 5 are in addition to CONTRACTOR's other express or implied warranties and other obligations under this Contract or state law, and in no way diminish any other rights that CalOptima may have against CONTRACTOR for faulty materials, software, or work. CalOptima rejects any disclaimer by CONTRACTOR of any warranty, standard, implied or express, unless specifically agreed to in writing by both Parties.

6. **Limitation Of Liability.** EXCEPT FOR BREACHES OF CONFIDENTIALITY OBLIGATIONS UNDER THE CONTRACT, DAMAGES ARISING FROM PERSONAL INJURY OR INJURY TO PHYSICAL PROPERTY, INDEMNIFICATION OBLIGATIONS, THE OBLIGATION OF INSURANCE UNDER THE CONTRACT, OR AS OTHERWISE EXPRESSLY SET FORTH IN THIS EXHIBIT A, NEITHER PARTY SHALL BE LIABLE TO THE OTHER PARTY FOR ANY LOST PROFITS OR FOR ANY CONSEQUENTIAL, INCIDENTAL, SPECIAL OR INDIRECT DAMAGES ARISING FROM OR RELATED TO THE CONTRACT, REGARDLESS OF THE CAUSE OF ACTION, EVEN IF THE PARTIES HAVE BEEN APPRISED OF THE LIKELIHOOD OF SUCH DAMAGES. [Optional liability cap provision, depending on value and risk of contract] NOTWITHSTANDING ANYTHING TO THE CONTRARY IN THE CONTRACT AND EXCLUDING BREACHES OF THE CONFIDENTIALITY OBLIGATIONS UNDER THE CONTRACT OR BREACHES OF THE TERMS OF ANY BUSINESS ASSOCIATE AGREEMENT BETWEEN THE PARTIES, NEITHER PARTY'S TOTAL LIABILITY UNDER THE CONTRACT SHALL EXCEED [enter liability cap amount].

7. **Insurance**. CONTRACTOR shall maintain the following insurance policies during the Term:

7.1. Comprehensive General Liability Insurance, including Contractual, Independent Contractors, Products/Completed Operations and Personal Injury Liability, with the following minimum limits of liability:

7.1.1. Primary Bodily Injury Liability with limits of one million dollars ($1,000,000) per Occurrence; and

7.1.2. Primary Property Damage Liability with limits of one million dollars $1,000,000 per Occurrence, or combined single limits of liability for Primary Bodily Injury and Primary Property Damage of two million dollars ($2,000,000) per Occurrence and in the aggregate.

7.2. If Contractor is on CalOptima's premises, Automobile Liability with the following minimum limits of liability:

7.2.1. Primary Bodily Injury Liability with limits of six hundred thousand dollars ($600,000) per Occurrence; and

7.2.2. Primary Property Damage Liability with limits of six hundred thousand dollars ($600,000) per occurrence or combined single limits of liability for Primary Bodily Injury and Primary Property Damage of one million, two hundred thousand dollars ($1,200,000) per Occurrence and in the aggregate.

7.3. Workers' Compensation Insurance within the limits established and required by the State of California.

7.4. Employer's Liability with limits of one million dollars ($1,000,000).

7.5. Professional Liability with a combined single limit of at least one million dollars ($1,000,000) per Occurrence and in the aggregate.

7.6. Electronic and Computer Crimes Insurance, Employee Fidelity Insurance, and Cyber Liability Insurance with limits of at least one million dollars ($1,000,000).

8. Transition. Upon termination or expiration of the Contract, the contents of all historical patient data and any other CalOptima Content shall remain subject to the exclusive control and responsibility of CalOptima, and CONTRACTOR shall have no property or other rights in such data. CONTRACTOR shall, in good faith, reasonably assist CalOptima with any requested data conversion, migration, and transition to a substitute software solution at no additional cost to CalOptima.

[Replace with the following two provisions as applicable for more sophisticated system**s]**

Transition. CONTRACTOR understands and agrees that CalOptima's business operations are dependent on the use of the Software or an equivalent system and that the inability to use the Software or an equivalent system could result in irreparable damage to CalOptima. Therefore, CONTRACTOR agrees that in the event of any termination of this Contract, CONTRACTOR shall fully cooperate with CalOptima in the transition to a new system. Such cooperation shall include data conversion/migration, converting demographic data, providing parallel services until CalOptima's system transition is completed, providing on-site technical support at CONTRACTOR's then current rates, and providing accounts receivable balances on line item detail forward. In the event the termination results from a breach of this Contract by CalOptima, CONTRACTOR shall be paid at its then current implementation rates for such services. Otherwise, such services shall be provided by CONTRACTOR at no additional cost to CalOptima, and CONTRACTOR shall be liable for the procurement costs of the same or similar products, software, and services, that were, and were yet to be, provided by CONTRACTOR under this Agreement (including costs and fees payable for such replacement products, software. CalOptima may seek specific performance of CONTRACTOR's obligations under this Section 8, and CONTRACTOR agrees not to raise the defense that damages are an adequate remedy.

9. **CalOptima Content**. Upon CalOptima's request and upon the expiration or termination of the Contract, CONTRACTOR shall promptly provide an electronic copy of all CalOptima Content to CalOptima in the format and with the file layouts reasonably requested by CalOptima at no additional charge to CalOptima. Upon CalOptima's written request, CONTRACTOR shall destroy all copies of the CalOptima Content in CONTRACTOR's possession, custody, or control. CONTRACTOR shall not withhold any CalOptima Content as a means of resolving any dispute. CONTRACTOR shall not use CalOptima Content for any purpose other than that of rendering Services under the Contract, nor shall CONTRACTOR sell, assign, lease, dispose of, or

otherwise exploit CalOptima Content. CONTRACTOR shall not possess or assert any lien or other right against or to CalOptima Content.

EXHIBIT A
ADDENDUM 1
Software Description and Service Levels

1. **Software Description**.

[insert Software Description

2. **Deliverables.**

[insert Service Levels]

3. **Service Levels**.

[insert Service Levels]

EXHIBIT A

Addendum 2

The following is a list of subcontractors approved to perform Services under this Contract:

Subcontractor Name	Functions

EXHIBIT B
Payment

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

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

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

4. Notwithstanding any provisions of this Contract to the contrary, CalOptima and CONTRACTOR mutually agree that CalOptima's maximum cumulative payment obligation hereunder for work performed and/or products received on Exhibit A of this Contract shall not exceed [Insert Maximum Cumulative Payment Amount, Written] Dollars ($[Insert Maximum Cumulative Payment Amount, Number]), including all amounts payable to CONTRACTOR for its direct labor and expenses, overhead costs, fixed fee, subcontracts, leases, materials, and costs arising from or due to termination of this Contract.

   [different compensation options]

5. CONTRACTOR's hourly billable rate shall be «Hourly billable spelled» Dollars ($«Hourly Billable») per hour. This rate is fixed for the duration of the Contract. CONTRACTOR agrees to extend this rate to CalOptima for a period of one (1) year after Contract termination. CalOptima shall not pay CONTRACTOR for time spent traveling.

5. CONTRACTOR's fees for the goods and/or services provided under Exhibit A, Scope of Work, will be billed based upon completion of the milestones as set forth in the schedule(s) in Exhibit B-1. These fees are fixed for the duration of the Contract. CONTRACTOR agrees to extend these fees to CalOptima for a period of one (1) year after Contract termination. CalOptima shall not pay CONTRACTOR for time spent traveling.

5. CONTRACTOR's fees for the goods and/or services provided under Exhibit A, Scope of Work, will be billed on a time and materials basis. Each CONTRACTOR employee will have an associated hourly rate, which CONTRACTOR will extend by the hours of service performed in order to determine the amount of fees to invoice. The CONTRACTOR's employees who will participate in this Contract, their titles/labor category and the [hourly/daily] rates associated with this Contract are set forth in Exhibit B-1. These fees and rates are fixed for the duration of the Contract. CONTRACTOR agrees to extend these fees and rates to CalOptima for a period of one (1) year after Contract termination. CalOptima shall not pay CONTRACTOR for time spent traveling.

5. CONTRACTOR's fees for the goods and/or services provided under Exhibit A, Scope of Work, will be billed based upon completion of the milestones as set forth in the schedule(s) in Exhibit B-1. For any additional work beyond that specified in Exhibit A, Scope of Work, that is authorized by CalOptima in a written amendment or change order, CONTRACTOR shall be paid at the hourly billable rate of «Hourly Billable Spelled» Dollars

($«Hourly Rate») per hour. These fees and rates are fixed for the duration of the Contract. CONTRACTOR agrees to extend these fees and rates to CalOptima for a period of one (1) year after Contract termination. CalOptima shall not pay CONTRACTOR for time spent traveling.

6. If CONTRACTOR incurs travel-related expenses under this Contract, CalOptima will only reimburse such expenses if CalOptima provides prior written approval of such expenses and those expenses are incurred and submitted in accordance with CalOptima Travel Policy (G.A.5004), as amended, which is incorporated into this Contract by this reference. CalOptima will make CalOptima Travel Policy (G.A.5004) available to CONTRACTOR upon written request.

EXHIBIT C
Regulatory Requirements

CalOptima is a public agency and is licensed by the DMHC. In addition, CalOptima arranges for the provision of Medi-Cal services to Medi-Cal beneficiaries under a contract with DHCS ("**DHCS Contract**") and Medicare Advantage ("**MA**") services to Medicare beneficiaries under a contract CMS ("**CMS Contract**"). This Exhibit C sets forth the statutory, regulatory, and contractual requirements that CalOptima must incorporate into the Contract as a public agency and DMHC-licensed health care service plan with MA and Medi-Cal products.

1. **Medi-Cal Requirements**.

1.1. Compliance with Medi-Cal Standards. CONTRACTOR agrees that the Contract shall be governed by and construed in accordance with all laws and applicable regulations governing the DHCS Contract. CONTRACTOR shall comply with all applicable requirements of the Medi-Cal program and comply with all monitoring of the DHCS Contract and any other monitoring requests by DHCS.

1.2. Disclosure of Officers, Owners, Stockholders and Creditors. Pursuant to Exhibit E, Attachment 2, Section 33 (a) of the DHCS Contract and 42 C.F.R. Section 455.104, upon the Effective Date, on an annual basis, and within thirty (30) days of any changes, CONTRACTOR shall identify the names of the following persons by listing them on Exhibit D of this Contract and submitting the form to CalOptima:

1.2.1. All officers and owners who own greater than five percent (5%) of the CONTRACTOR;

1.2.2. All stockholders owning greater than five percent (5%) of any stock issued by CONTRACTOR; and

1.2.3. All creditors of CONTRACTOR's business if such interest is over five percent (5%).

1.3. Compliance with Employment and Labor Laws. Each Party shall, at its own expense, comply with all applicable laws in performing their respective obligations under the Contract, including, but not limited to, the National Labor Relations Act, the Americans With Disabilities Act, all applicable employment discrimination laws, overtime laws, tax laws, immigration laws, workers' compensation laws, occupational safety and health laws, and unemployment insurance laws and any regulations related thereto. CONTRACTOR acknowledges and agrees that:

1.3.1. CONTRACTOR and its subcontractors will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. CONTRACTOR and its subcontractors will take affirmative action to ensure that qualified applicants are employed and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age, or status as a disabled veteran or veteran of the Vietnam era. Such action shall include the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. CONTRACTOR and its subcontractors agree to post in conspicuous places, available to employees and applicants for employment, notices 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 shall state CONTRACTOR and its subcontractors' obligation 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. [DHCS Contract, Exhibit D(F), Provision 1, Section A]

1.3.2. CONTRACTOR and its subcontractors will, in all solicitations or advancements for employees placed by or on behalf of CONTRACTOR and its subcontractors, state that all qualified applicants

will receive consideration for employment without regard to race, color, religion, sex, national origin, physical or mental handicap, disability, age, or status as a disabled veteran or veteran of the Vietnam era. [DHCS Contract, Exhibit D(F), Provision 1, Section B]

1.3.3. CONTRACTOR and its subcontractors will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the federal government or the State of California, advising the labor union or workers' representative of CONTRACTOR and its subcontractors' commitments under this Section 1.3 and shall post copies of the notice in conspicuous places available to employees and applicants for employment. [DHCS Contract, Exhibit D(F), Provision 1, Section C]

1.3.4. CONTRACTOR and its subcontractors will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212), and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity", and as supplemented by regulation at 41 C.F.R. 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. [DHCS Contract, Exhibit D(F), Provision 1, Section D]

1.3.5. CONTRACTOR and its subcontractors will furnish all information and reports required by Federal Executive Order No. 11246, as amended, including by Executive Order 11375, "Amending Executive Order No. 11246, Relating to Equal Employment Opportunity", and as supplemented by regulation at 41 C.F.R. 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. [DHCS Contract, Exhibit D(F), Provision 1, Section E]

1.3.6. If CONTRACTOR and its subcontractors' do not comply with the requirements of this Section 1.3 or with any federal rules, regulations, or orders referenced herein, this Contract may be cancelled, terminated, or suspended in whole or in part, and CONTRACTOR and its subcontractors may be declared ineligible for further federal and state contracts, in accordance with procedures authorized in Federal Executive Order No. 11246, as amended, and such other sanctions may be imposed and remedies invoked as provided in Federal Executive Order No. 11246, as amended, including by Executive Order 11375, "Amending Executive Order No. 11246 Relating to Equal Employment Opportunity", and as supplemented by regulation at 41 C.F.R. 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. [DHCS Contract, Exhibit D(F), Provision 1, Section F]

1.3.7. CONTRACTOR and its subcontractors will include the provisions of this Section 1.3 in every subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor, issued pursuant to Federal Executive Order No. 11246, as amended, including by Executive Order 11375, "Amending Executive Order No. 11246 Relating to Equal Employment Opportunity", and as supplemented by regulation at 41 C.F.R. 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. CONTRACTOR and its subcontractors will take such action with respect to any subcontract or purchase order as the Director of the Office of Federal Contract Compliance Programs or DHCS may direct as a means of enforcing such provisions, including sanctions for noncompliance; provided, however, that if CONTRACTOR and its subcontractors become involved in, or are threatened with litigation by a subcontractor as a result of such direction by DHCS, CONTRACTOR and its subcontractors may request in writing to DHCS, which, in turn, may request the United States to enter into such litigation

to protect the interests of the State of California and of the United States. [DHCS Contract, Exhibit D(F), Provision 1.G]

1.4. Debarment and Suspension Certification.

1.4.1. By signing this Contract, the CONTRACTOR agrees to comply with any and all applicable federal suspension and debarment regulations, including, as applicable, 7 C.F.R. 3017, 45 C.F.R. 76, 40 C.F.R. 32, or 34 C.F.R. 85. [DHCS Contract, Exhibit D(F), Provision 19, Section A]

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

1.4.2.1. Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any state or federal department or agency; [DHCS Contract, Exhibit D(F), Provision 19, Section B.1]

1.4.2.2. Have not within a three (3)-year period preceding this Contract been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, state or local) transaction or contract under a public transaction; violation of federal or state anti-trust statutes; or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property; [DHCS Contract, Exhibit D(F), Provision 19, Section B.2]

1.4.2.3. Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (federal, state or local) with commission of any of the offenses enumerated in Section 1.4.2.2 of this Exhibit C; [DHCS Contract, Exhibit D(F), Provision 19, Section B.3]

1.4.2.4. Have not within a three (3)-year period preceding the Effective Date of this Contract had one or more public transactions (federal, state or local) terminated for cause or default; [DHCS Contract, Exhibit D(F), Provision 19, Section B.4]

1.4.2.5. Have not and shall not knowingly enter into any lower-tier covered transaction with a person who is proposed for debarment under federal regulations (i.e., 48 C.F.R. 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State of California; and [DHCS Contract, Exhibit D(F), Provision 19, Section B.5]

1.4.2.6. Will include a clause entitled, “Debarment and Suspension Certification” that sets forth the provisions herein in all lower-tier covered transactions and in all solicitations for lower-tier covered transactions. [DHCS Contract, Exhibit D(F), Provision 19, Section B.6]

1.4.3. If the CONTRACTOR is unable to certify to any of the statements in this certification, the CONTRACTOR shall submit an explanation to CalOptima. [DHCS Contract, Exhibit D(F), Provision 19, Section C]

1.4.4. The terms and definitions herein have the meanings set out in the Definitions and Coverage sections of the rules implementing Federal Executive Order 12549. [DHCS Contract, Exhibit D(F), Provision 19, Section D]

1.4.5. If the CONTRACTOR knowingly violates this certification, in addition to other remedies available to the federal government, CalOptima may terminate this Contract for cause or default. [DHCS Contract, Exhibit D(F), Provision 19, Section E]

1.5. Lobbying Restrictions and Disclosure Certification.

1.5.1. *Certification and Disclosure Requirements*.

1.5.1.1. If Contract is subject to 31 U.S.C. § 1352 and exceeds $100,000 at any tier, CONTRACTOR and its subcontractors, as applicable, shall file a certification (in the form set forth in Exhibit E, consisting of one page, entitled "Certification Regarding Lobbying") that CONTRACTOR and its subcontractors, as applicable, have not made, and will not make, any payment prohibited by Section 1.5.2 below. [DHCS Contract, Exhibit D(F), Provision 31, Section A.1; 31 U.S.C. § 1352]

1.5.1.2. CONTRACTOR and its subcontractors, as applicable, shall file a disclosure (in the form set forth in Exhibit E, entitled "Certification Regarding Lobbying") if CONTRACTOR and its subcontractors, as applicable, have made or agreed to make any payment using non-appropriated funds (to include profits from any covered federal action) in connection with the Contract or a subcontract thereunder that would be prohibited under Section 1.5.2 below if paid for with appropriated funds. [DHCS Contract, Exhibit D(F), Provision 31, Section A.2]

1.5.1.3. CONTRACTOR and its subcontractors, as applicable, shall file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affect the accuracy of the information contained in any disclosure form previously filed by CONTRACTOR and its subcontractors, as applicable, under this Section 1.5.1. An event that materially affects the accuracy of the information reported includes: [DHCS Contract, Exhibit D(F), Provision 31, Section A.3]

1.5.1.3.1. A cumulative increase of $25,000 or more in the amount paid or expected to be paid for influencing or attempting to influence a covered federal action; [DHCS Contract, Exhibit D(F), Provision 31, Section A.3.a]

1.5.1.3.2. A change in the person(s) or individuals(s) influencing or attempting to influence a covered federal action; or [DHCS Contract, Exhibit D(F), Provision 31, Section A.3.b]

1.5.1.3.3. A change in the officer(s), employee(s), or member(s) contacted for the purpose of influencing or attempting to influence a covered federal action. [DHCS Contract, Exhibit D(F), Provision 31, Section A.3.c]

1.5.1.3.4. As applicable and required by this Section 1.5, CONTRACTOR's subcontractors shall file a certification and a disclosure form, if required, to the next tier above. [DHCS Contract, Exhibit D(F), Provision 31, Section A.4]

1.5.1.3.5. All disclosure forms (but not certifications) shall be forwarded from tier to tier until received by CONTRACTOR. CONTRACTOR shall forward all disclosure forms to CalOptima. [DHCS Contract, Exhibit D(F), Provision 31, Section A.5]

1.5.2. *Prohibition*. 31 U.S.C. § 1352 provides in part that no appropriated funds may be expended by the recipient of a federal contract, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with any of the following covered federal actions: the awarding of any federal contract, the making of any federal grant, the making of any federal loan, entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement. [DHCS Contract, Exhibit D(F), Provision 31, Section B]

1.6. Verification of CalOptima Costs by Government. Until the expiration of ten (10) years after the later of furnishing of any service pursuant to this Contract or completion of any audit, or longer as required by applicable regulations, CONTRACTOR will make available, upon written request of CalOptima, the Secretary of Health and Human Services Office of Inspector General, the Comptroller General of the United States, the U.S. Department of Justice, DHCS, the DMHC, the Bureau of Medical Fraud, or any of their duly authorized representatives copies of this Contract and any financial statements, books, documents, records, patient care documentation, and other records or data of CONTRACTOR that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under this Contract, or as are otherwise necessary to certify the nature and extent of costs incurred by CalOptima for such services. This provision shall also apply to any agreement with a CONTRACTOR subcontractor or an organization related to a CONTRACTOR subcontractor by control or common ownership. CONTRACTOR further agrees that regulating entities have the right to inspect, evaluate and audit any pertinent information and to facilitate the review of the items referenced herein, to make available its premises, physical facilities and equipment, records related to Medicare enrollees, and any additional relevant information that regulating entities may require. CONTRACTOR further agrees and acknowledges that this provision will be included in any and all agreements with CONTRACTOR's subcontractors. [DHCS Contract, Exhibit E, Attachment 2, Provision 20]

1.7. Confidentiality of Member Information.

1.7.1. If CONTRACTOR and its employees, agents, or subcontractors access or receive, whether intentionally or unintentionally, personally identifying information during the Term, CONRACTOR and its employees, agents, and subcontractors shall protect from unauthorized disclosure, the names and other identifying information concerning persons either receiving services pursuant to this Contract, or persons whose names or identifying information become available or are disclosed to CONTRACTOR, its employees, agents, or subcontractors as a result of services performed under this Contract, except for statistical information not identifying any such person. CONTRACTOR and its employees, agents, or subcontractors shall not use such identifying information for any purpose other than carrying out the express terms of and CONTRACTOR's obligations under this Contract. CONTRACTOR and its employees, agents, or subcontractors shall promptly transmit to CalOptima all requests for disclosure of such identifying information, except requests for medical records in accordance with applicable law, not emanating from the CalOptima member. CONTRACTOR shall not disclose, except as otherwise specifically permitted by this Contract or authorized by the CalOptima member, any such identifying information to anyone other than DHCS or CalOptima without prior written authorization from CalOptima specifying that the information is releasable under Title 42 C.F.R. Section 431.300 *et seq*., Section 14100.2, Welfare and Institutions Code, and regulations adopted there under. For purposes of this Section 1.7, identity shall include name, identifying number, symbol, or other identifying detail assigned to the individual, such as finger or voice print or a photograph. [DHCS Contract, Exhibit D(F), Provision 12, Exhibit E, Attachment 2, Provision 22, Section B]

1.7.2. Names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with Title 42 C.F.R. Section 431.300 *et seq*., Section 14100.2, Welfare and Institutions Code, and regulations adopted thereunder. For the purpose of this Contract, all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to CalOptima members shall be protected by CONTRACTOR from unauthorized disclosure. CONTRACTOR may release Medical Records in accordance with applicable law pertaining to the release of this type of information. CONTRACTOR is not required to report requests for Medical Records made in accordance with applicable law. With respect to any identifiable information concerning a CalOptima member under this Contract that is obtained by CONTRACTOR or its subcontractors, CONTRACTOR will, at the termination of this Contract, return all such information to CalOptima or maintain such information according to written procedures sent to the CONTRACTOR by CalOptima for this purpose. [DHCS Contract, Exhibit E, Attachment 2, Provision 22]

1.8. Member Hold Harmless. To the extent CONTRACTOR provides services or supplies to CalOptima members, CONTRACTOR hereby agrees that in no event, including nonpayment by CalOptima, the insolvency of CalOptima, or breach of the Contract, shall CONTRACTOR bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against CalOptima members, persons acting on their behalf, or DHCS. CONTRACTOR further agrees that this hold harmless provision shall survive the termination of the Contract regardless of the cause giving rise to the termination, shall be construed to be for the benefit of CalOptima members, and that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between CalOptima or CONTRACTOR and a CalOptima member or persons acting on their behalf that relates to liability for payment for services under the Contract. [DHCS Contract, Exhibit A, Attachment 6, Provision 13, Section B.15; CMS Medicare Managed Care Manual Chapter 11, Section 100.4]

1.9. Air and Water Pollution Requirements. If this Contract or any subcontract thereunder is in excess of one hundred thousand dollars ($100,000), CONTRACTOR agrees to comply with all applicable standards, orders, or requirements issued under the Clean Air Act (42 USC § 7401 *et seq*.), as amended, and the Federal Water Pollution Control Act (33 USC § 1251 *et seq*.), as amended. [DHCS Contract, Exhibit D(F), Provision 11]

2. **Medicare Requirements**.

2.1. CONTRACTOR expressly warrants that CONTRACTOR and CONTRACTOR's subcontractors, if any, shall comply with all applicable Medicare laws, regulations, and CMS instructions. CONTRACTOR further agrees and acknowledges that this provision will be included in all agreements with CONTRACTOR's subcontractors.

2.2. For any medical records or other health and enrollment information CONTRACTOR maintains with respect to Medicare enrollees, CONTRACTOR shall establish procedures to:

2.2.1. Abide by all federal and state laws regarding confidentiality and disclosure of medical records and other health and enrollment information. CONTRACTOR shall safeguard the privacy of any information that identifies a particular enrollee and shall have procedures that specify: (a) the purposes for which the information will be used within CONTRACTOR's organization; and (b) to whom and for what purposes CONTRACTOR will disclose the information.

2.2.2. Ensure that the medical information is used and released only in accordance with applicable federal or state law, or pursuant to court orders or subpoenas.

2.2.3. Maintain the records and information in an accurate and timely manner.

2.3. CONTRACTOR shall comply with the reporting requirements provided in 42 C.F.R. § 422.516, as well as the encounter data submission requirements in 42 C.F.R. § 422.257.

2.4. For all contracts in the amount of $100,000 or more, CONTRACTOR and CONTRACTOR's subcontractors, if any, shall comply with 41 C.F.R. 60-300.5(a) and 41 C.F.R. 60-741.5(a) as follows:

2.4.1. CONTRACTOR and Subcontractor shall abide by the requirements of 41 C.F.R. § 60-300.5(a). This regulation prohibits discrimination against qualified protected veterans and requires affirmative action by covered prime contractors and subcontractors to employ and advance in employment qualified protected veterans. [41 C.F.R. § 60-300.5(d)]

2.4.2. CONTRACTOR and subcontractor shall abide by the requirements of 41 C.F.R. § 60-741.5(a). This regulation prohibits discrimination against qualified individuals on the basis of disability and requires affirmative action by covered prime contractors and subcontractors to employ and advance in employment qualified individuals with disabilities. [41 C.F.R. § 60-741.5(d)]

2.5. In addition to the termination provisions of Section 14 of the Contract, CalOptima may terminate the Contract if CMS or CalOptima determines that CONTRACTOR has not satisfactorily performed its obligations under the Contract. Under such circumstances, CalOptima may pay CONTRACTOR its allowable costs incurred to the date of termination. Thereafter, CONTRACTOR shall have no further claims against CalOptima for matters pertaining to this Contract.

2.6. While CalOptima maintains ultimate responsibility for adhering to and complying with all terms and conditions of the CMS Contract, CONTRACTOR shall comply with all such applicable requirements in the CMS Contract, at the direction of CalOptima.

2.7. CONTRACTOR shall ensure that the persons it employs or contracts with for the provision of services pursuant to the Contract are in good standing and not on the preclusion list, defined in 42 C.F.R. § 422.2. CONTRACTOR shall promptly disclose to CalOptima any exclusion or other event that makes a CONTRACTOR employee or subcontractor ineligible to perform work related to federal health care programs. CONTRACTOR agrees to be bound by the provisions set forth at 2 C.F.R. Part 376. [42 C.F.R. § 422.752(a)(8)]

2.8. FDR Compliance. Upon execution of this Contract, CONTRACTOR agrees to execute and abide by the terms of the "FDR Compliance Attestation" in Exhibit F and shall submit an executed FDR Compliance Attestation no less than annually thereafter. [Delete if CONTRACTOR is not a FDR.]

3. **Offshore Performance**.

3.1. Due to security and identity protection concerns, direct services under this Contract shall not be performed by offshore subcontractors, unless otherwise authorized in writing by CalOptima prior to the provision of those services.

3.2. CONTRACTOR shall complete, sign, and return Exhibit G, "Attestation Concerning the Use of Offshore Subcontractors" as of the Effective Date and shall submit an executed Offshore Subcontractor Attestation to CalOptima no less than annually thereafter. CONTRACTOR represents and warrants that it has disclosed in Exhibit G any and all such offshore subcontractors and that it has obtained CalOptima's written approval to use such offshore subcontractors prior to the Effective Date.

3.3. Any subcontract with an offshore entity under which the offshore entity will have access to any confidential CalOptima member or other protected health information must be approved in writing by CalOptima prior to execution of the subcontract. CONTRACTOR is required to submit future Offshore Contractor Attestations to CalOptima within thirty (30) calendar days after it has signed a contract with any subcontractor that may be using an offshore subcontractor to perform any related work.

3.4. Unless specifically stated otherwise in this Contract, the restrictions of this Section 3 do not apply to indirect or "overhead" services, or services that are incidental to the performance of the Contract.

3.5. The provisions of this Section 3 apply to work performed by subcontractors at all tiers.

4. **Prohibited Interest**.

4.1. CONTRACTOR shall comply with all applicable federal, state, and local laws and regulations pertaining to conflict-of-interest laws, including CalOptima's Conflict of Interest Code, the California Political Reform Act (California Government Code § 81000 *et seq*.) and California Government Code § 1090 *et seq*. (collectively, the "**Conflict of Interest Laws**").

4.2. CONTRACTOR covenants that, to the best of its knowledge during the Term, no director, officer, or employee of CalOptima during his or her tenure has any interest, direct or indirect, in this Contract or the proceeds thereof. CONTRACTOR further covenants that, for the Term, and consistent with the provisions of 22 C.C.R. § 53600(f), no state officer or state employee shall be employed in a management or

contractor position by CONTRACTOR within one (1) year after the state office or state employee has terminated state employment.

4.3. CONTRACTOR, and any person designated by CONTRACTOR to make or participate in making a governmental decision on behalf of CalOptima, is considered a "**Consultant**" pursuant to CalOptima's Conflict of Interest Code and shall be required to file a statement of economic interests (Fair Political Practices Commission Form 700) with CalOptima annually. [2 C.C.R. Section 18734]

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

4.5. If CONTRACTOR becomes aware of any facts that might reasonably be expected to either create a conflict of interest under the Conflict of Interest Laws or violate the provisions of this Section 4, CONTRACTOR shall immediately make full written disclosure of such acts to CalOptima. Full written disclosure shall include identification of all persons, entities, and businesses implicated and a complete description of all relevant circumstances.

5. **State Auditor Audit Disclosure**. Pursuant to California Government Code § 8546.7, if this Contract is more than ten thousand dollars ($10,000), it is subject to examination and audit of the California State Auditor, at the request of CalOptima or as part of any audit of CalOptima for a period of three (3) years after final payment under this Contract. In addition to and notwithstanding any other right of access or inspection that may be otherwise set forth in this Contract, CONTRACTOR agrees that during the Term and for a period of three (3) years after its termination, CalOptima shall have access to and the right to examine any directly pertinent books, documents, invoices, and records of CONTRACTOR relating to services provided under this Contract. Where another right of access or inspection in this Contract provides for a period of greater than three (3) years, nothing herein shall be construed to shorten that time period. [Gov't Code § 8546.7]

EXHIBIT D
Medi-Cal Disclosure Form

Contractor Officer, Owner, Shareholder, and Creditor Information

Contractor's Business Name: _____

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

Business Address: _____

City:_____ State:_____ Zip:_____
Business Phone:_____ Email: :_____
President: _____ Contact Person:_____

Person(s) Signing Contract & Title: :_____

*Please provide names of owners, officers, stockholders, and creditors of Contractor's business if such interest is over 5%.

Name	Officer Title or Ownership/Creditorship %
_____	_____
_____	_____
_____	_____
_____	_____

BY SIGNING BELOW, THE UNDERSIGNED HEREBY CERTIFIES THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF HIS OR HER KNOWLEDGE AND BELIEF.

_____ _____
Authorized Signature Date

_____
Name and Title

EXHIBIT E

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES
CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the making, awarding or entering into of this federal contract, federal grant, or cooperative agreement, and the extension, continuation, renewal, amendment, or modification of this federal contract, grant, or cooperative agreement.

(2) If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency of the United States Government, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, or cooperative agreement, the undersigned shall complete and submit Standard Form LLL, "Disclosure of Lobbying Activities"' in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontractors, subgrants, and contracts under grants and cooperative agreements) of $100,000 or more, and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S.C., any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

_____	_____
Name of Contractor	Printed Name of Person Signing for Contractor
_____	_____
Contract/Grant Number	Signature of Person Signing for Contractor
_____	_____
Date	Title

After execution by or on behalf of Contractor, please return to:

Department of Health Care Services
Medi-Cal Managed Care Division
MS 4415, 1501 Capitol Avenue, Suite 71.4001
P.O. Box 997413
Sacramento, CA 95899-7413

CERTIFICATION REGARDING LOBBYING

Approved by OMB 0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure)

1. Type of Federal Action: ☐a. contract ☐b. grant ☐c. cooperative agreement ☐d. loan ☐e. loan guarantee ☐f. loan insurance	2. Status of Federal Action: ☐a. bid/offer/application ☐b. initial award ☐c. post-award	3. Report Type: ☐a. initial filing ☐b. material change **For Material Change Only:** Year _____ quarter_____ date of last report _____

4. Name and Address of Reporting Entity: ☐ Prime ☐ Subawardee Tier ____, *if known*: Congressional District, *if known*:	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime: Congressional District, *if known*:
6. Federal Department/Agency:	7. Federal Program Name/Description: CDFA Number, *if applicable*:
8. Federal Action Number, *if known*:	9. Award Amount, *if known*: $_____
10. a. Name and Address of Lobbying Entity (*If individual, last name, first name, MI*): (*attach Continuation Sheet(s) SF-LLLA, if necessary*)	b. Name and Address of Lobbying Entity (If individual, last name, first name, MI):
11. Amount of Payment (check all that apply): $_____ ☐actual ☐planned 12. Form of Payment (check all that apply): ☐ a. cash ☐ b. in-kind, specify: Nature _____ Value_____	13. Type of Payment ☐ a. retainer ☐ b. one-time fee ☐ c. commission ☐ d. contingent fee ☐ e. deferred ☐ f. other, specify: _____

14. Brief Description of Services Performed or to be Performed and Dates(s) of Service, including Officer(s), Employee(s), or Member(s) Contracted for Payment indicated in item 11:

(Attach Continuation Sheet(s) SF-LLL-A, If necessary)

15. Continuation Sheet(s) SF-LLL-A Attached: ☐Yes ☐No

16. Information requested through this form is authorized by Title 31, U.S.C., Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to Title 31, U.S.C., Section 1352. This information will be reported to the Congress semiannually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.	Signature: Print Name: Title: Telephone No.: Date:

Federal Use Only	Authorized for Local Reproduction Standard Form-LLL

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime federal recipients at the initiation or receipt of a covered federal action, or a material change to a previous filing, pursuant to Title 31, U.S.C., Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered federal action. Use the SF - LLL- A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered federal action.

2. Identify the status of the covered federal action.

3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered federal action.

4. Enter the full name, address, city, state, and ZIP code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants, and contract awards under grants.

5. If the organization filing the report in Item 4 checks "Subawardee," then enter the full name, address, city, state, and ZIP code of the prime federal recipient. Include Congressional District, if known.

6. Enter the name of the federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation United States Coast Guard.

7. Enter the federal program name or description for the covered federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CDFA) number for grants, cooperative agreements, loans, and loan commitments.

8. Enter the most appropriate federal identifying number available for the federal action identified in Item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract grant, or loan award number; the application/proposal control number assigned by the federal agency). Include prefixes, e.g., "RFP-DE-90401."

9. For a covered federal action where there has been an award or loan commitment by the federal agency, enter the federal amount of the award/loan commitment for the prime entity identified in Item 4 or 5.

10. (a) Enter the full name, address, city, state, and ZIP code of the lobbying entity engaged by the reporting entity identified in Item 4 to influence the covered federal action.

    (b) Enter the full names of the Individual(s) performing services and include full address if different from 10.(a). Enter last name, first name, and middle initial (MI).

11. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (Item 4) to the lobbying entity (Item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

12. Check the appropriate box(es). Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.

13. Check the appropriate box(es). Check all boxes that apply. If other, specify nature.

14. Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with federal officials. Identify the federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.

15. Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.

16. The certifying official shall sign and date the form, print his/her name, title, and telephone number.

EXHIBIT F
FDR Attestation

FDR COMPLIANCE ATTESTATION

Please complete and execute this attestation and return it to CalOptima's Office of Compliance via email Compliance@caloptima.org , or mail: CalOptima, Office of Compliance, Attn: Annie Phillips 505 City Parkway West, Orange, CA 92868, within thirty (30) calendar days for (existing FDRs) or sixty (60) calendar days for (new FDRs) of this notice.

Which CalOptima program(s) does this form pertain to? Select all that apply:	☐OneCare Connect ☐OneCare HMO SNP	☐Medi Cal ☐PACE

I hereby attest that [_____ (the "Organization")], and all its downstream entities, if any, that are involved in the provision of health or administrative services for any of the CalOptima programs identified above:

I. **General and HIPAA Compliance and FWA Training.** Provide effective Fraud, Waste and Abuse training, General Compliance training, General HIPAA training to all Organization and downstream entity board members, officers, employees, temporary employees, and volunteers, within ninety (90) calendar days of appointment, hire or contracting, as applicable, and at least annually thereafter as a condition of appointment, employment or contracting. The Organization and its downstream entities currently use (Select all that apply):

☐ CMS's Fraud, Waste, and Abuse training, General Compliance training, and General HIPAA training module. (The Organization shall maintain records per CMS retention requirement)

☐ An internal training program that meets CMS's Fraud, Waste, and Abuse training, General Compliance training, and HIPAA training module requirements. (The Organization shall maintain records per CMS retention requirement)
Note: If selecting an internal training program that meets CMS's FWA, HIPAA, and General Compliance, please submit a copy of your organization's trainings to CalOptima's Office of Compliance for review, and to ensure they meet CMS's requirements.

II. Administer specialized compliance training to Organization and downstream entity board members, employees, temporary employees, and volunteers: (i) based on their job function within the first ninety (90) days of hire and at least annually thereafter as a condition of appointment, employment or contracting, (ii) when requirements change; (iii) when such persons work in an area previously found to be non- compliant with program requirements or implicated in past misconduct.

III. **Compliance Plan and Code of Conduct Requirements.** Have established and publicized compliance policies and procedures, standards of conduct, and compliance reference material that meet the requirements outlined in 42 CFR § 422.503(b)(4)(vi)(A) and 42 CFR § 423.504(b)(4)(vi)(A) which information, and any updates thereto, are distributed to all Organization and downstream entity board members, officers, employees, temporary employees, and volunteers within ninety (90) days of appointment, hire or contracting, as applicable, and at least annually thereafter. Evidence of receipt of such compliance by such persons is obtained and retained by the Organization. (Select which applies to your organization):

☐ Organization has adopted, implemented, and distributed CalOptima's Compliance Plan and Code of Conduct

☐ Organization has distributed a comparable Compliance Plan and Code of Conduct
Note: If selecting a comparable Compliance Plan and Code of Conduct, please submit a copy of your organization's Compliance Plan and Code of Conduct to CalOptima's Office of Compliance for review, and to ensure they meet CMS's requirements

IV. **Exclusion Monitoring**. Review all Organization and downstream entity board members, officers, potential and actual employees, temporary employees, and volunteers against the (Suspended and Ineligible Provider List) S & I Medi-Cal, (Health and Human Services) HHS, (Office of Inspector General) OIG List of Excluded Individuals & Entities list, (System for Award Management) SAM/(General Services Administration) GSA Debarment list, Centers for Medicare & Medicaid Services (CMS) Preclusion List (as applicable), (here after "Lists") upon appointment, hire or contracting, as applicable, and monthly thereafter. Further, in the event that the Organization or downstream entity becomes aware that any of the foregoing persons or entities are included on these Lists, the Organization will notify CalOptima within five (5) calendar days, the relationship with the listed person/entity will be terminated as it relates to CalOptima, and appropriate corrective action will be taken.

V. **Conflict of Interest**. Screen the Organization and its subcontractors' governing bodies for conflicts of interest as defined in state and federal law and CalOptima policies and procedures upon hire or contracting and annually thereafter.

VI. **Reporting of FWA/Non-Compliance**. Will report suspected fraud, waste, and abuse, as well as all other forms of non- compliance, as it relates to CalOptima, confidentially and anonymously.

VII. **Disciplinary Action**. Understand that any violation of any laws, regulations, or CalOptima policies and procedures are grounds for disciplinary action, up to and including termination of Organization's contractual status.

VIII **Non-Retaliation**. Are aware that persons reporting suspected fraud, waste, and abuse, and other non- compliance are protected from retaliation under the False Claims Act and other applicable laws prohibiting retaliation.

IX. **Records Management**. Retain documented evidence of compliance with the above, including training and exclusion screening (i.e. sign-in sheets, certificates, attestations, OIG and GSA search results, etc.) for at least ten (10) years, and provide such documentation to CalOptima upon request.

The individual signing below is knowledgeable about and authorized to attest to the foregoing matters on behalf of the Organization.

_____	_____
Signature	Date
_____	_____
Name (Print)	Organization
_____	
Email (Print)	

EXHIBIT G

Attestation Concerning the Use of Offshore Subcontractors

If Organization offshores any protected health information (PHI) it must notify CalOptima prior to entering into or amending any agreement with an Offshore Subcontractor, and Contractor must complete the Offshore Subcontracting Attestation.

Which CalOptima program(s) does this form pertain to? Select all that apply.	☐ OneCare Connect ☐ PACE ☐ OneCare ☐ Medi-Cal

Please check one of the following:

☐ Our Organization does not offshore any protected health information.
Please skip to Part V below

☐ Our Organization does offshore protected health information.
Please complete Offshore Subcontractor Attestation (Part I through Part V) below

Part I — Offshore Subcontractor Information

Attestation	Response
Our Organization uses an offshore subcontractor or offshore staff to perform functions that support our contract with CalOptima	☐ Yes ☐ No
Offshore Subcontractor name:	
Offshore Subcontractor country:	
Offshore Subcontractor address:	
Describe offshore subcontractor functions:	
Proposed or actual effective date for offshore subcontractor (MM/DD/Year):	

Part II — Precautions for Protected Health Information (PHI)

Question	Response
1. Describe the PHI that will be provided to the offshore subcontractor	
2. Explain why providing PHI is necessary to accomplish the offshore subcontractor's objectives:	
3. Describe alternatives considered to avoid providing PHI, and why each alternative was rejected:	

Part III — Attestation of Safeguards to Protect Beneficiary Information in the Offshore Subcontract	
Attestation	**Response**
A. Offshore subcontracting arrangement has policies and procedures in place to ensure that Medicare beneficiary protected health information (PHI) and other personal information remains secure.	☐ Yes ☐ No*
B. Offshore subcontracting arrangement prohibits subcontractor's access to Medicare data not associated with CalOptima's contract with the offshore subcontractor.	☐ Yes ☐ No*
C. Offshore subcontracting arrangement has policies and procedures in place that allow for immediate termination of the subcontract upon discovery of a significant security breach.	☐ Yes ☐ No*
D. Offshore subcontracting arrangement includes all required Medicare Part C and D language (e.g., record retention requirements, compliance with all Medicare Part C and D requirements, etc.)	☐ Yes ☐ No*

Part IV — Attestation of Audit Requirements to Ensure Protection of PHI	
Attestation	**Response**
A. Our Organization will conduct an annual audit of the offshore subcontractor/employee.	☐ Yes ☐ No*
B. Audit results will be used by our Organization to evaluate the continuation of its relationship with the offshore subcontractor/employee.	☐ Yes ☐ No*
C. Our Organization agrees to share offshore subcontractor's/employee's audit results with CalOptima or CMS upon request.	☐ Yes ☐ No*

***Explanation required for all "no" responses to Part III and Part IV above:**

Part V — Organization Information	
By signing below, I hereby attest that the information contained herein is true, correct and complete.	
Printed name of authorized person:	Title:
Email:	Phone #:
Signature:	Date:

Note: CalOptima's policies and procedures, CMS training module instructions for FWA, General Compliance, General HIPAA, CalOptima's Code of Conduct, CalOptima's Compliance Plan can be accessed at https://www.caloptima.org/en/About/GeneralCompliance.aspx

EXHIBIT H

Business Associate Agreement

[insert CalOptima vendor BAA, if applicable]

CONTRACT NO. «Contract Number» ("**Contract**")
BETWEEN
ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY, dba
ORANGE PREVENTION & TREATMENT INTEGRATED MEDICAL ASSISTANCE, dba
CALOPTIMA ("**CalOptima**")
And
«Company Name»
("**CONTRACTOR**")

This Contract is made and entered into as of [insert date] ("**Effective Date**"), by and between the Orange County Health Authority, a public agency dba CalOptima, a public agency ("**CalOptima**") and «Company Name», a «Business Entity», hereinafter referred to as "**CONTRACTOR**." CalOptima and CONTRACTOR may be referred to herein collectively as the "**Parties**" or each individually as a "**Party**."

RECITALS

A. CalOptima desires to retain a contractor to provide «Description», as described in the Scope of Work in Exhibit A;

B. CONTRACTOR provides such services;

C. CONTRACTOR represents and warrants that it has the requisite personnel and experience and is capable of performing such services;

D. CONTRACTOR desires to perform these services for CalOptima; and

E. CalOptima and CONTRACTOR desire to enter into this Contract on the terms and conditions set forth herein below.

NOW, THEREFORE, in consideration of their mutual and respective promises, and subject to the terms and conditions hereinafter set forth, the Parties agree as follows:

1. Documents Constituting Contract. "**Contract Documents**" include the following documents in the order of descending precedence: (i) this Contract, inclusive of all its exhibits and addenda; (ii) CalOptima's Request for Proposal ("**RFP**"), if applicable, inclusive of any CalOptima revisions and addenda prior to the Effective Date; (iii) CONTRACTOR's best and final offer dated [Insert Date of Best and Final Offer], if applicable, and; (iv) CONTRACTOR's proposal dated [Insert Date CONTRACTOR's Response to RFP] ("**Proposal**"). Any new terms and conditions attached to CONTRACTOR's best and final offer, Proposal, invoices, or request for payment shall not be incorporated into the Contract Documents or be binding upon CalOptima unless expressly accepted by CalOptima in writing. All Contract Documents are incorporated into this Contract by this reference. Any changes to the Contract or the Contract Documents shall not be binding upon CalOptima except when specifically confirmed in writing by an authorized representative of CalOptima in accordance with Section 10, of this Contract. In the event of any conflict of provisions among the Contract and/or Contract Documents, the provisions shall prevail in the above-referenced descending order of precedence.

2. Scope of Work.

2.1. CONTRACTOR shall perform the work in accordance with (i) this Contract, including the Scope of Work in Exhibit A, (ii) the Contract Documents, (iii) the applicable standards and requirements of the Centers for Medicare and Medicaid Services ("**CMS**"), the California Department of Health Care Services ("**DHCS**"), and the California Department of Managed Health Care ("**DMHC**"), and (iv) all applicable laws.

3. Insurance.

3.1. At CONTRACTOR's sole expense and prior to undertaking performance of services under this Contract and at all times during performance hereunder, CONTRACTOR shall maintain insurance policies and amounts set forth in Exhibit A, which shall be full-coverage insurance not subject to self-insurance provisions, in accordance with applicable laws and industry standards. CONTRACTOR shall not of its own initiative cause such insurance to be canceled or materially changed during the Term.

3.2. Within five (5) days of the Effective Date and prior to commencing performance of any services or its receipt of any compensation under the Contract, CONTRACTOR shall furnish to CalOptima with additional insured endorsements broker-issued Certificate(s) of Insurance showing the required insurance coverages for CONTRACTOR. CONTRACTOR's Certificates of Insurance shall additionally comply with the following:

3.2.1. CalOptima's officers, officials, directors, employees, agents, and volunteers are to be covered as additional insureds with respect to liability arising out of work or operations performed by or on behalf of CONTRACTOR, including materials, parts, or equipment furnished in connection with such work or operations. This provision applies to CONTRACTOR's General Liability policy, as applicable, and must be on ISO form CG 20 10 or equivalent.

3.2.2. For any claims related to this Contract, the CONTRACTOR's insurance coverage shall be primary insurance with respect to CalOptima, its officers, officials, directors, employees, agents, and volunteers. This provision applies to the CONTRACTOR's General Liability, and Workers' Compensation and Employers' Liability policies, as applicable.

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

3.2.4. Insurance is to be placed with insurers with a current A.M. Best rating of no less than A-VII, unless otherwise acceptable to CalOptima.

3.2.5. CONTRACTOR shall furnish CalOptima with original certificates and amendatory endorsements affecting coverage required by this Section 3.2 and Exhibit A. CalOptima reserves the right to require complete, certified copies of all required insurance policies, including endorsements affecting the coverage required by these specifications, at any time.

3.2.6. Any deductibles or self-insured retentions must be declared to and approved by CalOptima. CalOptima may require the CONTRACTOR to purchase coverage with a lower deductible or retention or provide proof of ability to pay losses and related investigations, claim administration, and defense expenses within the retention or deductible.

3.2.7. All deductibles and retentions that the aforementioned policies contain are the responsibility of the CONTRACTOR and in no way shall CalOptima be responsible for payment of the deductibles/retentions.

3.2.8. If CONTRACTOR maintains higher limits than the minimums required in this Contract, CalOptima requires and shall be entitled to coverage for the higher limits maintained by CONTRACTOR. Any available insurance proceeds in excess of the specified minimum limits of insurance and coverage shall be available to CalOptima.

3.2.9. Require the insurance carrier to provide thirty (30) days' prior written notice of cancellation to CalOptima.

3.3. If CONTRACTOR fails or refuses to maintain or produce proof of the insurance required by this Section 3 and Exhibit A, CalOptima may terminate this Contract upon written notice to CONTRACTOR. Such termination shall not affect CONTRACTOR'S right to be paid for its time and materials expended prior to notification of termination. CONTRACTOR waives the right to receive compensation and agrees to indemnify CalOptima for any work performed prior to approval of insurance by CalOptima

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

3.5. CONTRACTOR shall require each of its subcontractors who perform services related to this Contract, if any, to maintain insurance coverage that meets all of the requirements set forth in this Contract.

3.6. "**Occurrence**" means any event or related exposure to conditions that result in bodily injury or property damage.

4. Indemnification.

4.1. To the fullest extent permitted by law, CONTRACTOR shall defend, indemnify, and hold harmless CalOptima and its respective officers, directors, agents, volunteers, consultants and employees (individually and collectively referred to as "**Indemnified Parties**") against any and all [third-party] claims, losses, demands, damages, costs, expenses, or liability arising out CONTRACTOR's, or its officers, employees, subcontractors, agents, or representatives', breach of this Contract, negligence, recklessness, or intentional conduct, except to the extent any such loss was caused by the gross negligence, recklessness, or intentional misconduct of CalOptima. CONTRACTOR shall defend the Indemnified Parties in any claim or action based upon any such alleged acts or omissions at its sole expense, which shall include all costs and fees, including attorneys' fees, cost of investigation, defense, and settlement or awards. CalOptima may make all reasonable decisions with respect to its representation in any legal proceeding. CONTRACTOR's duty to defend herein is wholly independent of and separate from the duty to indemnify and such duty to defend shall exist regardless of any ultimate liability of CONTRACTOR, save and except claims arising through the sole negligence or sole willful misconduct of CalOptima.

[Mutual indemnity option]

Each Party (an "**Indemnifying Party**") shall defend, indemnify, and hold harmless the other Party and the other Party's respective officers, directors, agents, volunteers, consultants, and employees (individually and collectively referred to as "**Indemnified Parties**") from and against any third-party claims losses, demands, damages, costs, expenses, or liability arising out of the Indemnifying Party's breach of this Contract, negligence, recklessness, or intentional conduct, except to the extent any such loss was caused by the negligence, recklessness, or intentional conduct of the Indemnified Parties. The Indemnifying Party shall defend the Indemnified Parties in any claim or action at its sole expense, which shall include all costs and fees, including attorneys' fees, cost of investigation, defense, and settlement or awards. The Indemnified Party may make all reasonable decisions with respect to its representation in any legal proceeding.

4.2. CONTRACTOR's obligation to indemnify hereunder is in addition to any liability CONTRACTOR may have to CalOptima for a breach by CONTRACTOR of any of the provisions of this Contract. Under no circumstances shall the insurance requirements and limits set forth in this Contract be construed to limit CONTRACTOR's indemnification and duty to defend obligation or other liability hereunder

4.3. CONTRACTOR's indemnification and duty to defend obligations shall survive the expiration or earlier termination of this Contract until such time as any action against the Indemnified Parties for such a matter indemnified hereunder is fully and finally barred by the applicable statute of limitations, including those set forth under the California Government Claims Act (Cal. Gov. Code §900 *et seq*.).

4.4. In the event of any conflict between this Section 4 and the indemnification provisions set forth elsewhere in the Contract, including any business associate agreement ("**BAA**") between the Parties, the indemnification provision(s) in the BAA or elsewhere in the Contract shall be interpreted to relate only to matters within the scope of the BAA or those other Contract provisions.

4.5. The terms of this Section 4 shall survive the termination of this Contract.

5. Independent Contractor. CalOptima and CONTRACTOR agree that CONTRACTOR, which shall include for purposes of this Section 5 all subcontractors, agents, and employees of the CONTRACTOR, in performance of this Contract, shall act in an independent capacity, and not as officers or employees of CalOptima. CONTRACTOR's relationship with CalOptima in the performance of this Contract is that of an independent contractor and nothing in this Contract shall be construed as creating a partnership, joint venture, or agency. CONTRACTOR's personnel performing services under this Contract shall be at all times under CONTRACTOR's exclusive direction and control and shall be employees of CONTRACTOR and not employees of CalOptima. CONTRACTOR shall pay all wages, salaries and other amounts due its employees, agents, and/or subcontractors in connection with this Contract and shall be responsible for all reports and obligations respecting them, such as social security, state and federal income tax withholding, other payroll taxes, unemployment compensation, workers' compensation, and similar matters. CONTRACTOR shall file all required returns related to such taxes, contributions, and payroll deductions.

6. Personnel.

6.1. CONTRACTOR Staffing. CONTRACTOR shall ensure that only fully qualified CONTRACTOR personnel are assigned to perform the services under the Contract, and such CONTRACTOR personnel shall perform services diligently and in a timely manner, according to the applicable professional and technical standards.

6.2. CONTRACTOR Personnel Restrictions. When on CalOptima's premises, CONTRACTOR personnel shall comply with CalOptima policies and procedures, including CalOptima's identification requirements (e.g., name badges).

6.3. Any CalOptima property damaged by CONTRACTOR, its subcontractor(s), or by the personnel of either, will be subject to repair or replacement by CONTRACTOR at no cost to CalOptima.

[optional non-compete clause]

6.4. Neither Party shall actively solicit employees of the other Party for employment that directly or indirectly provided services under the Contract during the Term and for a period of one (1) year after termination.

7. Compensation.

7.1. CalOptima agrees to pay, and CONTRACTOR agrees to accept as full compensation for the faithful performance of this Contract, the rates, charges, and other payment terms identified in Exhibit B.

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

7.3. CONTRACTOR's requests for payments and reimbursements must comply with the requirements set forth in Exhibit B. CalOptima will not make payment for work that fails to meet the standards of performance set forth in the Contract and Exhibit A. **CALOPTIMA SHALL NOT PAY ANY FEES, EXPENSES, OR COSTS WHATSOEVER INCURRED BY CONTRACTOR IN RENDERING ADDITIONAL SERVICES NOT AUTHORIZED IN WRITING BY CALOPTIMA UNDER THIS CONTRACT.**

7.4. In no event shall the total compensation payable to CONTRACTOR for the services performed under this Contract exceed the maximum cumulative payment obligation, as set forth in Exhibit B, without the express prior written authorization of CalOptima. **CONTRACTOR ACKNOWLEDGES AND AGREES THAT CALOPTIMA SHALL NOT BE LIABLE FOR ANY FEES, EXPENSES OR COMPENSATION IN EXCESS OF THE MAXIMUM CUMULATIVE PAYMENT OBLIGATION.**

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

8. Confidential Material.

8.1. During the Term, either Party may have access to confidential material or information ("**Confidential Information**") belonging to the other Party or the other Party's customers, vendors, or partners. Confidential Information includes the disclosing Party's computer programs and codes, business plans, customer/member lists and information, financial records, partnership arrangements, projections, methodologies, data, reports, agreements, intellectual property, trade secrets, licensing plans, and other proprietary information, or other information, materials, records, writings or data that is marked confidential or that due to its character and nature, a reasonable person under like circumstances would treat as confidential. CalOptima's Confidential Information also includes all user information, patient information, and clinical data that comes into CalOptima's possession, custody or control. Confidential Information will be used only for the purposes of this Contract and related internal administrative purposes. Each Party agrees to protect the other's Confidential Information at all times and in the same manner as each protects the confidentiality of its own confidential materials, but in no event with less than a reasonable standard of care.

8.2. For the purposes of Section 8.1, Confidential Information does not include information which: (i) is already known to the other Party at the time of disclosure; (ii) is or becomes publicly known through no wrongful act or failure of the receiving Party; (iii) is independently developed without use or benefit of the other Party's Confidential Information or proprietary information; (iv) is lawfully received from a third party that is not under and does not thereby breach an obligation of confidentiality; or (v) is a public record, not exempt from disclosure, pursuant to California Public Records Act, Government Code Section 6250 *et seq*., applicable provisions of California Welfare

and Institutions Code, or other state or federal laws, regardless of whether such information is marked as confidential or proprietary.

8.3. Disclosure of the Confidential Information will be restricted to the receiving Party's employees, consultants, suppliers, or agents, who are bound by confidentiality obligations no less stringent than those in this Section 8, on a "need to know" basis in connection with the services performed under this Contract. The receiving Party may disclose Confidential Information pursuant to legal, judicial, or administrative proceeding or otherwise as required by law; provided, however, that the receiving Party gives reasonable prior notice, if not prohibited by applicable law, to the disclosing Party and assists the disclosing Party, at the disclosing Party's expense, to obtain protective or other appropriate confidentiality orders, and further provided that a required disclosure of Confidential Information or proprietary information to an agency or court does not relieve the receiving Party of its confidentiality obligations with respect to the other Party.

8.4. CONTRACTOR shall establish and maintain environmental, safety, and facility procedures, data security procedures and other safeguards against the unauthorized access, destruction, loss, or alteration of CalOptima's Confidential Information in the possession, custody, or control of CONTRACTOR. Those security procedures and other safeguards shall be no less rigorous than those maintained by CONTRACTOR for its own information of a similar nature.

8.5. Upon written request of the disclosing Party, the receiving Party shall promptly return to the disclosing Party or destroy all documents, notes, and other tangible materials representing the disclosing Party's Confidential Information and all copies thereof. This obligation to return materials or copies thereof does not extend to automatically generated computer backup or archival copies generated in the ordinary course of the receiving Party's information systems procedures, provided that the receiving Party shall make no further use of such copies.

8.6. If a breach of the obligations under this Section 8 occurs, the injured Party may be entitled to such injunctive relief and any and all other remedies available at law or in equity. This Section 8 in no way limits the liability or damages that may be assessed against a Party if another Party breaches any of the provisions of this Section 8.

8.7. For the purposes of Section 8.6 only, Confidential Information does not include protected health information ("**PHI**") or individually identifiable information, as defined by the Health Insurance Portability and Accountability Act of 1996 ("**HIPAA**") and other privacy statutes or regulations. The access use and disclosure of PHI shall be governed by a BAA, which is Exhibit H to this Contract.

[alternative provision if no PHI involved]

This Contract does not require or permit CONTRACTOR to create, receive, maintain, use, or transmit protected health information ("**PHI**"). As such, no BAA is required for this Contract; provided, however, that if CONTRACTOR or its employees, agents, or subcontractors access or receive, whether intentionally or unintentionally, PHI regarding CalOptima members during the Term, CONRACTOR and its employees, agents, and subcontractors shall immediately notify CalOptima, protect such PHI from any additional disclosure, not use or disclose that PHI in any way that would violate a federal or state privacy or security law, its implementing regulations, or any other state or federal law, and execute a BAA with CalOptima, as necessary and requested by CalOptima.

9. California Public Records Act. As a local public agency, CalOptima is subject to the California Public Records Act (California Government Code Sections 6250 *et seq*.) (the "**PRA**"). CONTRACTOR hereby acknowledges that any materials, documents, data, or similar items are subject to disclosure upon public request, unless exempt from disclosure under the provisions of the PRA. CalOptima may be required to reveal certain information believed to be proprietary or confidential by CONTRACTOR pursuant to the PRA. If CONTRACTOR discloses information that it believes to be proprietary or confidential to

CalOptima, it shall mark such information as "Confidential," "Proprietary," or "Restricted" or other similar marking. Unless CONTRACTOR marks its materials as "Confidential," "Proprietary," or "Restricted," and also notifies CalOptima in writing that CONTRACTOR has so marked each piece of material, then CalOptima will not be responsible to take any actions to protect any CONTRACTOR's materials under the PRA that are not so marked. If CalOptima receives a request under the PRA that potentially encompasses CONTRACTOR materials that have been properly marked, CalOptima will provide CONTRACTOR with notice thereof to allow CONTRACTOR to take actions it deems appropriate to prevent disclosure of the marked material. Within five (5) days from receipt of CalOptima's notice, CONTRACTOR shall notify CalOptima if it intends to object to production of CONTRACTOR's information; otherwise CalOptima will respond to the PRA request according to the requirements of the PRA. CONTRACTOR agrees to defend, indemnify, and hold harmless CalOptima, its officers, agents, employees, members, subsidiaries, joint venture partners, and predecessors and successors in interest from and against any claim, action, proceeding, liability, loss, damage, cost, or expense, including attorneys' fees, and any costs awarded to the person or entity that sought CONTRACTOR's marked material, arising out of or related to CalOptima's failure to produce or provide the CONTRACTOR-marked material (collectively referred to for purposes of this Section 9 as "**Public Records Act Claim(s)**"). CONTRACTOR shall pay to CalOptima any expenses or charges relating to or arising from any such Public Record Act Claim(s) as they are incurred by CalOptima.

10. Modifications. CalOptima may modify the Contract upon written notice to CONTRACTOR at any time should such modification be required by CMS, DHCS, the DMHC, or applicable law or regulation ("**Regulatory Amendment**"). Any other modifications of the Contract that are not Regulatory Amendments shall be executed only by a written amendment to the Contract, signed by CalOptima and CONTRACTOR. Execution of amendments shall be contingent upon CONTRACTOR's notification to CalOptima, and CalOptima's approval, of any increase or decrease in the price of this Contract or in the time required for CONTRACTOR's performance.

11. Assignments.

    11.1. CONTRACTOR may not assign, transfer, or delegate any interest herein, either in whole or in part, without the prior written consent of CalOptima, which consent may be withheld in its sole discretion. If CalOptima provides such prior written consent, CONTRACTOR acknowledges and agrees that such assignment, transfer, or delegation may additionally be subject to the prior written approval of DHCS. Any assignment, transfer, or delegation made without CalOptima's express written consent shall be void.

    11.2. For purposes of this Section 11, an assignment is: (1) the change of more than fifty percent (50%) of the ownership or equity interest in CONTRACTOR (whether in a single transaction or in a series of transactions); (2) the change of more than fifty percent (50%) of the directors or trustees of CONTRACTOR (whether in a single transaction or in a series of transactions); (3) the merger, reorganization, or consolidation of CONTRACTOR with another entity with respect to which CONTRACTOR is not the surviving entity; and/or (4) a change in the management of CONTRACTOR from management by persons appointed, elected or otherwise selected by the governing body of CONTRACTOR (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

12. Subcontracts. CONTRACTOR may not subcontract or delegate its obligations or the performance of services under this Contract without CalOptima's prior written consent, which CalOptima may exercise in its sole discretion. CalOptima-approved subcontractors are listed in Addendum 1 to Exhibit A.

13. Term. This Contract shall commence on the Effective Date and shall continue in full force and effect through «Current Expiration» ("**Initial Term**"), unless earlier terminated as provided in this Contract. At the end of the Initial Term, CalOptima may, at its option, extend this Contract for up to «Extended Term spelled» («Extended Term») additional consecutive one (1)-year terms ("**Extended Terms**"), provided that if CalOptima does not exercise its option to extend at the end of the Initial Term, or any Extended Term,

the remaining option(s) shall automatically lapse. The Initial Term together with any Extended Terms constitute the "**Term**" of this Contract.

[optional term for fixed term agreements]

Term. This Contract shall commence on the Effective Date and shall continue in full force and effect through «CurrentExpiration» ("**Term**"), unless earlier terminated, as provided in this Contract.

14. Termination.

14.1. Termination without Cause. CalOptima may terminate this Contract at any time, in whole or in part, for its convenience and without cause, by giving CONTRACTOR thirty (30) days' prior written notice. Upon termination, CalOptima shall pay CONTRACTOR all fees and other charges due and payable for services satisfactorily performed and accepted by CalOptima as of the termination date. Thereafter, CONTRACTOR shall have no further claims against CalOptima under this Contract.

[optional mutual without cause termination]

Termination without Cause: Either Party may terminate this Contract at any time, in whole or in part, for its convenience and without cause, by giving the other Party sixty (60) days' prior written notice. Upon termination, CalOptima shall pay CONTRACTOR all fees and other charges due and payable for services satisfactorily performed and accepted by CalOptima as of the termination date.

14.2. Termination for Unavailability of Funds. In recognition that CalOptima is a governmental entity and its operations and budgets are determined on an annual basis, CalOptima shall have the right to terminate this Contract as follows:

14.2.1. CalOptima may terminate this Contract if it does not receive funding from the State of California or the federal government, as applicable, for any fiscal year.

14.2.2. In the event of termination under Section 14.2.1, CalOptima agrees to promptly pay CONTRACTOR all fees and other charges due and payable for services satisfactorily performed and accepted by CalOptima as of the termination date. CONTRACTOR shall not be entitled to payment for any other items, including lost or anticipated profit on work not performed, administrative costs, attorneys' fees, or consultants' fees.

14.3. Termination for Default. CalOptima may immediately terminate this Contract upon notice to CONTRACTOR for (i) CONTRACTOR's default, (ii) if a federal or state proceeding for the relief of debtors is undertaken by or against CONTRACTOR; or (iii) if CONTRACTOR makes an assignment, as defined in Section 11, for the benefit of creditors ("**Termination for Default**").

14.4. Termination for Breach. Either Party may at its option, terminate this Contract by notice to the other Party if the other Party breaches one of its obligations under this Contract and fails to cure that breach or default within thirty (30) days after receiving notice identifying that breach. The rights described in this Section 14.4 to terminate this Contract shall be in addition to any other remedy available to the non-breaching Party, whether under this Contract or in law or equity, on account of that breach.

14.5. Notwithstanding the foregoing, CalOptima may terminate this Contract immediately upon CONTRACTOR's breach of Section 3 (Insurance) or Section 8 (Confidential Material).

14.6. Effect of Termination. Upon expiration or receipt of a termination notice under this Section 14:

14.6.1. CONTRACTOR shall promptly discontinue all services (unless CalOptima's notice directs otherwise) and deliver or otherwise make available to CALOPTIMA all documents, reports, software programs, and any other products, data and such other materials, equipment, and information, including Confidential Information, or equipment provided by CalOptima, as may have been accumulated by CONTRACTOR in performing this Contract, whether completed or in process. If CONTRACTOR personnel were granted access to CalOptima's premises and issued a badge or access card, such badge or access card shall be returned prior to departure.

14.6.2. CalOptima may take over the services and may award another party a contract to complete the services under this Contract.

15. Dispute Resolution.

15.1. Meet and Confer. If either Party has a dispute arising under or related to this Contract, the Parties shall informally meet and confer to try and resolve the dispute. The Parties shall meet and confer within thirty (30) days of a written request submitted by either Party in an effort to settle any dispute. At each meet-and-confer meeting, each Party shall be represented by persons with final authority to settle the dispute. If either Party fails to meet within the thirty (30)-day period, that Party shall be deemed to have waived the meet-and-confer requirement, and at the other Party's option, the dispute may proceed immediately to arbitration under Section 15.2.

15.2. Subject to the California Government Claims Act (Cal. Gov. Code §900 *et seq*.) governing claims against public entities, either Party may submit the dispute for resolution exclusively through confidential, binding arbitration, instead of through trial by court or jury, in Orange County, California. The Parties may agree in writing prior to commencing the arbitration on the dispute resolution rules and arbitration service that will be used to resolve the dispute. If the Parties cannot reach such an agreement, the arbitration will be conducted by Judicial Arbitration and Mediation Services ("**JAMS**") in accordance with the commercial dispute rules then in effect for JAMS; provided, however, that this Contract shall control in instances where it conflicts with JAMS's (or the applicable arbitration service's) rules. The arbitration shall be conducted on an expedited basis by a single arbitrator. The Parties prefer that the arbitrator be a retired judge of the California Superior, Appellate, or Supreme Court or of a United States court sitting in California. If no such retired judge is available, the arbitrator may be an attorney with at least fifteen (15) years of experience, including at least five (5) years in managed health care. If the Parties are unable to agree on the arbitrator within thirty (30) days of the date that the arbitration service accepts the arbitration, the arbitrator shall be selected by the arbitration service from a list of four potential arbitrators (all of whom shall be on arbitration services' panel of arbitrators) submitted by the Parties, two from each side; provided, however, that nothing stated in this section shall prevent a Party from disqualifying an arbitrator based on a conflict of interest. In making decisions about discovery and case management, it is the Parties' express agreement and intent that the arbitrator at all times promote efficiency without denying either Party the ability to present relevant evidence. In reaching and issuing decisions, the arbitrator shall have no jurisdiction to make errors of law and/or legal reasoning. The Parties shall share the costs of arbitration equally, and each Party shall bear its own attorneys' fees and costs.

15.3. Exclusive Remedy. With the exception of any dispute that under applicable laws may not be settled through arbitration, arbitration under Section 15.2 is the exclusive method to resolve a dispute between the Parties arising out of or relating to this Contract that is not resolved through the meet-and-confer processes.

15.4. Waiver. By agreeing to binding arbitration as set forth in Section 15.2, the Parties acknowledge that they are waiving certain substantial rights and protections which otherwise may be available if a dispute between them was determined by litigation in a court, including the right to a jury trial, attorneys' fees, and certain rights of appeal.

16. General Provisions.

16.1. Non-Exclusive Relationship. This is a non-exclusive relationship between CalOptima and CONTRACTOR. CalOptima shall have the right to have any of the services that are the subject of this Contract performed by CalOptima personnel or enter into contractual arrangements with one or more contractors who can provide CalOptima with similar or like services.

16.2. Compliance with Applicable Law and Policies. CONTRACTOR warrants that, in the performance of this Contract, it shall, at its own expense, observe and comply with all applicable federal, state, and local laws, and CalOptima vendor policies relating to services under the Contract that are in effect when this Contract is signed or that come into effect during the Term and are available to CONTRACTOR on CalOptima's website.

16.3. Names and Marks. Neither Party shall use the name, logo or other proprietary mark of the other Party in any press release, advertising, promotional, marketing or similar publicly disseminated material without obtaining the other Party's express written approval of the material and consent to such use.

16.4. Time is of the Essence. Time is of the essence in performance of this Contract.

16.5. Choice of Law. This Contract shall be governed by and construed in accordance with all laws of the State of California. If any Party institutes legal proceedings to enforce or interpret this Contract, venue and jurisdiction shall be in the County of Orange, California.

16.6. Force Majeure. When satisfactory evidence of a cause beyond a Party's control is presented to the other Party, and nonperformance is unforeseeable, beyond the control, and not due to the fault of the Party not performing, a Party shall be excused from performing its obligations under this Contract during the time and to the extent that it is prevented from performing by such cause, including any incidence of fire, flood, acts of God, commandeering of material, products, plants or facilities by the federal, state or local governments, or a material act or omission by the other Party. A Party invoking this clause shall provide the other Party with prompt written notice of any delay or failure to perform that occurs by reason of force majeure. If the force majeure event continues for a period of XX (XX) days, the Party unaffected by the force majeure event may terminate this Contract upon notice to the other Party.

16.7. Notices. All notices required or permitted under this Contract shall be in writing and shall be sent by registered or certified mail, postage prepaid, return receipt requested, or by any other overnight delivery service which delivers to the noticed destination and provides proof of delivery to the sender. All notices shall be effective when first received at the following addresses set forth below. Any notice not related to termination of this Contract may be submitted electronically to the address set forth below. Any Party whose address changes shall notify the other Party in writing.

To CONTRACTOR:	**To CalOptima:**
	CalOptima
	505 City Parkway West
	Orange, CA 92868
	Attention:
	Email:

16.8. Notice of Labor Disputes. Whenever CONTRACTOR has knowledge that any actual or potential labor dispute may delay this Contract, CONTRACTOR shall immediately notify and submit all relevant information to CalOptima.

16.9. No Liability of County of Orange. As required under Ordinance No. 3896 of the County of Orange, State of California, as amended, the Parties agree that the obligations of CalOptima under this Contract are solely the obligations of CalOptima, and the County of Orange, State of California, shall have no obligation or liability related to this Contract. [County of Orange Ordinance No 3896, codified in Orange County Municipal Code Section 4-11-7(a)]

16.10. Entire Agreement. This Contract, including all exhibits, addenda, and Contract Documents, contains the entire agreement between CONTRACTOR and CalOptima with respect to the subject matter of this Contract, and it supersedes all prior written or oral and all or contemporaneous oral agreements, representations, understandings, discussions, negotiations, and commitments between CONTRACTOR and CalOptima, whether express or implied, with respect to the subject matter of this Contract.

16.11. Waiver. Any failure of a Party to insist upon strict compliance with any provision of this Contract shall not be deemed a waiver of such provision or any other provision of this Contract. To be effective, a waiver must be in a writing that is signed and dated by the Parties. A waiver by either of the Parties of a breach of any of the covenants, conditions, or agreements to be performed by the other Party shall not be construed to be a waiver of any succeeding breach of the Contract or of any other covenant or condition of the Contract. Any information delivered, exchanged, or otherwise provided hereunder shall be delivered, exchanged, or otherwise provided in a manner that does not constitute a waiver of immunity or privilege under applicable law.

16.12. Survival. The following provisions of this Contract shall survive termination or expiration of this Contract: Sections 4 (Indemnification), 5 (Independent Contractor), 8 (Confidential Material), 9 (California Public Records Act), 14.6 (Effect of Termination), 15 (Dispute Resolution), 16.3 (Names and Marks), 16.5 (Choice of Law), 16.9 (No Liability of County of Orange), this Section 16.12, 16.14 (Interpretation), 16.15 (Third-Party Beneficiaries), 16.16 (Successors and Assigns) and any other Contract provisions that by their nature are intended to survive termination or expiration of this Contract.

16.13. Severability. If any section, subsection or provision of this Contract, or the application of such section, subsection or provision, is held invalid or unenforceable by any court of competent jurisdiction, the remainder of this Contract, other than that to which it is held invalid, shall remain in effect.

16.14. Interpretation. The terms of this Contract are the result of negotiation between the Parties. Accordingly, any rule of construction of contracts (including California Civil Code Section 1654) that ambiguities are to be construed against the drafting party shall not be employed in the interpretation of this Contract.

16.15. Third Party Beneficiaries. There are no intended third-party beneficiaries of this Contract. Nothing in this Contract shall be construed as conferring any rights on any other persons.

16.16. Successors and Assigns. Except as otherwise expressly provided in this Contract, this Contract will be binding on, and will inure to the benefit of, the successors and permitted assigns of the Parties. Nothing in this Contract is intended to confer upon any party other than the Parties or their respective successors and permitted assigns any rights or obligations under or by reason of this Contract, except as expressly provided in this Contract.

16.17. Without Limitation. Any reference in the Contract to “include(s)” or “including” means inclusion without limitation, unless otherwise distinguished within the text.

16.18. Authority to Execute. The persons executing this Contract on behalf of the Parties warrant that they are duly authorized to execute this Contract and that by executing this Contract the Parties are formally bound.

16.19. Counterparts. This Contract may be executed and delivered in one or more counterparts, each of which shall be deemed an original, but all of which together will constitute one and the same instrument.

16.20. Recitals and Exhibits. The recitals, exhibits, and addenda attached to this Contract are made a part of the Contract by this reference.

[*Signatures on following page*]

IN WITNESS WHEREOF, these Parties have, by their duly authorized representatives, executed this Contract No. «Internal Number» on the day and year last shown below.

«Company Name»	CalOptima
By:	By:
Print Name:	Print Name:
Title: Date:	Title: Date:

By:	By:
Print Name:	Print Name:
Title: Date:	Title: Date:

EXHIBIT A
Scope of Work

1. **Description of Work**

[add for each RFP]

2. **Definitions**

2.1. Definitions. In addition to the terms used in this Exhibit A and otherwise defined in the Contract, the following definitions apply to this Exhibit A.

2.1.1. "**Agent**" means an individual appropriately licensed as a California Life licensee or Accident & Health licensee and authorized by CONTRACTOR to market and sell Medicare Advantage ("**MA**") and Medi-Cal health plans and enroll eligible Medicare and Medi-Cal beneficiaries on behalf of CONTRACTOR.

2.1.2. "**CalOptima Programs**" means the Medi-Cal and Medicare Advantage programs administered by CalOptima. [revise programs listed as applicable to the broker]

2.1.3. "**Member**" means any person who is eligible to receive benefits from and is enrolled in a CalOptima Program.

3. **CONTRACTOR Relationship with CalOptima**

3.1. Appointment of CONTRACTOR. CalOptima appoints CONTRACTOR and its Agents as agents of CalOptima to market and sell CalOptima Programs. CONTRACTOR consents to CalOptima submitting notice of this appointment to any applicable regulatory agencies, thereby allowing CalOptima to fulfill any obligation it may have under applicable laws, including California Insurance Code Section 1704. Nothing precludes CalOptima from appointing other entities and individuals, for the purposes of marketing and selling any other CalOptima Programs. CONTRACTOR and Agents may solicit and procure applications from interested and eligible applicants pursuant to CalOptima forms, applications, and agreements to process enrollments in compliance with standards and requirements that may be established by CalOptima as governed by CMS and DHCS.

3.2. Subagents. CONTRACTOR may endorse and supervise subagents to market and sell CalOptima Programs under this Contract. Any such subagents shall be licensed as required by law and applicable regulations. Further, CONTRACTOR is required to ensure that any agreements with subagents or other subcontracted agents shall be in writing and comply with all applicable provisions in this Contract and all applicable laws and regulations including, without limitation, laws and regulations governing Medi-Cal and Medicare programs, and the Medicare Communications and Marketing Guidelines ("**MCMG**"), as modified or clarified in state-specific marketing guidance for Medi-Cal or Medicare.

3.3. Marketing by CONTRACTOR and Independent Agents.

3.3.1. CONTRACTOR and its Agents are hereby authorized to market CalOptima Programs, provided that CONTRACTOR and its Agents have successfully completed certification training for each contract year, acceptable to CalOptima, and in compliance with all applicable laws and regulations, including laws and regulations governing Medi-Cal and Medicare programs and the MCMG, as modified or clarified in state-specific marketing guidance for Medi-Cal or MA. CONTRACTOR and its Agents must correctly answer no less than eighty-five percent (85%) of the certification examination questions to achieve a passing score.

3.3.2. CONTRACTOR and its Agents agree to abide by any restrictions imposed by regulatory agencies that regulate CalOptima Programs.

3.3.3. CONTRACTOR shall promptly notify CalOptima of any disciplinary proceedings against CONTRACTOR relating to any license issued to it by the California Insurance Commissioner

3.4. Use of Employed Agents by CalOptima. Nothing in this Contract shall be construed to preclude CalOptima from also using its own employees and other contracted agents to market CalOptima Programs. This Contract shall not be construed to limit the right of CalOptima to market a CalOptima Program under any other name in association with any other party.

3.5. Indebtedness. CONTRACTOR and CalOptima each shall be responsible for their own indebtedness unless otherwise agreed to in writing. CONTRACTOR and CalOptima shall not incur any indebtedness in the name of, or on behalf of, the other for advertising, office rent, clerical help or any other purpose whatsoever.

4. **Responsibilities of the Parties**

4.1. Promotional Material/Advertising Copy. CONTRACTOR shall develop drafts of the promotional material and advertising copy called for by the marketing plan and forward it to CalOptima for approval. CalOptima shall endeavor to secure the approval(s) required by any governmental agency having a right of review or approval. CalOptima and CONTRACTOR shall cooperate to make any change in the material required by the reviewing agencies. All materials developed and prepared by CONTRACTOR that utilize CalOptima's name, logos, or other service marks or trademarks shall utilize such name and marks in a manner consistent with graphic or other usage standards developed by CalOptima from time to time. All uses of the names and marks will be subject to prior approval by CalOptima. CONTRACTOR acknowledges and agrees that CalOptima's logo and other marks registered by CalOptima belong solely to CalOptima. In the event of termination of this Contract, CONTRACTOR agrees to destroy or return to CalOptima all materials containing CalOptima's name and marks and to refrain from any and all future use thereof.

4.2. Processing of Member Intake Forms. Completed intake forms for applicants shall be reviewed upon receipt by CONTRACTOR for completeness. If incomplete, CONTRACTOR shall make its best efforts to obtain any missing information. Whenever possible, and in accordance with all federal and state laws and regulations and the MCMG, the applicant shall be contacted, in person or by telephone, by CONTRACTOR to confirm that the prospective Member fully understands his or her obligations, CalOptima requirements, and the benefits available under CalOptima Programs. CalOptima may contact the prospective Member by telephone to assure full understanding of his or her obligations and benefits.

4.3. Application and Eligibility. CalOptima shall process all applications acceptable to CalOptima in CalOptima's reasonable discretion in accordance with procedures established by CMS and DHCS. An enrollment shall be effective on the day designated by DHCS and/or CMS. CalOptima shall provide CONTRACTOR with the date of eligibility of each Member as reported to CalOptima by DHCS and CMS. However, CalOptima shall not be held responsible for failure of DHCS and CMS to maintain or provide accurate or timely eligibility information.

4.4. Local Sales and Service. CONTRACTOR shall establish and maintain records and other resources necessary to assist and respond to questions by Members for whom CONTRACTOR receives commissions pursuant to this Contract.

4.5. Receipt of CalOptima Funds. If CONTRACTOR receives funds for the account of CalOptima, the following provisions shall apply:

4.5.1. Any such funds received by CONTRACTOR for the account of CalOptima shall at all times be segregated from the assets of CONTRACTOR and shall be deposited no later than the business day following their receipt by CONTRACTOR to a trust account for the benefit of CalOptima in a state or federal bank authorized to do business in California and insured by appropriate federal insurance.

4.5.2. CONTRACTOR shall transmit to CalOptima any such funds received by CONTRACTOR for the account of CalOptima within five (5) business days following CONTRACTOR's receipt of such funds.

4.5.3. The payment to CONTRACTOR of any premiums for CalOptima coverage by or on behalf of Members shall be deemed to have been received by CalOptima, and the payment of return premiums by CalOptima to CONTRACTOR shall not be deemed payment to Medicare Members until such payments are received by the Members. Nothing in this Section 4.5 shall limit any rights of CalOptima against CONTRACTOR resulting from its failure to make payments to CalOptima.

5. CONTRACTOR's Responsibilities

5.1. Application Services. CONTRACTOR shall use CalOptima's intake forms and other DHCS/CMS-approved application forms. CONTRACTOR agrees to use its best efforts to be diligent in ensuring that the facts set forth by an applicant on the intake form or enrollment application are true and correct. CONTRACTOR shall fully inform each applicant that CalOptima will rely solely upon these representations in rejecting, conditionally accepting, or enrolling the applicant and that the subsequent discovery by CalOptima of material facts known by applicant and either not disclosed or misrepresented on the application may result in the rescission or cancellation by CalOptima of coverage. CONTRACTOR shall receive all enrollment applications directly from contracted Agents or prospected individuals and shall initially verify any such forms received for their completeness, eligibility, and accuracy within two (2) business days of receipt. After verification, CONTRACTOR shall promptly forward all completed applications to CalOptima for processing.

5.2. Distribution of Premium Information to Members. CONTRACTOR and its Agents shall inform prospective Members how premium payments, if any, for the CalOptima Programs are to be made, as prescribed by CalOptima and consistent with CMS and DHCS requirements, provided that such notice shall be given prior to or at the time application information is accepted from prospective Members. CONTRACTOR shall immediately remit to CalOptima, for credit only against the proper account, any and all monies received on behalf of CalOptima as full or partial payment of initial premiums, bills, accounts, charges, and other items of any nature whatsoever and, until such monies are remitted, hold them in trust for the benefit of CalOptima in separate accounts, not comingled with CONTRACTOR's other funds. CONTRACTOR is not authorized to negotiate any check made payable to CalOptima.

5.3. Distribution of Information to Members. CONTRACTOR shall promptly forward to individuals any information provided to CONTRATOR by CalOptima for distribution. CONTRACTOR agrees to promptly forward to CalOptima any information from individuals that is or reasonably may be relevant to an applicant or Member's eligibility or coverage status. CONTRACTOR further agrees to promptly forward to CalOptima full particulars of all inquiries and other relevant correspondence received by CONTRACTOR from individuals and Members.

5.4. Support Services. CONTRACTOR and its Agents agree to render services to prospective Members, including all necessary support services for presentations, as required by CalOptima and conduct activities in such a manner so as not to affect adversely the business or reputation of CalOptima.

5.5. Agent Training and Testing. CONTRACTOR and its Agents agree to participate in and cooperate with CalOptima's ongoing education and training programs. CONTRACTOR shall at all times be and remain knowledgeable about the CalOptima Program requirements and CONTRACTOR's and Agents' obligations, all as promulgated by regulatory agencies and CalOptima.

5.6. Agency Compliance Oversight.

5.6.1. If CONTRACTOR or its Agents engage in behavior that is unethical, violates applicable laws, regulations or guidelines, or harms the reputation of CalOptima, CalOptima may request in writing that CONTRACTOR take appropriate corrective action, including the immediate suspension of marketing or selling of CalOptima Programs until CalOptima determines that appropriate corrective action has been implemented.

5.6.2. CalOptima is responsible for oversight or CONTRACTOR and Agents and will audit CONTRACTOR's compliance with applicable regulatory requirements.

5.6.3. CalOptima has established an anti-fraud plan to organize and implement an anti-fraud strategy to identify and reduce costs to CalOptima, Member, providers, and others caused by fraudulent activities and to protect consumers through the timely detection, investigation and prosecution of suspected fraud. CONTRACTOR and its Agents or subagents shall adhere to and comply with the requirements of CalOptima's anti-fraud plan or shall maintain its own anti-fraud/compliance program that meets or exceeds the standards of CalOptima's anti-fraud plan. Pursuant to CMS requirements and federal regulations, CONTRACTOR shall, on an annual basis, conduct training regarding measures to detect, correct and prevent fraud, waste and abuse in connection with services provided under this Contract. Further, CONTRACTOR shall, on an annual basis, review and attest to the review, understanding of and adherence to CalOptima's Code of Conduct.

5.7. Licensure. CONTRACTOR represents that it and its Agents have active licenses required by applicable law to perform the services under this Contract. CONTRACTOR and its Agents must maintain an active California license for Accident & Health ("**AH**") or Life ("**LO**") and maintain education up to date on American's Health Insurance Plans ("**AHIP**"). CONTRACTOR shall not solicit for CalOptima unless CONTRACTOR has the required licenses and governmental approvals to do so. CONTRACTOR shall maintain any such required licensure at its own sole cost and expense and shall immediately notify CalOptima of any termination, suspension, or expiration of any license, including those of its Agents. In addition, CONTRACTOR shall promptly notify CalOptima of any complaint, inquiry, regulatory investigation. or disciplinary proceeding against CONTRACTOR or any of its Agents relating to any license or any violation of insurance consumer protection or other laws or regulations. CONTRACTOR shall provide CalOptima with evidence of CONTRACTOR's current licensure and insurance coverage.

5.7.1. CONTRACTOR agrees that CalOptima, as CMS and DHCS contractor, may require that a specific Agent or subagent be removed from selling CalOptima Programs if the Agent or subagent has three sales allegations against him or her within a twelve (12)-month period.

5.7.2. CONTRACTOR may not process any CalOptima appeals or grievances. Appeals and grievances shall be referred to CalOptima within twenty-four (24) hours of receipt by CONTRACTOR. CONTRACTOR agrees to cooperate with CalOptima in the processing of any appeals or grievances.

5.7.3. If any Agent, subagent, or employee of CONTRACTOR engages in practices or conduct that is unethical, that materially violate a law or regulation applicable to CalOptima's business, or that CalOptima determines is harmful to its reputation, CalOptima may request in writing (the "**Request**") that appropriate corrective action may be taken with regard to such Agent, subagent, or

employee, including the immediate cessation of the marketing of CalOptima Programs by that person. With respect to any such Request, CalOptima shall describe the improper practices or conduct with specificity and describe the corrective action, if any, that CalOptima considers necessary or appropriate. CONTRACTOR shall promptly take appropriate corrective action.

5.7.4. CONTRACTOR shall have the right to select Agents, subagents, contractors, or subcontractors; however, CONTRACTOR understands and agrees that CalOptima retains the right to approve, suspend or terminate any such arrangement.

5.8. Marketing. CONTRACTOR agrees to market CalOptima Programs in accordance with the terms and conditions of this Contract. Within sixty (60) days after the Effective Date, CONTRACTOR shall prepare and submit to CalOptima a business and marketing plan ("**Work Plan**") that includes, among other specifications, minimum quarterly enrollment benchmarks ("**Enrollment Benchmarks**") and maximum disenrollment percentage thresholds ("**Disenrollment Thresholds**"). Within five (5) business days of receiving the Work Plan, CalOptima shall submit any modification or revision requests to CONTRACTOR, who shall update the Work Plan accordingly and submit a final draft to CalOptima for its review and final approval.

5.9. Regulatory Compliance. CONTRACTOR shall comply the Medicare Marketing Guidelines and CalOptima's contractual obligations under its agreements with CMS and DHCS. CONTRACTOR acknowledges that the payments it receives under this Contract are, in whole or in part, from federal funds, and CONTRACTOR may be subject to laws related to receiving federal funds. By entering into this Contract, CONTRACTOR acknowledges that it has received, read and understands the MCMG and that it will ensure that its Agents, subagents and other representatives shall receive, read and understand the MCMG. Applicable standards include, but are not limited to, the Sales and Marketing Guidelines as outlined in Exhibit C and CalOptima's applicable policies and procedures.

5.10. Quarterly Review. On a quarterly basis, CONTRACTOR, in collaboration with CalOptima, shall review Member enrollments and disenrollments in accordance with the Enrollment Benchmarks and Disenrollment Thresholds set forth in the Work Plan, as well as review all agents' productivity to ensure active enrollment in CalOptima Programs.

5.11. Reports. CONTRACTOR shall submit to CalOptima such reports as may be required from time to time by CalOptima pursuant to CalOptima's policies and procedures and regulatory requirements.

5.12. Limitations on Authority. Notwithstanding any other provision in this Contract, CONTRACTOR shall not have the authority to represent itself as having the authority to, or do any of the following:

5.12.1. Hold itself out as an employee, partner, joint venture or associate of CalOptima, or hold itself out as an agent of CalOptima in any manner or for any purpose, except as specified in this Contract;

5.12.2. Alter, modify, waive or change any of the terms, rates or conditions of any advertisements or other promotional literature, receipts, policies or contracts of CalOptima in any respect;

5.12.3. Insert any advertising with respect to CalOptima or CalOptima Programs in any publication whatsoever, distribute any promotional literature or other information in any media, or use the logos or marks of CalOptima without prior written approval from CalOptima;

5.12.4. Collect, or authorize any other persons to collect, any premiums or other payments on behalf of CalOptima whatsoever, except the initial month's premium if authorized by CalOptima to do so;

5.12.5. Bind CalOptima on any application, it being expressly understood that all applications must be approved by CalOptima and CMS and/or DHCS;

5.12.6. Incur any indebtedness or liability, make, alter or discharge contracts, waive or forfeit any of CalOptima's rights, requirements or conditions under CMC, extend time of payment of any premium or waive payment in cash on behalf of CalOptima;

5.12.7. Transfer or sell the business of the CONTRACTOR created by this Contract, without CalOptima's prior written consent, it being acknowledged and agreed by CONTRACTOR that such business belongs exclusively to CalOptima; or

5.12.8. Deduct any payments due CONTRACTOR from premiums or payments collected on behalf of CalOptima.

5.13. Separate Funds. CONTRACTOR shall not accept or receive funds from Members or CMS/DHCS on behalf of CalOptima at any time.

5.14. Insurance. Throughout the Term, and for a period of one (1) year thereafter if the insurance is claims-based, CONTRACTOR shall, at its own expense, maintain all of the insurance required in this Section 5.14 and shall not provide any services under this Contract if it is not in compliance with this Section 5.14. Procurement of insurance by CONTRACTOR shall not be construed as a limitation of CONTRACTOR's liability or as full performance of CONTRACTOR's duties to indemnify, hold harmless and defend CalOptima under this Contract.

5.14.1. Commercial General Liability Insurance, including bodily injury, property damage, personal injury, advertising injury, and products/completed operations, with a limit of not less than two million dollars ($2,000,000) per occurrence and four million dollars ($4,000,000) in the aggregate.

5.14.2. Worker's Compensation and Employer's Liability Insurance covering all of CONTRACTOR's Agents, subagents, brokers, and other personnel and employees performing the services pursuant to this Contract. Worker's Compensation insurance will be in accordance with the worker's compensation laws and requirements for the State of California. Employer's Liability Insurance shall be provided with limits of not less than one million dollars ($1,000,000) each disease and a One Million Dollars ($1,000,000) disease policy limit.

5.14.3. Professional Liability Insurance covering the negligent acts, errors or omissions committed by CONTRACTOR, its Agents, subagents, and other personnel pursuant to rendering services under this Contract with limits of not less than one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) in the aggregate.

6. CalOptima's Responsibilities

6.1. Marketing Materials and Forms. CalOptima shall provide CONTRACTOR with all CMS-approved marketing brochures and materials to be used in connection with the marketing and sale of CalOptima Programs. Any such templates may not be modified or incorporated into other materials without the prior written consent of CalOptima. CONTRACTOR acknowledges and agrees that it may incur expenses in connection with the preparation, production, or reproduction of marketing materials provided or made available by CalOptima. CalOptima shall also provide CONTRACTOR with any and all forms to be used in connection with enrollment and the provision of other services under this Contract.

6.2. Enrollment. CalOptima shall receive completed enrollment applications from CONTRACTOR and shall review such applications with respect to CalOptima's enrollment criteria and submit complete applications to DHCS and CMS. Notwithstanding the foregoing, CalOptima reserves the right to accept or reject any enrollment application, regardless of any determination made by CONTRACTOR regarding completeness or eligibility.

6.3. CalOptima's Right to Service Enrollees. Notwithstanding any other provision of this Contract, CalOptima may, at any time during the Term or following the termination of this Contract, take any actions and make

any communication necessary to allow CalOptima to fulfill its obligations to continue to provide coverage to Members, pursuant to its benefit agreement with such Members, and CMS and DHCS requirements. CONTRACTOR shall provide any information required by CalOptima to fulfill such obligation.

6.4. Rights of CalOptima. This Contract is subject to the right of CalOptima to:

6.4.1. Decline acceptance of any application deemed not acceptable by CalOptima, DHCS, or CMS, as determined in their sole discretions;

6.4.2. Amend or rescind any benefit agreements and all other rights under the terms of any issued policies;

6.4.3. Monitor the services performed by CONTRACTOR, its Agents and subagents; and

6.4.4. Modify any CalOptima policy.

7. **Standard of Performance; Warranties**.

7.1. CONTRACTOR agrees to perform all work under this Contract with the requisite skill and diligence consistent with professional standards for the industry and type of work performed under this Contract, and pursuant to the governing rules and regulations of the industry.

7.2. If CONTRACTOR may subcontract for services under this Contract, then CONTRACTOR represents and warrants that any individual or entity acting as a subcontractor to this Contract has the appropriate skill and expertise to perform the subcontracted work and will comply with all applicable provisions of this Contract.

7.3. CONTRACTOR's obligations under this Section 7 are in addition to CONTRACTOR's other express or implied warranties and other obligations under this Contract or state law, and in no way diminish any other rights that CalOptima may have against CONTRACTOR for faulty materials, equipment or work. CalOptima rejects any disclaimer by CONTRACTOR of any warranty, standard, implied or express, unless specifically agreed to in writing by both Parties.

8. **Record Ownership and Retention**.

8.1. Records. CONTRACTOR shall keep full, complete and accurate records of all transactions pertaining to this Contract and any and all other records pertaining to enrollments submitted and accepted hereunder, and any and all other records that may be required by any governmental entity or regulatory agency in connection with CONTRACTOR's relationship with CalOptima, its Members, and the public. CONTRACTOR shall preserve all books and records as required in Exhibit C.

8.2. The originals of all letters, documents, reports, and any other products and data prepared or generated for the purposes of this Contract shall be delivered to and become the property of CalOptima at no cost to CalOptima and in a form accessible for CalOptima's use. Copies may be made for CONTRACTOR's records but shall not be furnished to others without written authorization from CalOptima. Such deliverables shall become the sole property of CalOptima and all rights in copyright therein shall be retained by CalOptima. CalOptima's ownership of these documents includes use of, reproduction or reuse of, and all incidental rights. CONTRACTOR shall provide all deliverables within a reasonable amount of time upon CalOptima's request, but in no event shall such time exceed thirty (30) calendar days unless otherwise specified by CalOptima.

8.3. CONTRACTOR hereby assigns to CalOptima all of its rights in all materials prepared by or on behalf of CalOptima under this Contract ("**Works**"), and this Contract shall be deemed a transfer to CalOptima of the sole and exclusive copyright of any copyrightable subject matter CONTRACTOR created in these Works. CONTRACTOR agrees to cause its agents and employees to execute any documents necessary to secure or perfect CalOptima's legal rights and worldwide ownership in such materials, including

documents relating to patent, trademark and copyright applications. Upon CalOptima's request, CONTRACTOR will return or transfer all property and materials, including the Works, in CONTRACTOR's possession or control belonging to CalOptima.

8.4. CONTRACTOR acknowledges and agrees that, notwithstanding any provision herein to the contrary, CalOptima's Intellectual Property ("**CalOptima IP**") in the information, documents and other materials provided to CONTRACTOR shall remain the sole and exclusive property of CalOptima. Any information, documents or materials provided by CalOptima to CONTRACTOR pursuant to this Contract and all copies thereof (including CalOptima IP and Confidential Information) shall upon the earlier of CalOptima's request or the expiration or termination of this Contract be returned to CalOptima. For purposes of this Section 8.4, Intellectual Property means patents, copyrights, trademarks, trade secrets, and other proprietary information.

EXHIBIT A
Addendum 1

The following is a list of subcontractors approved to perform Services under this Contract:

Subcontractor Name	Functions

EXHIBIT B
Compensation Schedule

1. **Scope**. CONTRACTOR shall accept the compensation set forth in this Exhibit B as payment in full for all services performed and for all expenses incurred by CONTRACTOR under this Contract. Compensation shall only be made for the number of months that a Member is enrolled in the compensation year. Each compensation year will begin from January 1 through December 31, regardless of the date of enrollment. CalOptima shall calculate the total amount due CONTRACTOR for individuals enrolled as Members according to CMS's and DHCS's records, less any amount to be charged back. CONTRACTOR shall have no claim to commission except as provided herein. This compensation structure observes, and is subject to, present and future compensation guidelines or future regulations from CMS including those set forth in 42 C.F.R. §§422.2274(a) and 423.2274(a); and CMS 4138-IFC.

2. **First-Year Commission**. All new Member enrollments produced in a given calendar month by CONTRACTOR and its Agents for CalOptima Programs, as confirmed by CMS or DHCS, will be reimbursed as follows:

   2.1. CONTRACTOR shall receive total compensation of [insert amount] dollars ($[insert amount]) for each initial enrollment of a new Member in a CalOptima Program. CONTRACTOR shall pay to Agent, subagent, or CONTRACTOR's downstream broker, at or below the fair market value cut off amount published yearly by CMS, the amount of [insert amount] dollars ($[insert amount]) for each initial enrollment of a new Member in a CalOptima Program and retain [insert amount] dollars ($[insert amount]) as a management fee. The management fee is to cover Member service and retention services. Unless revised by CMS regulation, CONTRACTOR shall be paid in accordance with CMS requirements and 42 C.F.R §422.2274(a)(l)(iii) for new Members enrolling in a CalOptima Medicare Program.

   2.2. CalOptima will determine what constitutes an initial year enrollment in accordance with federal guidelines and regulations, including 42 C.F.R. §§422.2274 and 423.2274. In accordance with Medicare regulations CMS-4131-F and 4138-IFC, any first year Member who is transferring from a "Like Plan" (MA-PD) will be subject to the renewal Rate below.

3. **Timeframe of Commission Payment**. CalOptima shall process the commission reports for the CONTRACTOR by the 15th of the month immediately following submission of an application for enrollment, provided the enrollment application was accepted and processed by CalOptima and received final enrollment approval from DHCS or CMS. Notwithstanding the foregoing, CalOptima will pay all commission payments within the calendar year in which enrollment is effective.

4. **Renewal Commission**. Renewal commission* will be paid in accordance with state and federal requirements. As such, CONTRACTOR will receive lifetime renewal compensation for the preceding year after the second year in which the Member remains covered under a CalOptima Program. The renewal commission shall be as follows:

   4.1. [client to complete].

   4.2. CalOptima will determine what constitutes a renewal year enrollment in accordance with state and federal guidelines and regulations, including 42 C.F.R. § 422.2274.

5. **Timeframe of Renewal Commission Payment**. CalOptima shall pay renewal commission to CONTRACTOR beginning to complete a lifetime compensation cycle, so long as Member remains covered continuously by a CalOptima Program. Renewal commission payments will continue with every contract renewal.

6. **Charge Backs**. The initial commissions as set forth in this Exhibit B will be charged back by CalOptima from the CONTRACTOR if the Member dis-enrolls within three (3) months following the Member's enrollment effective date. Further, CONTRACTOR shall not be entitled to continued compensation should any Member dis-enroll from a CalOptima Program between month four (4) and month twelve (12) following the initial contract effective date. CalOptima will recover any compensation paid for a period in which a Member is not enrolled in a CalOptima Program. CalOptima may adjust or offset CONTRACTOR's compensation to recoup payments made on behalf of a Member that CMS or DHCS has dis-enrolled or determined as ineligible and for which CMS or DHCS has made retroactive adjustments to CalOptima's payment.

7. **Performance Measures**. CONTRACTOR will be evaluated through two (2) key performance measures: enrollment production and the quality of enrollment production. CalOptima will conduct quarterly reviews of the CONTRACTOR. This includes tracking of Enrollment Benchmarks as established in the Work Plan. In addition, CalOptima will evaluate the quality of the enrollment production, including disenrollment, sales allegations, and marketing misrepresentations. Should the performance of the CONTRACTOR not fall within measures designated by the Work Plan, CalOptima reserves the right to take action as necessary as outlined in the terms of this Contract.

EXHIBIT C
Regulatory Requirements

CalOptima is a public agency and is licensed by the DMHC. In addition, CalOptima arranges for the provision of Medi-Cal services to Medi-Cal beneficiaries under a contract with DHCS ("**DHCS Contract**") and Medicare Advantage ("**MA**") services to Medicare beneficiaries under a contract CMS ("**CMS Contract**"). This Exhibit C sets forth the statutory, regulatory, and contractual requirements that CalOptima must incorporate into the Contract as a public agency and DMHC-licensed health care service plan with MA and Medi-Cal products.

1. **Medi-Cal Requirements**.

1.1. Compliance with Medi-Cal Standards. CONTRACTOR agrees that the Contract shall be governed by and construed in accordance with all laws and applicable regulations governing the DHCS Contract. CONTRACTOR shall comply with all applicable requirements of the Medi-Cal program and comply with all monitoring of the DHCS Contract and any other monitoring requests by DHCS.

1.2. Disclosure of Officers, Owners, Stockholders and Creditors. Pursuant to Exhibit E, Attachment 2, Section 33 (a) of the DHCS Contract and 42 C.F.R. Section 455.104, upon the Effective Date, on an annual basis, and within thirty (30) days of any changes, CONTRACTOR shall identify the names of the following persons by listing them on Exhibit D of this Contract and submitting the form to CalOptima:

1.2.1. All officers and owners who own greater than five percent (5%) of the CONTRACTOR;

1.2.2. All stockholders owning greater than five percent (5%) of any stock issued by CONTRACTOR; and

1.2.3. All creditors of CONTRACTOR's business if such interest is over five percent (5%).

1.3. Compliance with Employment and Labor Laws. Each Party shall, at its own expense, comply with all applicable laws in performing their respective obligations under the Contract, including, but not limited to, the National Labor Relations Act, the Americans With Disabilities Act, all applicable employment discrimination laws, overtime laws, tax laws, immigration laws, workers' compensation laws, occupational safety and health laws, and unemployment insurance laws and any regulations related thereto. CONTRACTOR acknowledges and agrees that:

1.3.1. CONTRACTOR and its subcontractors will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. CONTRACTOR and its subcontractors will take affirmative action to ensure that qualified applicants are employed and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age, or status as a disabled veteran or veteran of the Vietnam era. Such action shall include the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. CONTRACTOR and its subcontractors agree to post in conspicuous places, available to employees and applicants for employment, notices 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 shall state CONTRACTOR and its subcontractors' obligation 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. [DHCS Contract, Exhibit D(F), Provision 1, Section A]

1.3.2. CONTRACTOR and its subcontractors will, in all solicitations or advancements for employees placed by or on behalf of CONTRACTOR and its subcontractors, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin, physical or mental handicap, disability, age, or status as a disabled veteran or veteran of the Vietnam era. [DHCS Contract, Exhibit D(F), Provision 1, Section B]

1.3.3. CONTRACTOR and its subcontractors will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the federal government or the State of California, advising the labor union or workers' representative of CONTRACTOR and its subcontractors' commitments under this Section 1.3 and shall post copies of the notice in conspicuous places available to employees and applicants for employment. [DHCS Contract, Exhibit D(F), Provision 1, Section C]

1.3.4. CONTRACTOR and its subcontractors will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212), and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity", and as supplemented by regulation at 41 C.F.R. 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. [DHCS Contract, Exhibit D(F), Provision 1, Section D]

1.3.5. CONTRACTOR and its subcontractors will furnish all information and reports required by Federal Executive Order No. 11246, as amended, including by Executive Order 11375, "Amending Executive Order No. 11246, Relating to Equal Employment Opportunity", and as supplemented by regulation at 41 C.F.R. 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. [DHCS Contract, Exhibit D(F), Provision 1, Section E]

1.3.6. If CONTRACTOR and its subcontractors' do not comply with the requirements of this Section 1.3 or with any federal rules, regulations, or orders referenced herein, this Contract may be cancelled, terminated, or suspended in whole or in part, and CONTRACTOR and its subcontractors may be declared ineligible for further federal and state contracts, in accordance with procedures authorized in Federal Executive Order No. 11246, as amended, and such other sanctions may be imposed and remedies invoked as provided in Federal Executive Order No. 11246, as amended, including by Executive Order 11375, "Amending Executive Order No. 11246 Relating to Equal Employment Opportunity", and as supplemented by regulation at 41 C.F.R. 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. [DHCS Contract, Exhibit D(F), Provision 1, Section F]

1.3.7. CONTRACTOR and its subcontractors will include the provisions of this Section 1.3 in every subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor, issued pursuant to Federal Executive Order No. 11246, as amended, including by Executive Order 11375, "Amending Executive Order No. 11246 Relating to Equal Employment Opportunity", and as supplemented by regulation at 41 C.F.R. 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. CONTRACTOR and its subcontractors will take such action with respect to any subcontract or purchase order as the Director of the Office of Federal Contract Compliance Programs or DHCS may direct as a means of enforcing such provisions, including sanctions for noncompliance;

provided, however, that if CONTRACTOR and its subcontractors become involved in, or are threatened with litigation by a subcontractor as a result of such direction by DHCS, CONTRACTOR and its subcontractors may request in writing to DHCS, which, in turn, may request the United States to enter into such litigation to protect the interests of the State of California and of the United States. [DHCS Contract, Exhibit D(F), Provision 1.G]

1.4. Debarment and Suspension Certification.

1.4.1. By signing this Contract, the CONTRACTOR agrees to comply with any and all applicable federal suspension and debarment regulations, including, as applicable, 7 C.F.R. 3017, 45 C.F.R. 76, 40 C.F.R. 32, or 34 C.F.R. 85. [DHCS Contract, Exhibit D(F), Provision 19, Section A]

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

1.4.2.1. Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any state or federal department or agency; [DHCS Contract, Exhibit D(F), Provision 19, Section B.1]

1.4.2.2. Have not within a three (3)-year period preceding this Contract been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, state or local) transaction or contract under a public transaction; violation of federal or state anti-trust statutes; or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property; [DHCS Contract, Exhibit D(F), Provision 19, Section B.2]

1.4.2.3. Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (federal, state or local) with commission of any of the offenses enumerated in Section 1.4.2.2 of this Exhibit C; [DHCS Contract, Exhibit D(F), Provision 19, Section B.3]

1.4.2.4. Have not within a three (3)-year period preceding the Effective Date of this Contract had one or more public transactions (federal, state or local) terminated for cause or default; [DHCS Contract, Exhibit D(F), Provision 19, Section B.4]

1.4.2.5. Have not and shall not knowingly enter into any lower-tier covered transaction with a person who is proposed for debarment under federal regulations (i.e., 48 C.F.R. 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State of California; and [DHCS Contract, Exhibit D(F), Provision 19, Section B.5]

1.4.2.6. Will include a clause entitled, "Debarment and Suspension Certification" that sets forth the provisions herein in all lower-tier covered transactions and in all solicitations for lower-tier covered transactions. [DHCS Contract, Exhibit D(F), Provision 19, Section B.6]

1.4.3. If the CONTRACTOR is unable to certify to any of the statements in this certification, the CONTRACTOR shall submit an explanation to CalOptima. [DHCS Contract, Exhibit D(F), Provision 19, Section C]

1.4.4. The terms and definitions herein have the meanings set out in the Definitions and Coverage sections of the rules implementing Federal Executive Order 12549. [DHCS Contract, Exhibit D(F), Provision 19, Section D]

1.4.5. If the CONTRACTOR knowingly violates this certification, in addition to other remedies available to the federal government, CalOptima may terminate this Contract for cause or default. [DHCS Contract, Exhibit D(F), Provision 19, Section E]

1.5. Lobbying Restrictions and Disclosure Certification.

1.5.1. *Certification and Disclosure Requirements*.

1.5.1.1. If Contract is subject to 31 U.S.C. § 1352 and exceeds $100,000 at any tier, CONTRACTOR and its subcontractors, as applicable, shall file a certification (in the form set forth in Exhibit E, consisting of one page, entitled "Certification Regarding Lobbying") that CONTRACTOR and its subcontractors, as applicable, have not made, and will not make, any payment prohibited by Section 1.5.2 below. [DHCS Contract, Exhibit D(F), Provision 31, Section A.1; 31 U.S.C. § 1352]

1.5.1.2. CONTRACTOR and its subcontractors, as applicable, shall file a disclosure (in the form set forth in Exhibit E, entitled "Certification Regarding Lobbying") if CONTRACTOR and its subcontractors, as applicable, have made or agreed to make any payment using non-appropriated funds (to include profits from any covered federal action) in connection with the Contract or a subcontract thereunder that would be prohibited under Section 1.5.2 below if paid for with appropriated funds. [DHCS Contract, Exhibit D(F), Provision 31, Section A.2]

1.5.1.3. CONTRACTOR and its subcontractors, as applicable, shall file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affect the accuracy of the information contained in any disclosure form previously filed by CONTRACTOR and its subcontractors, as applicable, under this Section 1.5.1. An event that materially affects the accuracy of the information reported includes: [DHCS Contract, Exhibit D(F), Provision 31, Section A.3]

1.5.1.3.1. A cumulative increase of $25,000 or more in the amount paid or expected to be paid for influencing or attempting to influence a covered federal action; [DHCS Contract, Exhibit D(F), Provision 31, Section A.3.a]

1.5.1.3.2. A change in the person(s) or individuals(s) influencing or attempting to influence a covered federal action; or [DHCS Contract, Exhibit D(F), Provision 31, Section A.3.b]

1.5.1.3.3. A change in the officer(s), employee(s), or member(s) contacted for the purpose of influencing or attempting to influence a covered federal action. [DHCS Contract, Exhibit D(F), Provision 31, Section A.3.c]

1.5.1.3.4. As applicable and required by this Section 1.5, CONTRACTOR's subcontractors shall file a certification and a disclosure form, if required, to the next tier above. [DHCS Contract, Exhibit D(F), Provision 31, Section A.4]

1.5.1.3.5. All disclosure forms (but not certifications) shall be forwarded from tier to tier until received by CONTRACTOR. CONTRACTOR shall forward all disclosure forms to CalOptima. [DHCS Contract, Exhibit D(F), Provision 31, Section A.5]

1.5.2. *Prohibition*. 31 U.S.C. § 1352 provides in part that no appropriated funds may be expended by the recipient of a federal contract, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in

connection with any of the following covered federal actions: the awarding of any federal contract, the making of any federal grant, the making of any federal loan, entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement. [DHCS Contract, Exhibit D(F), Provision 31, Section B]

1.6. Verification of CalOptima Costs by Government. Until the expiration of ten (10) years after the later of furnishing of any service pursuant to this Contract or completion of any audit, or longer as required by applicable regulations, CONTRACTOR will make available, upon written request of CalOptima, the Secretary of Health and Human Services ("**HHS**") Office of Inspector General, the Comptroller General of the United States, the U.S. Department of Justice, DHCS, the DMHC, the Bureau of Medical Fraud, or any of their duly authorized representatives copies of this Contract and any financial statements, books, documents, records, patient care documentation, and other records or data of CONTRACTOR that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under this Contract, or as are otherwise necessary to certify the nature and extent of costs incurred by CalOptima for such services. This provision shall also apply to any agreement with a CONTRACTOR subcontractor or an organization related to a CONTRACTOR subcontractor by control or common ownership. CONTRACTOR further agrees that regulating entities have the right to inspect, evaluate and audit any pertinent information and to facilitate the review of the items referenced herein, to make available its premises, physical facilities and equipment, records related to Medicare enrollees, and any additional relevant information that regulating entities may require. CONTRACTOR further agrees and acknowledges that this provision will be included in any and all agreements with CONTRACTOR's subcontractors. [DHCS Contract, Exhibit E, Attachment 2, Provision 20]

1.7. Confidentiality of Member Information.

1.7.1. If CONTRACTOR and its employees, agents, or subcontractors access or receive, whether intentionally or unintentionally, personally identifying information during the Term, CONRACTOR and its employees, agents, and subcontractors shall protect from unauthorized disclosure, the names and other identifying information concerning persons either receiving services pursuant to this Contract, or persons whose names or identifying information become available or are disclosed to CONTRACTOR, its employees, agents, or subcontractors as a result of services performed under this Contract, except for statistical information not identifying any such person. CONTRACTOR and its employees, agents, or subcontractors shall not use such identifying information for any purpose other than carrying out the express terms of and CONTRACTOR's obligations under this Contract. CONTRACTOR and its employees, agents, or subcontractors shall promptly transmit to CalOptima all requests for disclosure of such identifying information, except requests for medical records in accordance with applicable law, not emanating from the CalOptima member. CONTRACTOR shall not disclose, except as otherwise specifically permitted by this Contract or authorized by the CalOptima member, any such identifying information to anyone other than DHCS or CalOptima without prior written authorization from CalOptima specifying that the information is releasable under Title 42 C.F.R. Section 431.300 *et seq*., Section 14100.2, Welfare and Institutions Code, and regulations adopted there under. For purposes of this Section 1.7, identity shall include name, identifying number, symbol, or other identifying detail assigned to the individual, such as finger or voice print or a photograph. [DHCS Contract, Exhibit D(F), Provision 12, Exhibit E, Attachment 2, Provision 22, Section B]

1.7.2. Names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with Title 42 C.F.R. Section 431.300 *et seq*., Section 14100.2, Welfare and Institutions Code, and regulations adopted thereunder. For the purpose of this Contract, all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to CalOptima members shall be protected by CONTRACTOR from unauthorized disclosure. CONTRACTOR may release Medical Records in accordance with applicable law pertaining to the release of this type of information. CONTRACTOR is not required to report requests for Medical Records made in accordance with applicable law. With respect to any identifiable information concerning a CalOptima member

under this Contract that is obtained by CONTRACTOR or its subcontractors, CONTRACTOR will, at the termination of this Contract, return all such information to CalOptima or maintain such information according to written procedures sent to the CONTRACTOR by CalOptima for this purpose. [DHCS Contract, Exhibit E, Attachment 2, Provision 22]

1.8. Member Hold Harmless. To the extent CONTRACTOR provides services or supplies to CalOptima members, CONTRACTOR hereby agrees that in no event, including nonpayment by CalOptima, the insolvency of CalOptima, or breach of the Contract, shall CONTRACTOR bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against CalOptima members, persons acting on their behalf, or DHCS. CONTRACTOR further agrees that this hold harmless provision shall survive the termination of the Contract regardless of the cause giving rise to the termination, shall be construed to be for the benefit of CalOptima members, and that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between CalOptima or CONTRACTOR and a CalOptima member or persons acting on their behalf that relates to liability for payment for services under the Contract. [DHCS Contract, Exhibit A, Attachment 6, Provision 13, Section B.15; CMS Medicare Managed Care Manual Chapter 11, Section 100.4]

1.9. Air and Water Pollution Requirements. If this Contract or any subcontract thereunder is in excess of one hundred thousand dollars ($100,000), CONTRACTOR agrees to comply with all applicable standards, orders, or requirements issued under the Clean Air Act (42 USC § 7401 *et seq*.), as amended, and the Federal Water Pollution Control Act (33 USC § 1251 *et seq*.), as amended. [DHCS Contract, Exhibit D(F), Provision 11]

2. **Medicare Requirements**.

2.1. CONTRACTOR expressly warrants that CONTRACTOR and CONTRACTOR's subcontractors, if any, shall comply with all applicable Medicare laws, regulations, and CMS instructions. CONTRACTOR further agrees and acknowledges that this provision will be included in all agreements with CONTRACTOR's subcontractors.

2.2. For any medical records or other health and enrollment information CONTRACTOR maintains with respect to Medicare enrollees, CONTRACTOR shall establish procedures to:

2.2.1. Abide by all federal and state laws regarding confidentiality and disclosure of medical records and other health and enrollment information. CONTRACTOR shall safeguard the privacy of any information that identifies a particular enrollee and shall have procedures that specify: (a) the purposes for which the information will be used within CONTRACTOR's organization; and (b) to whom and for what purposes CONTRACTOR will disclose the information.

2.2.2. Ensure that the medical information is used and released only in accordance with applicable federal or state law, or pursuant to court orders or subpoenas.

2.2.3. Maintain the records and information in an accurate and timely manner.

2.3. CONTRACTOR shall comply with the reporting requirements provided in 42 C.F.R. § 422.516, as well as the encounter data submission requirements in 42 C.F.R. § 422.257.

2.4. For all contracts in the amount of $100,000 or more, CONTRACTOR and CONTRACTOR's subcontractors, if any, shall comply with 41 C.F.R. 60-300.5(a) and 41 C.F.R. 60-741.5(a) as follows:

2.4.1. CONTRACTOR and Subcontractor shall abide by the requirements of 41 C.F.R. § 60-300.5(a). This regulation prohibits discrimination against qualified protected veterans and requires affirmative action by covered prime contractors and subcontractors to employ and advance in employment qualified protected veterans. [41 C.F.R. § 60-300.5(d)]

2.4.2. CONTRACTOR and subcontractor shall abide by the requirements of 41 C.F.R. § 60-741.5(a). This regulation prohibits discrimination against qualified individuals on the basis of disability and requires affirmative action by covered prime contractors and subcontractors to employ and advance in employment qualified individuals with disabilities. [41 C.F.R. § 60-741.5(d)]

2.5. In addition to the termination provisions of Section 14 of the Contract, CalOptima may terminate the Contract if CMS or CalOptima determines that CONTRACTOR has not satisfactorily performed its obligations under the Contract. Under such circumstances, CalOptima may pay CONTRACTOR its allowable costs incurred to the date of termination. Thereafter, CONTRACTOR shall have no further claims against CalOptima for matters pertaining to this Contract.

2.6. While CalOptima maintains ultimate responsibility for adhering to and complying with all terms and conditions of the CMS Contract, CONTRACTOR shall comply with all such applicable requirements in the CMS Contract, at the direction of CalOptima.

2.7. CONTRACTOR shall ensure that the persons it employs or contracts with for the provision of services pursuant to the Contract are in good standing and not on the preclusion list, defined in 42 C.F.R. § 422.2. CONTRACTOR shall promptly disclose to CalOptima any exclusion or other event that makes a CONTRACTOR employee or subcontractor ineligible to perform work related to federal health care programs. CONTRACTOR agrees to be bound by the provisions set forth at 2 C.F.R. Part 376. [42 C.F.R. § 422.752(a)(8)]

2.8. FDR Compliance. Upon execution of this Contract, CONTRACTOR agrees to execute and abide by the terms of the "FDR Compliance Attestation" in Exhibit F and shall submit an executed FDR Compliance Attestation no less than annually thereafter. [Delete if CONTRACTOR is not a FDR.]

3. **Marketing Requirements**.

3.1. CONTRACTOR shall comply all applicable DHCS and CMS instructions and guidelines, including the MCMG and CMS marketing guidelines.

3.2. CONTRACTOR shall not solicit or sell CalOptima Programs to individuals in a physician's office, waiting room, or examining room, or in other areas in which patients primarily intend to receive health care services.

3.3. CONTRACTOR agrees to make the following disclosure, prior to enrollment or at the time of enrollment, in writing, for each individual: "The person that is discussing plan options with you is neither employed by or contracted with CalOptima. The person may be compensated based on your enrollment in the plan."

3.4. CalOptima's compensation to CONTRACTOR complies with applicable federal regulations and guidance on the payment of agents and brokers pursuant to 42 C.F.R. §§ 422 and 423, and any implementation guidance or instructions issued by CMS or DHCS.

3.5. CONTRACTOR, its Agents, subagents, brokers or other representatives cannot engage in activities that may mislead or confuse potential Members or misrepresent CalOptima. Such prohibited activities include the following:

3.5.1. Claiming recommendation or endorsement by CMS, Medicare, HHS, or DHCS or that CMS, Medicare, HHS, or DHCS recommend that individuals enroll in a CalOptima Program;

3.5.2. Making erroneous written or verbal statements, including any statement, claim or promise that conflicts with, materially alters or erroneously expands upon the information contained in the CMS-approved materials;

3.5.3. Using providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have received prior approval from CMS;

3.5.4. Using providers to accept enrollment applications or offer inducement to persuade individuals to join a CalOptima Program;

3.5.5. Using providers to offer anything of value to induce Members to select them as a provider;

3.5.6. Accepting CalOptima's enrollment applications in provider offices or other places where health care is delivered, except in the case where such activities are conducted in common areas in the health care setting;

3.5.7. Conducting sales presentations or distributing and accepting applications at educational events;

3.5.8. Providing meals regardless of value at sales events;

3.5.9. Marketing non-health related products to prospective Members during any CMC sales activity or presentation;

3.5.10. Marketing health-related products beyond the scope agreed upon by the Member and documented by CalOptima prior to the appointment;

3.5.11. Offering gifts or payment as an inducement to enroll in a CalOptima Program;

3.5.12. Offering cash gifts, including charitable contributions made on behalf of people attending a marketing presentation and gift certificates and gift cards that can be readily converted to cash;

3.5.13. Engaging in any discriminatory marketing practice, such as targeted marketing to Medicare or Medicaid beneficiaries from higher income areas, without making comparable efforts to enroll Medicare or Medicaid beneficiaries from lower income areas;

3.5.14. Using high-pressure sales tactics to enroll individuals into a CalOptima Program or require an in-home appointment;

3.5.15. Sending unsolicited emails unless an individual agrees to receive emails;

3.5.16. Buying or renting email lists to distribute information about CalOptima Programs;

3.5.17. Making unsolicited telephone calls to prospective Members;

3.5.18. Conducting door-to-door solicitation of Medicare or Medicaid beneficiaries or through other unsolicited means of direct contact, including contacting the beneficiary without the beneficiary initiating contact;

3.5.19. Distributing marketing materials prior to being CalOptima and CMS or DHCS approved;

3.5.20. Charging a marketing fee to Medicare or Medicaid beneficiaries; or

3.5.21. Engaging in any other marketing activity prohibited by CMS or DHCS in its marketing guidance.

3.6. Any marketing representative who is meeting with a potential Member must clearly identify the types of products that he or she will be discussing before marketing those products to the potential Member. The CMS approved Scope of Appointment form is required prior to any face-to-face personal or individual marketing appointment, and must be turned in to CalOptima with each completed application form.

3.7. Payment by any person marketing CalOptima Programs to anyone else is prohibited.

3.8. CONTRACTOR's compensation structure avoids incentives toward misleading potential Members, "cherry picking" certain individuals, or churning Members between CalOptima and any other health plan.

3.9. Third-Party Marketing Organizations Requirements. CONTRACTOR and its subcontractors shall comply with all CMS requirements applicable to third-party marketing organizations, as outlined in 42 C.F.R §§ 422.2260, 422.2267(e)(41), and 422.2274 and set forth in this Section 3.9.

3.9.1. If CONTRACTOR sells MA plans on behalf more than one MA organization, CONTRACTOR shall comply with the following disclaimer requirements unless CONTRACTOR sells all commercially available MA plans in a given service area:

3.9.1.1. Use the disclaimer language provided by CMS as may be amended or updated by CMS: "We do not offer every plan available in your area. Any information we provide is limited to those plans we do offer in your area. Please contact Medicare.gov or 1–800–MEDICARE to get information on all of your options."

3.9.1.2. Verbally convey the disclaimer within the first minute of a sales call.

3.9.1.3. Electronically convey the disclaimer when communicating with a Member or potential Member through email, online chat, or other electronic means of communication;

3.9.1.4. Prominently display the disclaimer on CONTRACTOR's websites.

3.9.1.5. Include the disclaimer in any marketing materials, including print materials and television advertisements, developed, used or distributed by the CONTRACTOR.

3.9.2. CONTRACTOR shall disclose to CalOptima any subcontracted relationships used for marketing, lead generation, and enrollment.

3.9.3. CONTRACTOR shall record calls with Member or potential Members in their entirety, including the enrollment process.

3.9.4. CONTRACTOR shall report to CalOptima monthly any staff disciplinary actions or violations of any requirements that apply to CalOptima's Program for MA Members associated with Member interactions.

3.9.5. When conducting lead generation activities, CONTRACTOR shall disclose to the Member or potential Member that his or her information will be provided to a licensed Agent for future contact. This disclosure must be provided as follows:

3.9.5.1. Verbally when communicating with a Member or potential Member through telephone.

3.9.5.2. In writing when communicating with a Member or potential Member through mail or other written format.

3.9.5.3. Electronically when communicating with a Member or potential Member through email, online chat, or other electronic messaging platform.

3.9.6. CONTRACTOR shall disclose to the Member or potential Member that he or she is being transferred to a licensed Agent who can enroll him or her into a new plan.

4. **Offshore Performance**.

4.1. Due to security and identity protection concerns, direct services under this Contract shall not be performed by offshore subcontractors, unless otherwise authorized in writing by CalOptima prior to the provision of those services.

4.2. CONTRACTOR shall complete, sign, and return Exhibit G, "Attestation Concerning the Use of Offshore Subcontractors" as of the Effective Date and shall submit an executed Offshore Subcontractor Attestation to CalOptima no less than annually thereafter. CONTRACTOR represents and warrants that it has disclosed in Exhibit G any and all such offshore subcontractors and that it has obtained CalOptima's written approval to use such offshore subcontractors prior to the Effective Date.

4.3. Any subcontract with an offshore entity under which the offshore entity will have access to any confidential CalOptima member or other protected health information must be approved in writing by CalOptima prior to execution of the subcontract. CONTRACTOR is required to submit future Offshore Contractor Attestations to CalOptima within thirty (30) calendar days after it has signed a contract with any subcontractor that may be using an offshore subcontractor to perform any related work.

4.4. Unless specifically stated otherwise in this Contract, the restrictions of this Section 4 do not apply to indirect or "overhead" services, or services that are incidental to the performance of the Contract.

4.5. The provisions of this Section 4 apply to work performed by subcontractors at all tiers.

5. **Prohibited Interest**.

5.1. CONTRACTOR shall comply with all applicable federal, state, and local laws and regulations pertaining to conflict-of-interest laws, including CalOptima's Conflict of Interest Code, the California Political Reform Act (California Government Code § 81000 *et seq*.) and California Government Code § 1090 *et seq*. (collectively, the "**Conflict of Interest Laws**").

5.2. CONTRACTOR covenants that, to the best of its knowledge during the Term, no director, officer, or employee of CalOptima during his or her tenure has any interest, direct or indirect, in this Contract or the proceeds thereof. CONTRACTOR further covenants that, for the Term, and consistent with the provisions of 22 C.C.R. § 53600(f), no state officer or state employee shall be employed in a management or contractor position by CONTRACTOR within one (1) year after the state office or state employee has terminated state employment.

5.3. CONTRACTOR, and any person designated by CONTRACTOR to make or participate in making a governmental decision on behalf of CalOptima, is considered a "**Consultant**" pursuant to CalOptima's Conflict of Interest Code and shall be required to file a statement of economic interests (Fair Political Practices Commission Form 700) with CalOptima annually. [2 C.C.R. Section 18734]

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

5.5. If CONTRACTOR becomes aware of any facts that might reasonably be expected to either create a conflict of interest under the Conflict of Interest Laws or violate the provisions of this Section 5, CONTRACTOR shall immediately make full written disclosure of such acts to CalOptima. Full written disclosure shall include identification of all persons, entities, and businesses implicated and a complete description of all relevant circumstances.

6. **State Auditor Audit Disclosure**. Pursuant to California Government Code § 8546.7, if this Contract is more than ten thousand dollars ($10,000), it is subject to examination and audit of the California State Auditor, at the request of CalOptima or as part of any audit of CalOptima for a period of three (3) years after final payment under this Contract. In addition to and notwithstanding any other right of access or inspection that may be otherwise set forth in this Contract, CONTRACTOR agrees that during the Term and for a period of three (3) years after its termination, CalOptima shall have access to and the right to examine any directly pertinent books, documents, invoices, and records of CONTRACTOR relating to services provided under this Contract. Where another right of access or inspection in this Contract provides for a period of greater than three (3) years, nothing herein shall be construed to shorten that time period. [Gov't Code § 8546.7]

EXHIBIT D
Medi-Cal Disclosure Form

CONTRACTOR Officer, Owner, Shareholder, and Creditor Information

CONTRACTOR's Business Name: _____

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

Business Address: _____

City:_____ State:_____ Zip:_____
Business Phone:_____ Email: :_____
President: _____ Contact Person:_____

Person(s) Signing Contract & Title: :_____

*Please provide names of owners, officers, stockholders, and creditors of CONTRACTOR's business if such interest is over 5%.

Name	Officer Title or Ownership/Creditorship %
_____	_____
_____	_____
_____	_____
_____	_____

BY SIGNING BELOW, THE UNDERSIGNED HEREBY CERTIFIES THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF HIS OR HER KNOWLEDGE AND BELIEF.

_____ _____
Authorized Signature Date

_____
Name and Title

EXHIBIT E

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES
CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the making, awarding or entering into of this federal contract, federal grant, or cooperative agreement, and the extension, continuation, renewal, amendment, or modification of this federal contract, grant, or cooperative agreement.

(2) If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency of the United States Government, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, or cooperative agreement, the undersigned shall complete and submit Standard Form LLL, "Disclosure of Lobbying Activities"' in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontractors, subgrants, and contracts under grants and cooperative agreements) of $100,000 or more, and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S.C., any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

_____	_____
Name of CONTRACTOR	Printed Name of Person Signing for CONTRACTOR
_____	_____
Contract/Grant Number	Signature of Person Signing for CONTRACTOR
_____	_____
Date	Title

After execution by or on behalf of CONTRACTOR, please return to:

Department of Health Care Services
Medi-Cal Managed Care Division
MS 4415, 1501 Capitol Avenue, Suite 71.4001
P.O. Box 997413
Sacramento, CA 95899-7413

CERTIFICATION REGARDING LOBBYING

Approved by OMB 0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure)

1. Type of Federal Action: ☐a. contract ☐b. grant ☐c. cooperative agreement ☐d. loan ☐e. loan guarantee ☐f. loan insurance	2. Status of Federal Action: ☐a. bid/offer/application ☐b. initial award ☐c. post-award	3. Report Type: ☐a. initial filing ☐b. material change **For Material Change Only:** Year _____ quarter_____ date of last report _____

4. Name and Address of Reporting Entity: ☐ Prime ☐ Subawardee Tier ____, *if known*: Congressional District, *if known*:	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime: Congressional District, *if known*:
6. Federal Department/Agency:	7. Federal Program Name/Description: CDFA Number, *if applicable*:
8. Federal Action Number, *if known*:	9. Award Amount, *if known*: $_____
10. a. Name and Address of Lobbying Entity (*If individual, last name, first name, MI*):	b. Name and Address of Lobbying Entity (If individual, last name, first name, MI):

(*attach Continuation Sheet(s) SF-LLLA, if necessary)*

11. Amount of Payment (check all that apply): $_____ ☐actual ☐planned	13. Type of Payment ☐ a. retainer ☐ b. one-time fee ☐ c. commission ☐ d. contingent fee ☐ e. deferred ☐ f. other, specify: _____
12. Form of Payment (check all that apply): ☐ a. cash ☐ b. in-kind, specify: Nature _____ Value _____	

14. Brief Description of Services Performed or to be Performed and Dates(s) of Service, including Officer(s), Employee(s), or Member(s) Contracted for Payment indicated in item 11:

(Attach Continuation Sheet(s) SF-LLL-A, If necessary)

15. Continuation Sheet(s) SF-LLL-A Attached: ☐Yes ☐No

16. Information requested through this form is authorized by Title 31, U.S.C., Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to Title 31, U.S.C., Section 1352. This information will be reported to the Congress semiannually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.	Signature: Print Name: Title: Telephone No.: Date:

Federal Use Only	Authorized for Local Reproduction Standard Form-LLL

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime federal recipients at the initiation or receipt of a covered federal action, or a material change to a previous filing, pursuant to Title 31, U.S.C., Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered federal action. Use the SF - LLL- A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered federal action.

2. Identify the status of the covered federal action.

3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered federal action.

4. Enter the full name, address, city, state, and ZIP code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants, and contract awards under grants.

5. If the organization filing the report in Item 4 checks "Subawardee," then enter the full name, address, city, state, and ZIP code of the prime federal recipient. Include Congressional District, if known.

6. Enter the name of the federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation United States Coast Guard.

7. Enter the federal program name or description for the covered federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CDFA) number for grants, cooperative agreements, loans, and loan commitments.

8. Enter the most appropriate federal identifying number available for the federal action identified in Item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract grant, or loan award number; the application/proposal control number assigned by the federal agency). Include prefixes, e.g., "RFP-DE-90401."

9. For a covered federal action where there has been an award or loan commitment by the federal agency, enter the federal amount of the award/loan commitment for the prime entity identified in Item 4 or 5.

10. (a) Enter the full name, address, city, state, and ZIP code of the lobbying entity engaged by the reporting entity identified in Item 4 to influence the covered federal action.

    (b) Enter the full names of the Individual(s) performing services and include full address if different from 10.(a). Enter last name, first name, and middle initial (MI).

11. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (Item 4) to the lobbying entity (Item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

12. Check the appropriate box(es). Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.

13. Check the appropriate box(es). Check all boxes that apply. If other, specify nature.

14. Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with federal officials. Identify the federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.

15. Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.

16. The certifying official shall sign and date the form, print his/her name, title, and telephone number.

EXHIBIT F
FDR Attestation

FDR COMPLIANCE ATTESTATION

Please complete and execute this attestation and return it to CalOptima's Office of Compliance via email Compliance@caloptima.org , or mail: CalOptima, Office of Compliance, Attn: Annie Phillips 505 City Parkway West, Orange, CA 92868, within thirty (30) calendar days for (existing FDRs) or sixty (60) calendar days for (new FDRs) of this notice.

Which CalOptima program(s) does this form pertain to? Select all that apply:	☐OneCare Connect ☐OneCare HMO SNP	☐Medi Cal ☐PACE

I hereby attest that [_____ (the "Organization")], and all its downstream entities, if any, that are involved in the provision of health or administrative services for any of the CalOptima programs identified above:

I. **General and HIPAA Compliance and FWA Training.** Provide effective Fraud, Waste and Abuse training, General Compliance training, General HIPAA training to all Organization and downstream entity board members, officers, employees, temporary employees, and volunteers, within ninety (90) calendar days of appointment, hire or contracting, as applicable, and at least annually thereafter as a condition of appointment, employment or contracting. The Organization and its downstream entities currently use (Select all that apply):

☐ CMS's Fraud, Waste, and Abuse training, General Compliance training, and General HIPAA training module. (The Organization shall maintain records per CMS retention requirement)

☐ An internal training program that meets CMS's Fraud, Waste, and Abuse training, General Compliance training, and HIPAA training module requirements. (The Organization shall maintain records per CMS retention requirement)
Note: If selecting an internal training program that meets CMS's FWA, HIPAA, and General Compliance, please submit a copy of your organization's trainings to CalOptima's Office of Compliance for review, and to ensure they meet CMS's requirements.

II. Administer specialized compliance training to Organization and downstream entity board members, employees, temporary employees, and volunteers: (i) based on their job function within the first ninety (90) days of hire and at least annually thereafter as a condition of appointment, employment or contracting, (ii) when requirements change: (iii) when such persons work in an area previously found to be non- compliant with program requirements or implicated in past misconduct.

III. **Compliance Plan and Code of Conduct Requirements.** Have established and publicized compliance policies and procedures, standards of conduct, and compliance reference material that meet the requirements outlined in 42 CFR § 422.503(b)(4)(vi)(A) and 42 CFR § 423.504(b)(4)(vi)(A) which information, and any updates thereto, are distributed to all Organization and downstream entity board members, officers, employees, temporary employees, and volunteers within ninety (90) days of appointment, hire or contracting, as applicable, and at least annually thereafter. Evidence of receipt of such compliance by such persons is obtained and retained by the Organization. (Select which applies to your organization):

☐ Organization has adopted, implemented, and distributed CalOptima's Compliance Plan and Code of Conduct

☐ Organization has distributed a comparable Compliance Plan and Code of Conduct
Note: If selecting a comparable Compliance Plan and Code of Conduct, please submit a copy of your organization's Compliance Plan and Code of Conduct to CalOptima's Office of Compliance for review, and to ensure they meet CMS's requirements

IV. **Exclusion Monitoring**. Review all Organization and downstream entity board members, officers, potential and actual employees, temporary employees, and volunteers against the (Suspended and Ineligible Provider List) S & I Medi-Cal, (Health and Human Services) HHS, (Office of Inspector General) OIG List of Excluded Individuals & Entities list, (System for Award Management) SAM/(General Services Administration) GSA Debarment list, Centers for Medicare & Medicaid Services (CMS) Preclusion List (as applicable), (here after "Lists") upon appointment, hire or contracting, as applicable, and monthly thereafter. Further, in the event that the Organization or downstream entity becomes aware that any of the foregoing persons or entities are included on these Lists, the Organization will notify CalOptima within five (5) calendar days, the relationship with the listed person/entity will be terminated as it relates to CalOptima, and appropriate corrective action will be taken.

V. **Conflict of Interest**. Screen the Organization and its subcontractors' governing bodies for conflicts of interest as defined in state and federal law and CalOptima policies and procedures upon hire or contracting and annually thereafter.

VI. **Reporting of FWA/Non-Compliance**. Will report suspected fraud, waste, and abuse, as well as all other forms of non- compliance, as it relates to CalOptima, confidentially and anonymously.

VII. **Disciplinary Action**. Understand that any violation of any laws, regulations, or CalOptima policies and procedures are grounds for disciplinary action, up to and including termination of Organization's contractual status.

VIII **Non-Retaliation**. Are aware that persons reporting suspected fraud, waste, and abuse, and other non- compliance are protected from retaliation under the False Claims Act and other applicable laws prohibiting retaliation.

IX. **Records Management**. Retain documented evidence of compliance with the above, including training and exclusion screening (i.e. sign-in sheets, certificates, attestations, OIG and GSA search results, etc.) for at least ten (10) years, and provide such documentation to CalOptima upon request.

The individual signing below is knowledgeable about and authorized to attest to the foregoing matters on behalf of the Organization.

_____	_____
Signature	Date
_____	_____
Name (Print)	Organization
_____	
Email (Print)	

EXHIBIT G

CalOptima
Better. Together.

Attestation Concerning the Use of Offshore Subcontractors

If Organization offshores any protected health information (PHI) it must notify CalOptima prior to entering into or amending any agreement with an Offshore Subcontractor, and Contractor must complete the Offshore Subcontracting Attestation.

Which CalOptima program(s) does this form pertain to? Select all that apply.	☐ OneCare Connect ☐ PACE ☐ OneCare ☐ Medi-Cal
Please check one of the following: ☐ Our Organization does not offshore any protected health information. **Please skip to Part V below** ☐ Our Organization does offshore protected health information. **Please complete Offshore Subcontractor Attestation (Part I through Part V) below**	

Part I — Offshore Subcontractor Information	
Attestation	**Response**
Our Organization uses an offshore subcontractor or offshore staff to perform functions that support our contract with CalOptima	☐ Yes ☐ No
Offshore Subcontractor name:	
Offshore Subcontractor country:	
Offshore Subcontractor address:	
Describe offshore subcontractor functions:	
Proposed or actual effective date for offshore subcontractor (MM/DD/Year):	

Part II — Precautions for Protected Health Information (PHI)	
Question	**Response**
1. Describe the PHI that will be provided to the offshore subcontractor	
2. Explain why providing PHI is necessary to accomplish the offshore subcontractor's objectives:	
3. Describe alternatives considered to avoid providing PHI, and why each alternative was rejected:	

Part III — Attestation of Safeguards to Protect Beneficiary Information in the Offshore Subcontract	
Attestation	**Response**
A. Offshore subcontracting arrangement has policies and procedures in place to ensure that Medicare beneficiary protected health information (PHI) and other personal information remains secure.	☐ Yes ☐ No*
B. Offshore subcontracting arrangement prohibits subcontractor's access to Medicare data not associated with CalOptima's contract with the offshore subcontractor.	☐ Yes ☐ No*
C. Offshore subcontracting arrangement has policies and procedures in place that allow for immediate termination of the subcontract upon discovery of a significant security breach.	☐ Yes ☐ No*
D. Offshore subcontracting arrangement includes all required Medicare Part C and D language (e.g., record retention requirements, compliance with all Medicare Part C and D requirements, etc.)	☐ Yes ☐ No*

Part IV — Attestation of Audit Requirements to Ensure Protection of PHI	
Attestation	**Response**
A. Our Organization will conduct an annual audit of the offshore subcontractor/employee.	☐ Yes ☐ No*
B. Audit results will be used by our Organization to evaluate the continuation of its relationship with the offshore subcontractor/employee.	☐ Yes ☐ No*
C. Our Organization agrees to share offshore subcontractor's/employee's audit results with CalOptima or CMS upon request.	☐ Yes ☐ No*

***Explanation required for all "no" responses to Part III and Part IV above:**

Part V — Organization Information	
By signing below, I hereby attest that the information contained herein is true, correct and complete.	
Printed name of authorized person:	Title:
Email:	Phone #:
Signature:	Date:

Note: CalOptima's policies and procedures, CMS training module instructions for FWA, General Compliance, General HIPAA, CalOptima's Code of Conduct, CalOptima's Compliance Plan can be accessed at https://www.caloptima.org/en/About/GeneralCompliance.aspx

EXHIBIT H
Business Associate Contract

[insert CalOptima vendor BAA if applicable]

CONTRACT NO. «Contract Number» ("**Contract**")
BETWEEN
ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY, dba
ORANGE PREVENTION & TREATMENT INTEGRATED MEDICAL ASSISTANCE, dba
CALOPTIMA ("**CalOptima**")
And
«Company Name»
("**CONTRACTOR**")

This Contract is made and entered into as of [insert date] ("**Effective Date**"), by and between the Orange County Health Authority, a public agency dba CalOptima, a public agency ("**CalOptima**") and «Company Name», a «Business Entity», hereinafter referred to as "**CONTRACTOR**." CalOptima and CONTRACTOR may be referred to herein collectively as the "**Parties**" or each individually as a "**Party**."

RECITALS

A. CalOptima desires to retain a contractor to provide «Description», as described in the Scope of Work in Exhibit A;

B. CONTRACTOR provides such services;

C. CONTRACTOR represents and warrants that it has the requisite personnel and experience and is capable of performing such services;

D. CONTRACTOR desires to perform these services for CalOptima; and

E. CalOptima and CONTRACTOR desire to enter into this Contract on the terms and conditions set forth herein below.

NOW, THEREFORE, in consideration of their mutual and respective promises, and subject to the terms and conditions hereinafter set forth, the Parties agree as follows:

1. Documents Constituting Contract. "**Contract Documents**" include the following documents in the order of descending precedence: (i) this Contract, inclusive of all its exhibits and addenda; (ii) CalOptima's Request for Proposal ("**RFP**"), if applicable, inclusive of any CalOptima revisions and addenda prior to the Effective Date; (iii) CONTRACTOR's best and final offer dated [Insert Date of Best and Final Offer], if applicable, and; (iv) CONTRACTOR's proposal dated [Insert Date CONTRACTOR's Response to RFP] ("**Proposal**"). Any new terms and conditions attached to CONTRACTOR's best and final offer, Proposal, invoices, or request for payment shall not be incorporated into the Contract Documents or be binding upon CalOptima unless expressly accepted by CalOptima in writing. All Contract Documents are incorporated into this Contract by this reference. Any changes to the Contract or the Contract Documents shall not be binding upon CalOptima except when specifically confirmed in writing by an authorized representative of CalOptima in accordance with Section 10, of this Contract. In the event of any conflict of provisions among the Contract and/or Contract Documents, the provisions shall prevail in the above-referenced descending order of precedence.

2. Scope of Work.

2.1 CONTRACTOR shall perform the work in accordance with (i) this Contract, including the Scope of Work in Exhibit A, (ii) the Contract Documents, (iii) the applicable standards and requirements of the Centers for Medicare and Medicaid Services ("**CMS**"), the California Department of Health Care Services ("**DHCS**"), and the California Department of Managed Health Care ("**DMHC**"), and (iv) all applicable laws.

3. Insurance.

3.1 At CONTRACTOR's sole expense and prior to undertaking performance of services under this Contract and at all times during performance hereunder, CONTRACTOR shall maintain insurance policies and amounts set forth in Exhibit A, which shall be full-coverage insurance not subject to self-insurance provisions, in accordance with applicable laws and industry standards. CONTRACTOR shall not of its own initiative cause such insurance to be canceled or materially changed during the Term.

3.2 Within five (5) days of the Effective Date and prior to commencing performance of any services or its receipt of any compensation under the Contract, CONTRACTOR shall furnish to CalOptima with additional insured endorsements broker-issued Certificate(s) of Insurance showing the required insurance coverages for CONTRACTOR. CONTRACTOR's Certificates of Insurance shall additionally comply with the following:

3.2.1 CalOptima's officers, officials, directors, employees, agents, and volunteers are to be covered as additional insureds with respect to liability arising out of work or operations performed by or on behalf of CONTRACTOR, including materials, parts, or equipment furnished in connection with such work or operations. This provision applies to CONTRACTOR's General Liability and Auto Liability policies, as applicable, and must be on ISO form CG 20 10 or equivalent.

3.2.2 For any claims related to this Contract, the CONTRACTOR's insurance coverage shall be primary insurance with respect to CalOptima, its officers, officials, directors, employees, agents, and volunteers. This provision applies to the CONTRACTOR's General Liability, Auto Liability and Workers' Compensation and Employers' Liability policies, as applicable.

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

3.2.4 Insurance is to be placed with insurers with a current A.M. Best rating of no less than A-VII, unless otherwise acceptable to CalOptima.

3.2.5 CONTRACTOR shall furnish CalOptima with original certificates and amendatory endorsements affecting coverage required by this Section 3.2 and Exhibit A. CalOptima reserves the right to require complete, certified copies of all required insurance policies, including endorsements affecting the coverage required by these specifications, at any time.

3.2.6 Any deductibles or self-insured retentions must be declared to and approved by CalOptima. CalOptima may require the CONTRACTOR to purchase coverage with a lower deductible or retention or provide proof of ability to pay losses and related investigations, claim administration, and defense expenses within the retention or deductible.

3.2.7 All deductibles and retentions that the aforementioned policies contain are the responsibility of the CONTRACTOR and in no way shall CalOptima be responsible for payment of the deductibles/retentions.

3.2.8 If CONTRACTOR maintains higher limits than the minimums required in this Contract, CalOptima requires and shall be entitled to coverage for the higher limits maintained by CONTRACTOR. Any available insurance proceeds in excess of the specified minimum limits of insurance and coverage shall be available to CalOptima.

3.2.9 Require the insurance carrier to provide thirty (30) days' prior written notice of cancellation to CalOptima.

3.3 If CONTRACTOR fails or refuses to maintain or produce proof of the insurance required by this Section 3 and Exhibit A, CalOptima may terminate this Contract upon written notice to CONTRACTOR. Such termination shall not affect CONTRACTOR'S right to be paid for its time and materials expended prior to notification of termination. CONTRACTOR waives the right to receive compensation and agrees to indemnify CalOptima for any work performed prior to approval of insurance by CalOptima

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

3.5 CONTRACTOR shall require each of its subcontractors who perform services related to this Contract, if any, to maintain insurance coverage that meets all of the requirements set forth in this Contract.

3.6 "**Occurrence**" means any event or related exposure to conditions that result in bodily injury or property damage.

4. Indemnification.

4.1 To the fullest extent permitted by law, CONTRACTOR shall defend, indemnify, and hold harmless CalOptima and its respective officers, directors, agents, volunteers, consultants and employees (individually and collectively referred to as "**Indemnified Parties**") against any and all [third-party] claims, losses, demands, damages, costs, expenses, or liability arising out CONTRACTOR's, or its officers, employees, subcontractors, agents, or representatives', breach of this Contract, negligence, recklessness, or intentional conduct, except to the extent any such loss was caused by the gross negligence, recklessness, or intentional misconduct of CalOptima. CONTRACTOR shall defend the Indemnified Parties in any claim or action based upon any such alleged acts or omissions at its sole expense, which shall include all costs and fees, including attorneys' fees, cost of investigation, defense, and settlement or awards. CalOptima may make all reasonable decisions with respect to its representation in any legal proceeding. CONTRACTOR's duty to defend herein is wholly independent of and separate from the duty to indemnify and such duty to defend shall exist regardless of any ultimate liability of CONTRACTOR, save and except claims arising through the sole negligence or sole willful misconduct of CalOptima.

[Mutual indemnity option]

Each Party (an "**Indemnifying Party**") shall defend, indemnify, and hold harmless the other Party and the other Party's respective officers, directors, agents, volunteers, consultants, and employees (individually and collectively referred to as "**Indemnified Parties**") from and against any third-party claims losses, demands, damages, costs, expenses, or liability arising out of the Indemnifying Party's breach of this Contract, negligence, recklessness, or intentional conduct, except to the extent any such loss was caused by the negligence, recklessness, or intentional conduct of the Indemnified Parties. The Indemnifying Party shall defend the Indemnified Parties in any claim or action at its sole expense, which shall include all costs and fees, including attorneys' fees, cost of investigation, defense, and settlement or awards. The Indemnified Party may make all reasonable decisions with respect to its representation in any legal proceeding.

4.2 CONTRACTOR's obligation to indemnify hereunder is in addition to any liability CONTRACTOR may have to CalOptima for a breach by CONTRACTOR of any of the provisions of this Contract. Under no circumstances shall the insurance requirements and limits set forth in this Contract be construed to limit CONTRACTOR's indemnification and duty to defend obligation or other liability hereunder

4.3 CONTRACTOR's indemnification and duty to defend obligations shall survive the expiration or earlier termination of this Contract until such time as any action against the Indemnified Parties for such a matter indemnified hereunder is fully and finally barred by the applicable statute of limitations, including those set forth under the California Government Claims Act (Cal. Gov. Code §900 *et seq*.).

4.4 In the event of any conflict between this Section 4 and the indemnification provisions set forth elsewhere in the Contract, including any business associate agreement ("**BAA**") between the Parties, the indemnification provision(s) in the BAA or elsewhere in the Contract shall be interpreted to relate only to matters within the scope of the BAA or those other Contract provisions.

4.5 The terms of this Section 4 shall survive the termination of this Contract.

5. Independent Contractor. CalOptima and CONTRACTOR agree that CONTRACTOR, which shall include for purposes of this Section 5 all subcontractors, agents, and employees of the CONTRACTOR, in performance of this Contract, shall act in an independent capacity, and not as officers or employees of CalOptima. CONTRACTOR's relationship with CalOptima in the performance of this Contract is that of an independent contractor and nothing in this Contract shall be construed as creating a partnership, joint venture, or agency. CONTRACTOR's personnel performing services under this Contract shall be at all times under CONTRACTOR's exclusive direction and control and shall be employees of CONTRACTOR and not employees of CalOptima. CONTRACTOR shall pay all wages, salaries and other amounts due its employees, agents, and/or subcontractors in connection with this Contract and shall be responsible for all reports and obligations respecting them, such as social security, state and federal income tax withholding, other payroll taxes, unemployment compensation, workers' compensation, and similar matters. CONTRACTOR shall file all required returns related to such taxes, contributions, and payroll deductions.

6. Personnel.

6.1 CONTRACTOR Staffing. CONTRACTOR shall ensure that only fully qualified CONTRACTOR personnel are assigned to perform the services under the Contract, and such CONTRACTOR personnel shall perform services diligently and in a timely manner, according to the applicable professional and technical standards.

6.2 CONTRACTOR Personnel Restrictions. When on CalOptima's premises, CONTRACTOR personnel shall comply with CalOptima policies and procedures, including CalOptima's identification requirements (e.g., name badges).

6.3 Any CalOptima property damaged by CONTRACTOR, its subcontractor(s), or by the personnel of either, will be subject to repair or replacement by CONTRACTOR at no cost to CalOptima.

[optional non-compete clause]

6.4 Neither Party shall actively solicit employees of the other Party for employment that directly or indirectly provided services under the Contract during the Term and for a period of one (1) year after termination.

7. Compensation.

7.1 CalOptima agrees to pay, and CONTRACTOR agrees to accept as full compensation for the faithful performance of this Contract, the rates, charges, and other payment terms identified in Exhibit B.

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

7.3 CONTRACTOR's requests for payments and reimbursements must comply with the requirements set forth in Exhibit B. CalOptima will not make payment for work that fails to meet the standards of performance set forth in the Contract and Exhibit A. **CALOPTIMA SHALL NOT PAY ANY FEES, EXPENSES, OR COSTS WHATSOEVER INCURRED BY CONTRACTOR IN RENDERING ADDITIONAL SERVICES NOT AUTHORIZED IN WRITING BY CALOPTIMA UNDER THIS CONTRACT.**

7.4 In no event shall the total compensation payable to CONTRACTOR for the services performed under this Contract exceed the maximum cumulative payment obligation, as set forth in Exhibit B, without the express prior written authorization of CalOptima. **CONTRACTOR ACKNOWLEDGES AND AGREES THAT CALOPTIMA SHALL NOT BE LIABLE FOR ANY FEES, EXPENSES OR COMPENSATION IN EXCESS OF THE MAXIMUM CUMULATIVE PAYMENT OBLIGATION.**

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

8. Confidential Material.

8.1 During the Term, either Party may have access to confidential material or information ("**Confidential Information**") belonging to the other Party or the other Party's customers, vendors, or partners. Confidential Information includes the disclosing Party's computer programs and codes, business plans, customer/member lists and information, financial records, partnership arrangements, projections, methodologies, data, reports, agreements, intellectual property, trade secrets, licensing plans, and other proprietary information, or other information, materials, records, writings or data that is marked confidential or that due to its character and nature, a reasonable person under like circumstances would treat as confidential. CalOptima's Confidential Information also includes all user information, patient information, and clinical data that comes into CalOptima's possession, custody or control. Confidential Information will be used only for the purposes of this Contract and related internal administrative purposes. Each Party agrees to protect the other's Confidential Information at all times and in the same manner as each protects the confidentiality of its own confidential materials, but in no event with less than a reasonable standard of care.

8.2 For the purposes of Section 8.1, Confidential Information does not include information which: (i) is already known to the other Party at the time of disclosure; (ii) is or becomes publicly known through no wrongful act or failure of the receiving Party; (iii) is independently developed without use or benefit of the other Party's Confidential Information or proprietary information; (iv) is lawfully received from a third party that is not under and does not thereby breach an obligation of confidentiality; or (v) is a public record, not exempt from disclosure, pursuant to California Public Records Act, Government Code Section 6250 *et seq*., applicable provisions of California Welfare

and Institutions Code, or other state or federal laws, regardless of whether such information is marked as confidential or proprietary.

8.3 Disclosure of the Confidential Information will be restricted to the receiving Party's employees, consultants, suppliers, or agents, who are bound by confidentiality obligations no less stringent than those in this Section 8, on a "need to know" basis in connection with the services performed under this Contract. The receiving Party may disclose Confidential Information pursuant to legal, judicial, or administrative proceeding or otherwise as required by law; provided, however, that the receiving Party gives reasonable prior notice, if not prohibited by applicable law, to the disclosing Party and assists the disclosing Party, at the disclosing Party's expense, to obtain protective or other appropriate confidentiality orders, and further provided that a required disclosure of Confidential Information or proprietary information to an agency or court does not relieve the receiving Party of its confidentiality obligations with respect to the other Party.

8.4 CONTRACTOR shall establish and maintain environmental, safety, and facility procedures, data security procedures and other safeguards against the unauthorized access, destruction, loss, or alteration of CalOptima's Confidential Information in the possession, custody, or control of CONTRACTOR. Those security procedures and other safeguards shall be no less rigorous than those maintained by CONTRACTOR for its own information of a similar nature.

8.5 Upon written request of the disclosing Party, the receiving Party shall promptly return to the disclosing Party or destroy all documents, notes, and other tangible materials representing the disclosing Party's Confidential Information and all copies thereof. This obligation to return materials or copies thereof does not extend to automatically generated computer backup or archival copies generated in the ordinary course of the receiving Party's information systems procedures, provided that the receiving Party shall make no further use of such copies.

8.6 If a breach of the obligations under this Section 8 occurs, the injured Party may be entitled to such injunctive relief and any and all other remedies available at law or in equity. This Section 8 in no way limits the liability or damages that may be assessed against a Party if another Party breaches any of the provisions of this Section 8.

8.7 For the purposes of Section 8.6 only, Confidential Information does not include protected health information ("**PHI**") or individually identifiable information, as defined by the Health Insurance Portability and Accountability Act of 1996 ("**HIPAA**") and other privacy statutes or regulations. The access use and disclosure of PHI shall be governed by a BAA, which is Exhibit H to this Contract.

[alternative provision if no PHI involved]

This Contract does not require or permit CONTRACTOR to create, receive, maintain, use, or transmit protected health information ("**PHI**"). As such, no BAA is required for this Contract; provided, however, that if CONTRACTOR or its employees, agents, or subcontractors access or receive, whether intentionally or unintentionally, PHI regarding CalOptima members during the Term, CONRACTOR and its employees, agents, and subcontractors shall immediately notify CalOptima, protect such PHI from any additional disclosure, not use or disclose that PHI in any way that would violate a federal or state privacy or security law, its implementing regulations, or any other state or federal law, and execute a BAA with CalOptima, as necessary and requested by CalOptima.

9. California Public Records Act. As a local public agency, CalOptima is subject to the California Public Records Act (California Government Code Sections 6250 *et seq*.) (the "**PRA**"). CONTRACTOR hereby acknowledges that any materials, documents, data, or similar items are subject to disclosure upon public request, unless exempt from disclosure under the provisions of the PRA. CalOptima may be required to reveal certain information believed to be proprietary or confidential by CONTRACTOR pursuant to the PRA. If CONTRACTOR discloses information that it believes to be proprietary or confidential to

CalOptima, it shall mark such information as "Confidential," "Proprietary," or "Restricted" or other similar marking. Unless CONTRACTOR marks its materials as "Confidential," "Proprietary," or "Restricted," and also notifies CalOptima in writing that CONTRACTOR has so marked each piece of material, then CalOptima will not be responsible to take any actions to protect any CONTRACTOR's materials under the PRA that are not so marked. If CalOptima receives a request under the PRA that potentially encompasses CONTRACTOR materials that have been properly marked, CalOptima will provide CONTRACTOR with notice thereof to allow CONTRACTOR to take actions it deems appropriate to prevent disclosure of the marked material. Within five (5) days from receipt of CalOptima's notice, CONTRACTOR shall notify CalOptima if it intends to object to production of CONTRACTOR's information; otherwise CalOptima will respond to the PRA request according to the requirements of the PRA. CONTRACTOR agrees to defend, indemnify, and hold harmless CalOptima, its officers, agents, employees, members, subsidiaries, joint venture partners, and predecessors and successors in interest from and against any claim, action, proceeding, liability, loss, damage, cost, or expense, including attorneys' fees, and any costs awarded to the person or entity that sought CONTRACTOR's marked material, arising out of or related to CalOptima's failure to produce or provide the CONTRACTOR-marked material (collectively referred to for purposes of this Section 9 as "**Public Records Act Claim(s)**"). CONTRACTOR shall pay to CalOptima any expenses or charges relating to or arising from any such Public Record Act Claim(s) as they are incurred by CalOptima.

10. Modifications. CalOptima may modify the Contract upon written notice to CONTRACTOR at any time should such modification be required by CMS, DHCS, the DMHC, or applicable law or regulation ("**Regulatory Amendment**"). Any other modifications of the Contract that are not Regulatory Amendments shall be executed only by a written amendment to the Contract, signed by CalOptima and CONTRACTOR. Execution of amendments shall be contingent upon CONTRACTOR's notification to CalOptima, and CalOptima's approval, of any increase or decrease in the price of this Contract or in the time required for CONTRACTOR's performance.

11. Assignments.

    11.1 CONTRACTOR may not assign, transfer, or delegate any interest herein, either in whole or in part, without the prior written consent of CalOptima, which consent may be withheld in its sole discretion. If CalOptima provides such prior written consent, CONTRACTOR acknowledges and agrees that such assignment, transfer, or delegation may additionally be subject to the prior written approval of DHCS. Any assignment, transfer, or delegation made without CalOptima's express written consent shall be void.

    11.2 For purposes of this Section 11, an assignment is: (1) the change of more than fifty percent (50%) of the ownership or equity interest in CONTRACTOR (whether in a single transaction or in a series of transactions); (2) the change of more than fifty percent (50%) of the directors or trustees of CONTRACTOR (whether in a single transaction or in a series of transactions); (3) the merger, reorganization, or consolidation of CONTRACTOR with another entity with respect to which CONTRACTOR is not the surviving entity; and/or (4) a change in the management of CONTRACTOR from management by persons appointed, elected or otherwise selected by the governing body of CONTRACTOR (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

12. Subcontracts. CONTRACTOR may not subcontract or delegate its obligations or the performance of services under this Contract without CalOptima's prior written consent, which CalOptima may exercise in its sole discretion. CalOptima-approved subcontractors are listed in Addendum 1 to Exhibit A.

13. Term. This Contract shall commence on the Effective Date and shall continue in full force and effect through «Current Expiration» ("**Initial Term**"), unless earlier terminated as provided in this Contract. At the end of the Initial Term, CalOptima may, at its option, extend this Contract for up to «Extended Term spelled» («Extended Term») additional consecutive one (1)-year terms ("**Extended Terms**"), provided that if CalOptima does not exercise its option to extend at the end of the Initial Term, or any Extended Term,

the remaining option(s) shall automatically lapse. The Initial Term together with any Extended Terms constitute the "**Term**" of this Contract.

[optional term for fixed term agreements]

Term. This Contract shall commence on the Effective Date and shall continue in full force and effect through «CurrentExpiration» ("**Term**"), unless earlier terminated, as provided in this Contract.

14. Termination.

14.1 Termination without Cause. CalOptima may terminate this Contract at any time, in whole or in part, for its convenience and without cause, by giving CONTRACTOR thirty (30) days' prior written notice. Upon termination, CalOptima shall pay CONTRACTOR all fees and other charges due and payable for services satisfactorily performed and accepted by CalOptima as of the termination date. Thereafter, CONTRACTOR shall have no further claims against CalOptima under this Contract.

[optional mutual without cause termination]

Termination without Cause: Either Party may terminate this Contract at any time, in whole or in part, for its convenience and without cause, by giving the other Party sixty (60) days' prior written notice. Upon termination, CalOptima shall pay CONTRACTOR all fees and other charges due and payable for services satisfactorily performed and accepted by CalOptima as of the termination date.

14.2 Termination for Unavailability of Funds. In recognition that CalOptima is a governmental entity and its operations and budgets are determined on an annual basis, CalOptima shall have the right to terminate this Contract as follows:

14.2.1 CalOptima may terminate this Contract if it does not receive funding from the State of California or the federal government, as applicable, for any fiscal year.

14.2.2 In the event of termination under Section 14.2.1, CalOptima agrees to promptly pay CONTRACTOR all fees and other charges due and payable for services satisfactorily performed and accepted by CalOptima as of the termination date. CONTRACTOR shall not be entitled to payment for any other items, including lost or anticipated profit on work not performed, administrative costs, attorneys' fees, or consultants' fees.

14.3 Termination for Default. CalOptima may immediately terminate this Contract upon notice to CONTRACTOR for (i) CONTRACTOR's default, (ii) if a federal or state proceeding for the relief of debtors is undertaken by or against CONTRACTOR; or (iii) if CONTRACTOR makes an assignment, as defined in Section 11, for the benefit of creditors ("**Termination for Default**").

14.4 Termination for Breach. Either Party may at its option, terminate this Contract by notice to the other Party if the other Party breaches one of its obligations under this Contract and fails to cure that breach or default within thirty (30) days after receiving notice identifying that breach. The rights described in this Section 14.4 to terminate this Contract shall be in addition to any other remedy available to the non-breaching Party, whether under this Contract or in law or equity, on account of that breach.

14.5 Notwithstanding the foregoing, CalOptima may terminate this Contract immediately upon CONTRACTOR's breach of Section 3 (Insurance) or Section 8 (Confidential Material).

14.6 Effect of Termination. Upon expiration or receipt of a termination notice under this Section 14:

14.6.1 CONTRACTOR shall promptly discontinue all services (unless CalOptima's notice directs otherwise) and deliver or otherwise make available to CALOPTIMA all documents, reports, software programs, and any other products, data and such other materials, equipment, and information, including Confidential Information, or equipment provided by CalOptima, as may have been accumulated by CONTRACTOR in performing this Contract, whether completed or in process. If CONTRACTOR personnel were granted access to CalOptima's premises and issued a badge or access card, such badge or access card shall be returned prior to departure.

14.6.2 CalOptima may take over the services and may award another party a contract to complete the services under this Contract.

15. Dispute Resolution

15.1 Meet and Confer. If either Party has a dispute arising under or related to this Contract, the Parties shall informally meet and confer to try and resolve the dispute. The Parties shall meet and confer within thirty (30) days of a written request submitted by either Party in an effort to settle any dispute. At each meet-and-confer meeting, each Party shall be represented by persons with final authority to settle the dispute. If either Party fails to meet within the thirty (30)-day period, that Party shall be deemed to have waived the meet-and-confer requirement, and at the other Party's option, the dispute may proceed immediately to arbitration under Section 15.2.

15.2 Subject to the California Government Claims Act (Cal. Gov. Code §900 *et seq*.) governing claims against public entities, either Party may submit the dispute for resolution exclusively through confidential, binding arbitration, instead of through trial by court or jury, in Orange County, California. The Parties may agree in writing prior to commencing the arbitration on the dispute resolution rules and arbitration service that will be used to resolve the dispute. If the Parties cannot reach such an agreement, the arbitration will be conducted by Judicial Arbitration and Mediation Services ("**JAMS**") in accordance with the commercial dispute rules then in effect for JAMS; provided, however, that this Contract shall control in instances where it conflicts with JAMS's (or the applicable arbitration service's) rules. The arbitration shall be conducted on an expedited basis by a single arbitrator. The Parties prefer that the arbitrator be a retired judge of the California Superior, Appellate, or Supreme Court or of a United States court sitting in California. If no such retired judge is available, the arbitrator may be an attorney with at least fifteen (15) years of experience, including at least five (5) years in managed health care. If the Parties are unable to agree on the arbitrator within thirty (30) days of the date that the arbitration service accepts the arbitration, the arbitrator shall be selected by the arbitration service from a list of four potential arbitrators (all of whom shall be on arbitration services' panel of arbitrators) submitted by the Parties, two from each side; provided, however, that nothing stated in this section shall prevent a Party from disqualifying an arbitrator based on a conflict of interest. In making decisions about discovery and case management, it is the Parties' express agreement and intent that the arbitrator at all times promote efficiency without denying either Party the ability to present relevant evidence. In reaching and issuing decisions, the arbitrator shall have no jurisdiction to make errors of law and/or legal reasoning. The Parties shall share the costs of arbitration equally, and each Party shall bear its own attorneys' fees and costs.

15.3 Exclusive Remedy. With the exception of any dispute that under applicable laws may not be settled through arbitration, arbitration under Section 15.2 is the exclusive method to resolve a dispute between the Parties arising out of or relating to this Contract that is not resolved through the meet-and-confer processes.

15.4 Waiver. By agreeing to binding arbitration as set forth in Section 15.2, the Parties acknowledge that they are waiving certain substantial rights and protections which otherwise may be available if a dispute between them was determined by litigation in a court, including the right to a jury trial, attorneys' fees, and certain rights of appeal.

16. General Provisions.

16.1 Non-Exclusive Relationship. This is a non-exclusive relationship between CalOptima and CONTRACTOR. CalOptima shall have the right to have any of the services that are the subject of this Contract performed by CalOptima personnel or enter into contractual arrangements with one or more contractors who can provide CalOptima with similar or like services.

16.2 Compliance with Applicable Law and Policies. CONTRACTOR warrants that, in the performance of this Contract, it shall, at its own expense, observe and comply with all applicable federal, state, and local laws, and CalOptima vendor policies relating to services under the Contract that are in effect when this Contract is signed or that come into effect during the Term and are available to CONTRACTOR on CalOptima's website.

16.3 Names and Marks. Neither Party shall use the name, logo or other proprietary mark of the other Party in any press release, advertising, promotional, marketing or similar publicly disseminated material without obtaining the other Party's express written approval of the material and consent to such use.

16.4 Time is of the Essence. Time is of the essence in performance of this Contract.

16.5 Choice of Law. This Contract shall be governed by and construed in accordance with all laws of the State of California. If any Party institutes legal proceedings to enforce or interpret this Contract, venue and jurisdiction shall be in the County of Orange, California.

16.6 Force Majeure. When satisfactory evidence of a cause beyond a Party's control is presented to the other Party, and nonperformance is unforeseeable, beyond the control, and not due to the fault of the Party not performing, a Party shall be excused from performing its obligations under this Contract during the time and to the extent that it is prevented from performing by such cause, including any incidence of fire, flood, acts of God, commandeering of material, products, plants or facilities by the federal, state or local governments, or a material act or omission by the other Party. A Party invoking this clause shall provide the other Party with prompt written notice of any delay or failure to perform that occurs by reason of force majeure. If the force majeure event continues for a period of XX (XX) days, the Party unaffected by the force majeure event may terminate this Contract upon notice to the other Party.

16.7 Notices. All notices required or permitted under this Contract shall be in writing and shall be sent by registered or certified mail, postage prepaid, return receipt requested, or by any other overnight delivery service which delivers to the noticed destination and provides proof of delivery to the sender. All notices shall be effective when first received at the following addresses set forth below. Any notice not related to termination of this Contract may be submitted electronically to the address set forth below. Any Party whose address changes shall notify the other Party in writing.

To CONTRACTOR:	**To CalOptima:**
	CalOptima
	505 City Parkway West
	Orange, CA 92868
	Attention:
	Email:

16.8 Notice of Labor Disputes. Whenever CONTRACTOR has knowledge that any actual or potential labor dispute may delay this Contract, CONTRACTOR shall immediately notify and submit all relevant information to CalOptima.

16.9 No Liability of County of Orange. As required under Ordinance No. 3896 of the County of Orange, State of California, as amended, the Parties agree that the obligations of CalOptima under this Contract are solely the obligations of CalOptima, and the County of Orange, State of California, shall have no obligation or liability related to this Contract. [County of Orange Ordinance No 3896, codified in Orange County Municipal Code Section 4-11-7(a)]

16.10 Entire Agreement. This Contract, including all exhibits, addenda, and Contract Documents, contains the entire agreement between CONTRACTOR and CalOptima with respect to the subject matter of this Contract, and it supersedes all prior written or oral and all or contemporaneous oral agreements, representations, understandings, discussions, negotiations, and commitments between CONTRACTOR and CalOptima, whether express or implied, with respect to the subject matter of this Contract.

16.11 Waiver. Any failure of a Party to insist upon strict compliance with any provision of this Contract shall not be deemed a waiver of such provision or any other provision of this Contract. To be effective, a waiver must be in a writing that is signed and dated by the Parties. A waiver by either of the Parties of a breach of any of the covenants, conditions, or agreements to be performed by the other Party shall not be construed to be a waiver of any succeeding breach of the Contract or of any other covenant or condition of the Contract. Any information delivered, exchanged, or otherwise provided hereunder shall be delivered, exchanged, or otherwise provided in a manner that does not constitute a waiver of immunity or privilege under applicable law.

16.12 Survival. The following provisions of this Contract shall survive termination or expiration of this Contract: Sections 4 (Indemnification), 5 (Independent Contractor), 8 (Confidential Material), 9 (California Public Records Act), 14.6 (Effect of Termination), 15 (Dispute Resolution), 16.3 (Names and Marks), 16.5 (Choice of Law), 16.9 (No Liability of County of Orange), this Section 16.12, 16.14 (Interpretation), 16.15 (Third-Party Beneficiaries), 16.16 (Successors and Assigns) and any other Contract provisions that by their nature are intended to survive termination or expiration of this Contract.

16.13 Severability. If any section, subsection or provision of this Contract, or the application of such section, subsection or provision, is held invalid or unenforceable by any court of competent jurisdiction, the remainder of this Contract, other than that to which it is held invalid, shall remain in effect.

16.14 Interpretation. The terms of this Contract are the result of negotiation between the Parties. Accordingly, any rule of construction of contracts (including California Civil Code Section 1654) that ambiguities are to be construed against the drafting party shall not be employed in the interpretation of this Contract.

16.15 Third Party Beneficiaries. There are no intended third-party beneficiaries of this Contract. Nothing in this Contract shall be construed as conferring any rights on any other persons.

16.16 Successors and Assigns. Except as otherwise expressly provided in this Contract, this Contract will be binding on, and will inure to the benefit of, the successors and permitted assigns of the Parties. Nothing in this Contract is intended to confer upon any party other than the Parties or their respective successors and permitted assigns any rights or obligations under or by reason of this Contract, except as expressly provided in this Contract.

16.17 Without Limitation. Any reference in the Contract to “include(s)” or “including” means inclusion without limitation, unless otherwise distinguished within the text.

16.18 Authority to Execute. The persons executing this Contract on behalf of the Parties warrant that they are duly authorized to execute this Contract and that by executing this Contract the Parties are formally bound.

16.19 Counterparts. This Contract may be executed and delivered in one or more counterparts, each of which shall be deemed an original, but all of which together will constitute one and the same instrument.

16.20 Recitals and Exhibits. The recitals, exhibits, and addenda attached to this Contract are made a part of the Contract by this reference.

IN WITNESS WHEREOF, these Parties have, by their duly authorized representatives, executed this Contract No. «Internal Number» on the day and year last shown below.

«Company Name»	CalOptima
By:	By:
Print Name:	Print Name:
Title: Date:	Title: Date:

By:	By:
Print Name:	Print Name:
Title: Date:	Title: Date:

EXHIBIT A
Scope of Work

1. **Description of Work**

[add for each RFP]

2. **Standard of Performance; Warranties**.

2.1 CONTRACTOR agrees to perform all work under this Contract with the requisite skill and diligence consistent with professional standards for the industry and type of work performed under this Contract, and pursuant to the governing rules and regulations of the industry.

2.2 If CONTRACTOR may subcontract for services under this Contract, then CONTRACTOR represents and warrants that any individual or entity acting as a subcontractor to this Contract has the appropriate skill and expertise to perform the subcontracted work and will comply with all applicable provisions of this Contract.

2.3 CONTRACTOR expressly warrants that all material and work will conform to applicable specifications, drawings, description and samples, including CalOptima's designs, drawings, and specifications, and will be merchantable, of good workmanship and material, and free from defect. CONTRACTOR further warrants that all material covered by this Contract, if any, which is the product of CONTRACTOR will be new and unused unless otherwise specified and shall be fit and sufficient for the purpose intended by CalOptima, as disclosed to CONTRACTOR. CONTRACTOR shall promptly make whatever adjustments or corrections that may be necessary to cure any defects, including repairs of any damage resulting from such defects. CalOptima shall give notice to CONTRACTOR of any observed defects. If CONTRACTOR fails to adjust, repair, correct, or perform other work made necessary by such defects, CalOptima may make such adjustments, repairs, and/or corrections and charge CONTRACTOR the costs incurred.

2.4 CONTRACTOR's warranties, together with its service guarantees, must run to CalOptima and its customers or users of the material and services, and must not be deemed exclusive. CalOptima's inspection, approval, acceptance, use of and payment for all or any part of the material and services must in no way affect its warranty rights whether or not a breach of warranty had become evident in time.

2.5 CONTRACTOR's obligations under this Section 2 are in addition to CONTRACTOR's other express or implied warranties and other obligations under this Contract or state law, and in no way diminish any other rights that CalOptima may have against CONTRACTOR for faulty materials, equipment or work. CalOptima rejects any disclaimer by CONTRACTOR of any warranty, standard, implied or express, unless specifically agreed to in writing by both Parties.

2.6 Any CalOptima property damaged by CONTRACTOR, its subcontractor(s), or by the personnel of either, will be subject to repair or replacement by CONTRACTOR at no cost to CalOptima.

3. **Record Ownership and Retention**.

3.1 The originals of all letters, documents, reports, and any other products and data prepared or generated for the purposes of this Contract shall be delivered to and become the property of CalOptima at no cost to CalOptima and in a form accessible for CalOptima's use. Copies may be made for CONTRACTOR's records but shall not be furnished to others without written authorization from CalOptima. Such deliverables shall become the sole property of CalOptima and all rights in copyright therein shall be retained by CalOptima. CalOptima's ownership of these documents includes use of, reproduction or reuse of, and all incidental rights. CONTRACTOR shall provide all deliverables within a reasonable amount of time upon CalOptima's request, but in no event shall such time exceed thirty (30) calendar days unless otherwise specified by CalOptima.

3.2 CONTRACTOR hereby assigns to CalOptima all of its rights in all materials prepared by or on behalf of CalOptima under this Contract ("**Works**"), and this Contract shall be deemed a transfer to CalOptima of the sole and exclusive copyright of any copyrightable subject matter CONTRACTOR created in these Works. CONTRACTOR agrees to cause its agents and employees to execute any documents necessary to secure or perfect CalOptima's legal rights and worldwide ownership in such materials, including documents relating to patent, trademark and copyright applications. Upon CalOptima's request, CONTRACTOR will return or transfer all property and materials, including the Works, in CONTRACTOR's possession or control belonging to CalOptima.

4. **Required Insurance**

4.1. Commercial General Liability, including contractual liability and coverage for independent contractors on an occurrence basis on an ISO form GC 00 01 or equivalent covering bodily injury and property damage with the following minimum liability limits:

4.1.1. Per occurrence: $1,000,000

4.1.2. Personal Advertising Injury: $1,000,000

4.1.3. Products Completed Operations: $2,000,000

4.1.4. General Aggregate: $2,000,000

4.2. If Contractor or subcontractors are on CalOptima's premises or transporting CalOptima members or employees, Commercial Automobile Liability covering any auto, whether owned, lease, hired, or rented, on an ISO form CA 0001 or equivalent in the amount of $1,000,000 combined single limit for bodily injury or property damage.

4.3. Worker's Compensation and Employer's Liability Policy written in accordance with applicable laws and providing coverage for all of CONTRACTOR's employees:

4.3.1. The policy must provide statutory coverage for Worker's Compensation.

4.3.2. The policy must also provide coverage for $1,000,000 Employers' Liability for each employee, each accident, and in the general aggregate.

4.4. Professional Liability insurance covering the CONTRACTOR's professional errors and omissions with $1,000,000 per occurrence and $2,000,000 general aggregate. [Only applicable if the contract is for professional services]

4.5. Commercial crime policy covering employee theft and dishonesty, forgery and alteration, money orders and counterfeit currency, credit card fraud, wire transfer fraud, and them of client property with $1,000,000 limits per occurrence.

4.6. Cyber and Privacy Liability insurance with the minimum limits of insurance listed below covering claims involving privacy violations, information theft, damage to or destruction of electronic information, intentional and/or unintentional release of private information, alteration of electronic information, extortion and network security. Such coverage is required only if any products and/or services related to information technology (including hardware and/or software) are provided to CalOptima and for claims involving any professional services for which CONTRACTOR is engaged with CalOptima for such length of time as necessary to cover any and all claims. [This can be removed if Contractor is not accessing or hosting any of CalOptima's information]

4.6.1. Privacy and Network Liability: $1,000,000

4.6.2. Internet Media Liability: $1,000,000

4.6.3. Business Interruption & Expense: $1,000,000

4.6.4. Data Extortion: $1,000,000

4.6.5. Regulatory Proceeding: $1,000,000

4.6.6. Data Breach Notification & Credit Monitoring: $1,000,000

EXHIBIT A
Addendum 1

The following is a list of subcontractors approved to perform Services under this Contract:

Subcontractor Name	Functions

EXHIBIT B
Payment

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

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

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

4. Notwithstanding any provisions of this Contract to the contrary, CalOptima and CONTRACTOR mutually agree that CalOptima's maximum cumulative payment obligation hereunder for work performed and/or products received on Exhibit A of this Contract shall not exceed [Insert Maximum Cumulative Payment Amount, Written] Dollars ($[Insert Maximum Cumulative Payment Amount, Number]), including all amounts payable to CONTRACTOR for its direct labor and expenses, overhead costs, fixed fee, subcontracts, leases, materials, and costs arising from or due to termination of this Contract.

   [different compensation options]

5. CONTRACTOR's hourly billable rate shall be «Hourly billable spelled» Dollars ($«Hourly Billable») per hour. This rate is fixed for the duration of the Contract. CONTRACTOR agrees to extend this rate to CalOptima for a period of one (1) year after Contract termination. CalOptima shall not pay CONTRACTOR for time spent traveling.

5. CONTRACTOR's fees for the goods and/or services provided under Exhibit A, Scope of Work, will be billed based upon completion of the milestones as set forth in the schedule(s) in Exhibit B-1. These fees are fixed for the duration of the Contract. CONTRACTOR agrees to extend these fees to CalOptima for a period of one (1) year after Contract termination. CalOptima shall not pay CONTRACTOR for time spent traveling.

5. CONTRACTOR's fees for the goods and/or services provided under Exhibit A, Scope of Work, will be billed on a time and materials basis. Each CONTRACTOR employee will have an associated hourly rate, which CONTRACTOR will extend by the hours of service performed in order to determine the amount of fees to invoice. The CONTRACTOR's employees who will participate in this Contract, their titles/labor category and the [hourly/daily] rates associated with this Contract are set forth in Exhibit B-1. These fees and rates are fixed for the duration of the Contract. CONTRACTOR agrees to extend these fees and rates to CalOptima for a period of one (1) year after Contract termination. CalOptima shall not pay CONTRACTOR for time spent traveling.

5. CONTRACTOR's fees for the goods and/or services provided under Exhibit A, Scope of Work, will be billed based upon completion of the milestones as set forth in the schedule(s) in Exhibit B-1. For any additional work beyond that specified in Exhibit A, Scope of Work, that is authorized by CalOptima in a written amendment or change order, CONTRACTOR shall be paid at the hourly billable rate of «Hourly Billable Spelled» Dollars

($«Hourly Rate») per hour. These fees and rates are fixed for the duration of the Contract. CONTRACTOR agrees to extend these fees and rates to CalOptima for a period of one (1) year after Contract termination. CalOptima shall not pay CONTRACTOR for time spent traveling.

5. CONTRACTOR's fees for the goods and/or services provided under Exhibit A, Scope of Work, will be billed at the rates set forth in Exhibit B-1. These fees are fixed for the duration of the Contract. CONTRACTOR agrees to extend these fees to CalOptima for a period of one (1) year after Contract termination. CalOptima shall not pay CONTRACTOR for time spent traveling.

6. If CONTRACTOR incurs travel-related expenses under this Contract, CalOptima will only reimburse such expenses if CalOptima provides prior written approval of such expenses and those expenses are incurred and submitted in accordance with CalOptima Travel Policy (G.A.5004), as amended, which is incorporated into this Contract by this reference. CalOptima will make CalOptima Travel Policy (G.A.5004) available to CONTRACTOR upon written request.

EXHIBIT B-1
Payment Schedule

Milestone	Completion Date	Fee
_____	_____	_____
_____	_____	_____
_____	_____	_____
TOTAL		

Name	Title/Labor Category	Rate
_____	_____	_____
_____	_____	_____
_____	_____	_____

EXHIBIT C
Regulatory Requirements

CalOptima is a public agency and is licensed by the DMHC. In addition, CalOptima arranges for the provision of Medi-Cal services to Medi-Cal beneficiaries under a contract with DHCS ("**DHCS Contract**") and Medicare Advantage ("**MA**") services to Medicare beneficiaries under a contract CMS ("**CMS Contract**"). This Exhibit C sets forth the statutory, regulatory, and contractual requirements that CalOptima must incorporate into the Contract as a public agency and DMHC-licensed health care service plan with MA and Medi-Cal products.

1. **Medi-Cal Requirements**.

1.1. Compliance with Medi-Cal Standards. CONTRACTOR agrees that the Contract shall be governed by and construed in accordance with all laws and applicable regulations governing the DHCS Contract. CONTRACTOR shall comply with all applicable requirements of the Medi-Cal program and comply with all monitoring of the DHCS Contract and any other monitoring requests by DHCS.

1.2. Disclosure of Officers, Owners, Stockholders and Creditors. Pursuant to Exhibit E, Attachment 2, Section 33 (a) of the DHCS Contract and 42 C.F.R. Section 455.104, upon the Effective Date, on an annual basis, and within thirty (30) days of any changes, CONTRACTOR shall identify the names of the following persons by listing them on Exhibit D of this Contract and submitting the form to CalOptima:

1.2.1. All officers and owners who own greater than five percent (5%) of the CONTRACTOR;

1.2.2. All stockholders owning greater than five percent (5%) of any stock issued by CONTRACTOR; and

1.2.3. All creditors of CONTRACTOR's business if such interest is over five percent (5%).

1.3. Compliance with Employment and Labor Laws. Each Party shall, at its own expense, comply with all applicable laws in performing their respective obligations under the Contract, including, but not limited to, the National Labor Relations Act, the Americans With Disabilities Act, all applicable employment discrimination laws, overtime laws, tax laws, immigration laws, workers' compensation laws, occupational safety and health laws, and unemployment insurance laws and any regulations related thereto. CONTRACTOR acknowledges and agrees that:

1.3.1. CONTRACTOR and its subcontractors will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. CONTRACTOR and its subcontractors will take affirmative action to ensure that qualified applicants are employed and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age, or status as a disabled veteran or veteran of the Vietnam era. Such action shall include the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. CONTRACTOR and its subcontractors agree to post in conspicuous places, available to employees and applicants for employment, notices 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 shall state CONTRACTOR and its subcontractors' obligation 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. [DHCS Contract, Exhibit D(F), Provision 1, Section A]

1.3.2. CONTRACTOR and its subcontractors will, in all solicitations or advancements for employees placed by or on behalf of CONTRACTOR and its subcontractors, state that all qualified applicants

will receive consideration for employment without regard to race, color, religion, sex, national origin, physical or mental handicap, disability, age, or status as a disabled veteran or veteran of the Vietnam era. [DHCS Contract, Exhibit D(F), Provision 1, Section B]

1.3.3. CONTRACTOR and its subcontractors will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the federal government or the State of California, advising the labor union or workers' representative of CONTRACTOR and its subcontractors' commitments under this Section 1.3 and shall post copies of the notice in conspicuous places available to employees and applicants for employment. [DHCS Contract, Exhibit D(F), Provision 1, Section C]

1.3.4. CONTRACTOR and its subcontractors will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212), and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity", and as supplemented by regulation at 41 C.F.R. 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. [DHCS Contract, Exhibit D(F), Provision 1, Section D]

1.3.5. CONTRACTOR and its subcontractors will furnish all information and reports required by Federal Executive Order No. 11246, as amended, including by Executive Order 11375, "Amending Executive Order No. 11246, Relating to Equal Employment Opportunity", and as supplemented by regulation at 41 C.F.R. 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. [DHCS Contract, Exhibit D(F), Provision 1, Section E]

1.3.6. If CONTRACTOR and its subcontractors' do not comply with the requirements of this Section 1.3 or with any federal rules, regulations, or orders referenced herein, this Contract may be cancelled, terminated, or suspended in whole or in part, and CONTRACTOR and its subcontractors may be declared ineligible for further federal and state contracts, in accordance with procedures authorized in Federal Executive Order No. 11246, as amended, and such other sanctions may be imposed and remedies invoked as provided in Federal Executive Order No. 11246, as amended, including by Executive Order 11375, "Amending Executive Order No. 11246 Relating to Equal Employment Opportunity", and as supplemented by regulation at 41 C.F.R. 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. [DHCS Contract, Exhibit D(F), Provision 1, Section F]

1.3.7. CONTRACTOR and its subcontractors will include the provisions of this Section 1.3 in every subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor, issued pursuant to Federal Executive Order No. 11246, as amended, including by Executive Order 11375, "Amending Executive Order No. 11246 Relating to Equal Employment Opportunity", and as supplemented by regulation at 41 C.F.R. 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. CONTRACTOR and its subcontractors will take such action with respect to any subcontract or purchase order as the Director of the Office of Federal Contract Compliance Programs or DHCS may direct as a means of enforcing such provisions, including sanctions for noncompliance; provided, however, that if CONTRACTOR and its subcontractors become involved in, or are threatened with litigation by a subcontractor as a result of such direction by DHCS, CONTRACTOR and its subcontractors may request in writing to DHCS, which, in turn, may request the United States to enter into such litigation

to protect the interests of the State of California and of the United States. [DHCS Contract, Exhibit D(F), Provision 1.G]

1.4. Debarment and Suspension Certification.

1.4.1. By signing this Contract, the CONTRACTOR agrees to comply with any and all applicable federal suspension and debarment regulations, including, as applicable, 7 C.F.R. 3017, 45 C.F.R. 76, 40 C.F.R. 32, or 34 C.F.R. 85. [DHCS Contract, Exhibit D(F), Provision 19, Section A]

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

1.4.2.1. Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any state or federal department or agency; [DHCS Contract, Exhibit D(F), Provision 19, Section B.1]

1.4.2.2. Have not within a three (3)-year period preceding this Contract been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, state or local) transaction or contract under a public transaction; violation of federal or state anti-trust statutes; or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property; [DHCS Contract, Exhibit D(F), Provision 19, Section B.2]

1.4.2.3. Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (federal, state or local) with commission of any of the offenses enumerated in Section 1.4.2.2 of this Exhibit C; [DHCS Contract, Exhibit D(F), Provision 19, Section B.3]

1.4.2.4. Have not within a three (3)-year period preceding the Effective Date of this Contract had one or more public transactions (federal, state or local) terminated for cause or default; [DHCS Contract, Exhibit D(F), Provision 19, Section B.4]

1.4.2.5. Have not and shall not knowingly enter into any lower-tier covered transaction with a person who is proposed for debarment under federal regulations (i.e., 48 C.F.R. 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State of California; and [DHCS Contract, Exhibit D(F), Provision 19, Section B.5]

1.4.2.6. Will include a clause entitled, "Debarment and Suspension Certification" that sets forth the provisions herein in all lower-tier covered transactions and in all solicitations for lower-tier covered transactions. [DHCS Contract, Exhibit D(F), Provision 19, Section B.6]

1.4.3. If the CONTRACTOR is unable to certify to any of the statements in this certification, the CONTRACTOR shall submit an explanation to CalOptima. [DHCS Contract, Exhibit D(F), Provision 19, Section C]

1.4.4. The terms and definitions herein have the meanings set out in the Definitions and Coverage sections of the rules implementing Federal Executive Order 12549. [DHCS Contract, Exhibit D(F), Provision 19, Section D]

1.4.5. If the CONTRACTOR knowingly violates this certification, in addition to other remedies available to the federal government, CalOptima may terminate this Contract for cause or default. [DHCS Contract, Exhibit D(F), Provision 19, Section E]

1.5. Lobbying Restrictions and Disclosure Certification.

1.5.1. *Certification and Disclosure Requirements*.

1.5.1.1. If Contract is subject to 31 U.S.C. § 1352 and exceeds $100,000 at any tier, CONTRACTOR and its subcontractors, as applicable, shall file a certification (in the form set forth in Exhibit E, consisting of one page, entitled "Certification Regarding Lobbying") that CONTRACTOR and its subcontractors, as applicable, have not made, and will not make, any payment prohibited by Section 1.5.2 below. [DHCS Contract, Exhibit D(F), Provision 31, Section A.1; 31 U.S.C. § 1352]

1.5.1.2. CONTRACTOR and its subcontractors, as applicable, shall file a disclosure (in the form set forth in Exhibit E, entitled "Certification Regarding Lobbying") if CONTRACTOR and its subcontractors, as applicable, have made or agreed to make any payment using non-appropriated funds (to include profits from any covered federal action) in connection with the Contract or a subcontract thereunder that would be prohibited under Section 1.5.2 below if paid for with appropriated funds. [DHCS Contract, Exhibit D(F), Provision 31, Section A.2]

1.5.1.3. CONTRACTOR and its subcontractors, as applicable, shall file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affect the accuracy of the information contained in any disclosure form previously filed by CONTRACTOR and its subcontractors, as applicable, under this Section 1.5.1. An event that materially affects the accuracy of the information reported includes: [DHCS Contract, Exhibit D(F), Provision 31, Section A.3]

1.5.1.3.1. A cumulative increase of $25,000 or more in the amount paid or expected to be paid for influencing or attempting to influence a covered federal action; [DHCS Contract, Exhibit D(F), Provision 31, Section A.3.a]

1.5.1.3.2. A change in the person(s) or individuals(s) influencing or attempting to influence a covered federal action; or [DHCS Contract, Exhibit D(F), Provision 31, Section A.3.b]

1.5.1.3.3. A change in the officer(s), employee(s), or member(s) contacted for the purpose of influencing or attempting to influence a covered federal action. [DHCS Contract, Exhibit D(F), Provision 31, Section A.3.c]

1.5.1.3.4. As applicable and required by this Section 1.5, CONTRACTOR's subcontractors shall file a certification and a disclosure form, if required, to the next tier above. [DHCS Contract, Exhibit D(F), Provision 31, Section A.4]

1.5.1.3.5. All disclosure forms (but not certifications) shall be forwarded from tier to tier until received by CONTRACTOR. CONTRACTOR shall forward all disclosure forms to CalOptima. [DHCS Contract, Exhibit D(F), Provision 31, Section A.5]

1.5.2. *Prohibition*. 31 U.S.C. § 1352 provides in part that no appropriated funds may be expended by the recipient of a federal contract, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with any of the following covered federal actions: the awarding of any federal contract, the making of any federal grant, the making of any federal loan, entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement. [DHCS Contract, Exhibit D(F), Provision 31, Section B]

1.6. Verification of CalOptima Costs by Government. Until the expiration of ten (10) years after the later of furnishing of any service pursuant to this Contract or completion of any audit, or longer as required by applicable regulations, CONTRACTOR will make available, upon written request of CalOptima, the Secretary of Health and Human Services Office of Inspector General, the Comptroller General of the United States, the U.S. Department of Justice, DHCS, the DMHC, the Bureau of Medical Fraud, or any of their duly authorized representatives copies of this Contract and any financial statements, books, documents, records, patient care documentation, and other records or data of CONTRACTOR that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under this Contract, or as are otherwise necessary to certify the nature and extent of costs incurred by CalOptima for such services. This provision shall also apply to any agreement with a CONTRACTOR subcontractor or an organization related to a CONTRACTOR subcontractor by control or common ownership. CONTRACTOR further agrees that regulating entities have the right to inspect, evaluate and audit any pertinent information and to facilitate the review of the items referenced herein, to make available its premises, physical facilities and equipment, records related to Medicare enrollees, and any additional relevant information that regulating entities may require. CONTRACTOR further agrees and acknowledges that this provision will be included in any and all agreements with CONTRACTOR's subcontractors. [DHCS Contract, Exhibit E, Attachment 2, Provision 20]

1.7. Confidentiality of Member Information.

1.7.1. If CONTRACTOR and its employees, agents, or subcontractors access or receive, whether intentionally or unintentionally, personally identifying information during the Term, CONRACTOR and its employees, agents, and subcontractors shall protect from unauthorized disclosure, the names and other identifying information concerning persons either receiving services pursuant to this Contract, or persons whose names or identifying information become available or are disclosed to CONTRACTOR, its employees, agents, or subcontractors as a result of services performed under this Contract, except for statistical information not identifying any such person. CONTRACTOR and its employees, agents, or subcontractors shall not use such identifying information for any purpose other than carrying out the express terms of and CONTRACTOR's obligations under this Contract. CONTRACTOR and its employees, agents, or subcontractors shall promptly transmit to CalOptima all requests for disclosure of such identifying information, except requests for medical records in accordance with applicable law, not emanating from the CalOptima member. CONTRACTOR shall not disclose, except as otherwise specifically permitted by this Contract or authorized by the CalOptima member, any such identifying information to anyone other than DHCS or CalOptima without prior written authorization from CalOptima specifying that the information is releasable under Title 42 C.F.R. Section 431.300 *et seq*., Section 14100.2, Welfare and Institutions Code, and regulations adopted there under. For purposes of this Section 1.7, identity shall include name, identifying number, symbol, or other identifying detail assigned to the individual, such as finger or voice print or a photograph. [DHCS Contract, Exhibit D(F), Provision 12, Exhibit E, Attachment 2, Provision 22, Section B]

1.7.2. Names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with Title 42 C.F.R. Section 431.300 *et seq*., Section 14100.2, Welfare and Institutions Code, and regulations adopted thereunder. For the purpose of this Contract, all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to CalOptima members shall be protected by CONTRACTOR from unauthorized disclosure. CONTRACTOR may release Medical Records in accordance with applicable law pertaining to the release of this type of information. CONTRACTOR is not required to report requests for Medical Records made in accordance with applicable law. With respect to any identifiable information concerning a CalOptima member under this Contract that is obtained by CONTRACTOR or its subcontractors, CONTRACTOR will, at the termination of this Contract, return all such information to CalOptima or maintain such information according to written procedures sent to the CONTRACTOR by CalOptima for this purpose. [DHCS Contract, Exhibit E, Attachment 2, Provision 22]

1.8. Member Hold Harmless. To the extent CONTRACTOR provides services or supplies to CalOptima members, CONTRACTOR hereby agrees that in no event, including nonpayment by CalOptima, the insolvency of CalOptima, or breach of the Contract, shall CONTRACTOR bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against CalOptima members, persons acting on their behalf, or DHCS. CONTRACTOR further agrees that this hold harmless provision shall survive the termination of the Contract regardless of the cause giving rise to the termination, shall be construed to be for the benefit of CalOptima members, and that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between CalOptima or CONTRACTOR and a CalOptima member or persons acting on their behalf that relates to liability for payment for services under the Contract. [DHCS Contract, Exhibit A, Attachment 6, Provision 13, Section B.15; CMS Medicare Managed Care Manual Chapter 11, Section 100.4]

1.9. Air and Water Pollution Requirements. If this Contract or any subcontract thereunder is in excess of one hundred thousand dollars ($100,000), CONTRACTOR agrees to comply with all applicable standards, orders, or requirements issued under the Clean Air Act (42 USC § 7401 *et seq*.), as amended, and the Federal Water Pollution Control Act (33 USC § 1251 *et seq*.), as amended. [DHCS Contract, Exhibit D(F), Provision 11]

2. **Medicare Requirements**.

2.1. CONTRACTOR expressly warrants that CONTRACTOR and CONTRACTOR's subcontractors, if any, shall comply with all applicable Medicare laws, regulations, and CMS instructions. CONTRACTOR further agrees and acknowledges that this provision will be included in all agreements with CONTRACTOR's subcontractors.

2.2. For any medical records or other health and enrollment information CONTRACTOR maintains with respect to Medicare enrollees, CONTRACTOR shall establish procedures to:

2.2.1. Abide by all federal and state laws regarding confidentiality and disclosure of medical records and other health and enrollment information. CONTRACTOR shall safeguard the privacy of any information that identifies a particular enrollee and shall have procedures that specify: (a) the purposes for which the information will be used within CONTRACTOR's organization; and (b) to whom and for what purposes CONTRACTOR will disclose the information.

2.2.2. Ensure that the medical information is used and released only in accordance with applicable federal or state law, or pursuant to court orders or subpoenas.

2.2.3. Maintain the records and information in an accurate and timely manner.

2.3. CONTRACTOR shall comply with the reporting requirements provided in 42 C.F.R. § 422.516, as well as the encounter data submission requirements in 42 C.F.R. § 422.257.

2.4. For all contracts in the amount of $100,000 or more, CONTRACTOR and CONTRACTOR's subcontractors, if any, shall comply with 41 C.F.R. 60-300.5(a) and 41 C.F.R. 60-741.5(a) as follows:

2.4.1. CONTRACTOR and Subcontractor shall abide by the requirements of 41 C.F.R. § 60-300.5(a). This regulation prohibits discrimination against qualified protected veterans and requires affirmative action by covered prime contractors and subcontractors to employ and advance in employment qualified protected veterans. [41 C.F.R. § 60-300.5(d)]

2.4.2. CONTRACTOR and subcontractor shall abide by the requirements of 41 C.F.R. § 60-741.5(a). This regulation prohibits discrimination against qualified individuals on the basis of disability and requires affirmative action by covered prime contractors and subcontractors to employ and advance in employment qualified individuals with disabilities. [41 C.F.R. § 60-741.5(d)]

2.5. In addition to the termination provisions of Section 14 of the Contract, CalOptima may terminate the Contract if CMS or CalOptima determines that CONTRACTOR has not satisfactorily performed its obligations under the Contract. Under such circumstances, CalOptima may pay CONTRACTOR its allowable costs incurred to the date of termination. Thereafter, CONTRACTOR shall have no further claims against CalOptima for matters pertaining to this Contract.

2.6. While CalOptima maintains ultimate responsibility for adhering to and complying with all terms and conditions of the CMS Contract, CONTRACTOR shall comply with all such applicable requirements in the CMS Contract, at the direction of CalOptima.

2.7. CONTRACTOR shall ensure that the persons it employs or contracts with for the provision of services pursuant to the Contract are in good standing and not on the preclusion list, defined in 42 C.F.R. § 422.2. CONTRACTOR shall promptly disclose to CalOptima any exclusion or other event that makes a CONTRACTOR employee or subcontractor ineligible to perform work related to federal health care programs. CONTRACTOR agrees to be bound by the provisions set forth at 2 C.F.R. Part 376. [42 C.F.R. § 422.752(a)(8)]

2.8. FDR Compliance. Upon execution of this Contract, CONTRACTOR agrees to execute and abide by the terms of the "FDR Compliance Attestation" in Exhibit F and shall submit an executed FDR Compliance Attestation no less than annually thereafter. [Delete if CONTRACTOR is not a FDR.]

3. **Offshore Performance**.

3.1. Due to security and identity protection concerns, direct services under this Contract shall not be performed by offshore subcontractors, unless otherwise authorized in writing by CalOptima prior to the provision of those services.

3.2. CONTRACTOR shall complete, sign, and return Exhibit G, "Attestation Concerning the Use of Offshore Subcontractors" as of the Effective Date and shall submit an executed Offshore Subcontractor Attestation to CalOptima no less than annually thereafter. CONTRACTOR represents and warrants that it has disclosed in Exhibit G any and all such offshore subcontractors and that it has obtained CalOptima's written approval to use such offshore subcontractors prior to the Effective Date.

3.3. Any subcontract with an offshore entity under which the offshore entity will have access to any confidential CalOptima member or other protected health information must be approved in writing by CalOptima prior to execution of the subcontract. CONTRACTOR is required to submit future Offshore Contractor Attestations to CalOptima within thirty (30) calendar days after it has signed a contract with any subcontractor that may be using an offshore subcontractor to perform any related work.

3.4. Unless specifically stated otherwise in this Contract, the restrictions of this Section 3 do not apply to indirect or "overhead" services, or services that are incidental to the performance of the Contract.

3.5. The provisions of this Section 3 apply to work performed by subcontractors at all tiers.

4. **Prohibited Interest**.

4.1. CONTRACTOR shall comply with all applicable federal, state, and local laws and regulations pertaining to conflict-of-interest laws, including CalOptima's Conflict of Interest Code, the California Political Reform Act (California Government Code § 81000 *et seq*.) and California Government Code § 1090 *et seq*. (collectively, the "**Conflict of Interest Laws**").

4.2. CONTRACTOR covenants that, to the best of its knowledge during the Term, no director, officer, or employee of CalOptima during his or her tenure has any interest, direct or indirect, in this Contract or the proceeds thereof. CONTRACTOR further covenants that, for the Term, and consistent with the provisions of 22 C.C.R. § 53600(f), no state officer or state employee shall be employed in a management or

contractor position by CONTRACTOR within one (1) year after the state office or state employee has terminated state employment.

4.3. CONTRACTOR, and any person designated by CONTRACTOR to make or participate in making a governmental decision on behalf of CalOptima, is considered a "**Consultant**" pursuant to CalOptima's Conflict of Interest Code and shall be required to file a statement of economic interests (Fair Political Practices Commission Form 700) with CalOptima annually. [2 C.C.R. Section 18734]

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

4.5. If CONTRACTOR becomes aware of any facts that might reasonably be expected to either create a conflict of interest under the Conflict of Interest Laws or violate the provisions of this Section 4, CONTRACTOR shall immediately make full written disclosure of such acts to CalOptima. Full written disclosure shall include identification of all persons, entities, and businesses implicated and a complete description of all relevant circumstances.

5. **State Auditor Audit Disclosure**. Pursuant to California Government Code § 8546.7, if this Contract is more than ten thousand dollars ($10,000), it is subject to examination and audit of the California State Auditor, at the request of CalOptima or as part of any audit of CalOptima for a period of three (3) years after final payment under this Contract. In addition to and notwithstanding any other right of access or inspection that may be otherwise set forth in this Contract, CONTRACTOR agrees that during the Term and for a period of three (3) years after its termination, CalOptima shall have access to and the right to examine any directly pertinent books, documents, invoices, and records of CONTRACTOR relating to services provided under this Contract. Where another right of access or inspection in this Contract provides for a period of greater than three (3) years, nothing herein shall be construed to shorten that time period. [Gov't Code § 8546.7]

EXHIBIT D
Medi-Cal Disclosure Form

Contractor Officer, Owner, Shareholder, and Creditor Information

Contractor's Business Name: _____

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

Business Address: _____

City:_____ State:_____ Zip:_____
Business Phone:_____ Email: :_____
President: _____ Contact Person:_____

Person(s) Signing Contract & Title: :_____

*Please provide names of owners, officers, stockholders, and creditors of Contractor's business if such interest is over 5%.

Name	Officer Title or Ownership/Creditorship %
_____	_____
_____	_____
_____	_____
_____	_____

BY SIGNING BELOW, THE UNDERSIGNED HEREBY CERTIFIES THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF HIS OR HER KNOWLEDGE AND BELIEF.

_____ _____
Authorized Signature Date

_____
Name and Title

EXHIBIT E

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES
CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the making, awarding or entering into of this federal contract, federal grant, or cooperative agreement, and the extension, continuation, renewal, amendment, or modification of this federal contract, grant, or cooperative agreement.

(2) If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency of the United States Government, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, or cooperative agreement, the undersigned shall complete and submit Standard Form LLL, "Disclosure of Lobbying Activities"' in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontractors, subgrants, and contracts under grants and cooperative agreements) of $100,000 or more, and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S.C., any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

_____	_____
Name of Contractor	Printed Name of Person Signing for Contractor
_____	_____
Contract/Grant Number	Signature of Person Signing for Contractor
_____	_____
Date	Title

After execution by or on behalf of Contractor, please return to:

Department of Health Care Services
Medi-Cal Managed Care Division
MS 4415, 1501 Capitol Avenue, Suite 71.4001
P.O. Box 997413
Sacramento, CA 95899-7413

CERTIFICATION REGARDING LOBBYING

Approved by OMB 0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure)

1. Type of Federal Action: ☐a. contract ☐b. grant ☐c. cooperative agreement ☐d. loan ☐e. loan guarantee ☐f. loan insurance	2. Status of Federal Action: ☐a. bid/offer/application ☐b. initial award ☐c. post-award	3. Report Type: ☐a. initial filing ☐b. material change **For Material Change Only:** Year _____ quarter_____ date of last report _____

4. Name and Address of Reporting Entity: ☐ Prime ☐ Subawardee Tier ____, *if known*: Congressional District, *if known*:	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime: Congressional District, *if known*:
6. Federal Department/Agency:	7. Federal Program Name/Description: CDFA Number, *if applicable*:
8. Federal Action Number, *if known*:	9. Award Amount, *if known*: $_____
10. a. Name and Address of Lobbying Entity (*If individual, last name, first name, MI*):	b. Name and Address of Lobbying Entity (If individual, last name, first name, MI):

(*attach Continuation Sheet(s) SF-LLLA, if necessary)*

11. Amount of Payment (check all that apply): $_____ ☐actual ☐planned	13. Type of Payment ☐ a. retainer ☐ b. one-time fee ☐ c. commission ☐ d. contingent fee ☐ e. deferred ☐ f. other, specify: _____
12. Form of Payment (check all that apply): ☐ a. cash ☐ b. in-kind, specify: Nature _____ Value _____	

14. Brief Description of Services Performed or to be Performed and Dates(s) of Service, including Officer(s), Employee(s), or Member(s) Contracted for Payment indicated in item 11:

(Attach Continuation Sheet(s) SF-LLL-A, If necessary)

15. Continuation Sheet(s) SF-LLL-A Attached: ☐Yes ☐No

16. Information requested through this form is authorized by Title 31, U.S.C., Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to Title 31, U.S.C., Section 1352. This information will be reported to the Congress semiannually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.	Signature: Print Name: Title: Telephone No.: Date:

Federal Use Only	Authorized for Local Reproduction Standard Form-LLL

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime federal recipients at the initiation or receipt of a covered federal action, or a material change to a previous filing, pursuant to Title 31, U.S.C., Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered federal action. Use the SF - LLL- A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered federal action.

2. Identify the status of the covered federal action.

3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered federal action.

4. Enter the full name, address, city, state, and ZIP code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants, and contract awards under grants.

5. If the organization filing the report in Item 4 checks "Subawardee," then enter the full name, address, city, state, and ZIP code of the prime federal recipient. Include Congressional District, if known.

6. Enter the name of the federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation United States Coast Guard.

7. Enter the federal program name or description for the covered federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CDFA) number for grants, cooperative agreements, loans, and loan commitments.

8. Enter the most appropriate federal identifying number available for the federal action identified in Item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract grant, or loan award number; the application/proposal control number assigned by the federal agency). Include prefixes, e.g., "RFP-DE-90401."

9. For a covered federal action where there has been an award or loan commitment by the federal agency, enter the federal amount of the award/loan commitment for the prime entity identified in Item 4 or 5.

10. (a) Enter the full name, address, city, state, and ZIP code of the lobbying entity engaged by the reporting entity identified in Item 4 to influence the covered federal action.

    (b) Enter the full names of the Individual(s) performing services and include full address if different from 10.(a). Enter last name, first name, and middle initial (MI).

11. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (Item 4) to the lobbying entity (Item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

12. Check the appropriate box(es). Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.

13. Check the appropriate box(es). Check all boxes that apply. If other, specify nature.

14. Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with federal officials. Identify the federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.

15. Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.

16. The certifying official shall sign and date the form, print his/her name, title, and telephone number.

EXHIBIT F
FDR Attestation

FDR COMPLIANCE ATTESTATION

Please complete and execute this attestation and return it to CalOptima's Office of Compliance via email Compliance@caloptima.org , or mail: CalOptima, Office of Compliance, Attn: Annie Phillips 505 City Parkway West, Orange, CA 92868, within thirty (30) calendar days for (existing FDRs) or sixty (60) calendar days for (new FDRs) of this notice.

Which CalOptima program(s) does this form pertain to? Select all that apply:	☐OneCare Connect ☐OneCare HMO SNP	☐Medi Cal ☐PACE

I hereby attest that [_____ (the "Organization")], and all its downstream entities, if any, that are involved in the provision of health or administrative services for any of the CalOptima programs identified above:

I. **General and HIPAA Compliance and FWA Training.** Provide effective Fraud, Waste and Abuse training, General Compliance training, General HIPAA training to all Organization and downstream entity board members, officers, employees, temporary employees, and volunteers, within ninety (90) calendar days of appointment, hire or contracting, as applicable, and at least annually thereafter as a condition of appointment, employment or contracting. The Organization and its downstream entities currently use (Select all that apply):

- ☐ CMS's Fraud, Waste, and Abuse training, General Compliance training, and General HIPAA training module. (The Organization shall maintain records per CMS retention requirement)
- ☐ An internal training program that meets CMS's Fraud, Waste, and Abuse training, General Compliance training, and HIPAA training module requirements. (The Organization shall maintain records per CMS retention requirement)

Note: If selecting an internal training program that meets CMS's FWA, HIPAA, and General Compliance, please submit a copy of your organization's trainings to CalOptima's Office of Compliance for review, and to ensure they meet CMS's requirements.

II. Administer specialized compliance training to Organization and downstream entity board members, employees, temporary employees, and volunteers: (i) based on their job function within the first ninety (90) days of hire and at least annually thereafter as a condition of appointment, employment or contracting, (ii) when requirements change; (iii) when such persons work in an area previously found to be non- compliant with program requirements or implicated in past misconduct.

III. **Compliance Plan and Code of Conduct Requirements.** Have established and publicized compliance policies and procedures, standards of conduct, and compliance reference material that meet the requirements outlined in 42 CFR § 422.503(b)(4)(vi)(A) and 42 CFR § 423.504(b)(4)(vi)(A) which information, and any updates thereto, are distributed to all Organization and downstream entity board members, officers, employees, temporary employees, and volunteers within ninety (90) days of appointment, hire or contracting, as applicable, and at least annually thereafter. Evidence of receipt of such compliance by such persons is obtained and retained by the Organization. (Select which applies to your organization):

- ☐ Organization has adopted, implemented, and distributed CalOptima's Compliance Plan and Code of Conduct
- ☐ Organization has distributed a comparable Compliance Plan and Code of Conduct

Note: If selecting a comparable Compliance Plan and Code of Conduct, please submit a copy of your organization's Compliance Plan and Code of Conduct to CalOptima's Office of Compliance for review, and to ensure they meet CMS's requirements

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IV. **Exclusion Monitoring**. Review all Organization and downstream entity board members, officers, potential and actual employees, temporary employees, and volunteers against the (Suspended and Ineligible Provider List) S & I Medi-Cal, (Health and Human Services) HHS, (Office of Inspector General) OIG List of Excluded Individuals & Entities list, (System for Award Management) SAM/(General Services Administration) GSA Debarment list, Centers for Medicare & Medicaid Services (CMS) Preclusion List (as applicable), (here after "Lists") upon appointment, hire or contracting, as applicable, and monthly thereafter. Further, in the event that the Organization or downstream entity becomes aware that any of the foregoing persons or entities are included on these Lists, the Organization will notify CalOptima within five (5) calendar days, the relationship with the listed person/entity will be terminated as it relates to CalOptima, and appropriate corrective action will be taken.

V. **Conflict of Interest**. Screen the Organization and its subcontractors' governing bodies for conflicts of interest as defined in state and federal law and CalOptima policies and procedures upon hire or contracting and annually thereafter.

VI. **Reporting of FWA/Non-Compliance**. Will report suspected fraud, waste, and abuse, as well as all other forms of non- compliance, as it relates to CalOptima, confidentially and anonymously.

VII. **Disciplinary Action**. Understand that any violation of any laws, regulations, or CalOptima policies and procedures are grounds for disciplinary action, up to and including termination of Organization's contractual status.

VIII **Non-Retaliation**. Are aware that persons reporting suspected fraud, waste, and abuse, and other non- compliance are protected from retaliation under the False Claims Act and other applicable laws prohibiting retaliation.

IX. **Records Management**. Retain documented evidence of compliance with the above, including training and exclusion screening (i.e. sign-in sheets, certificates, attestations, OIG and GSA search results, etc.) for at least ten (10) years, and provide such documentation to CalOptima upon request.

The individual signing below is knowledgeable about and authorized to attest to the foregoing matters on behalf of the Organization.

_____	_____
Signature	Date
_____	_____
Name (Print)	Organization
_____	
Email (Print)	

EXHIBIT G

Attestation Concerning the Use of Offshore Subcontractors

If Organization offshores any protected health information (PHI) it must notify CalOptima prior to entering into or amending any agreement with an Offshore Subcontractor, and Contractor must complete the Offshore Subcontracting Attestation.

Which CalOptima program(s) does this form pertain to? Select all that apply.	☐ OneCare Connect ☐ PACE ☐ OneCare ☐ Medi-Cal

Please check one of the following:

☐ Our Organization does not offshore any protected health information.
Please skip to Part V below

☐ Our Organization does offshore protected health information.
Please complete Offshore Subcontractor Attestation (Part I through Part V) below

Part I — Offshore Subcontractor Information	
Attestation	**Response**
Our Organization uses an offshore subcontractor or offshore staff to perform functions that support our contract with CalOptima	☐ Yes ☐ No
Offshore Subcontractor name:	
Offshore Subcontractor country:	
Offshore Subcontractor address:	
Describe offshore subcontractor functions:	
Proposed or actual effective date for offshore subcontractor (MM/DD/Year):	

Part II — Precautions for Protected Health Information (PHI)	
Question	**Response**
1. Describe the PHI that will be provided to the offshore subcontractor	
2. Explain why providing PHI is necessary to accomplish the offshore subcontractor's objectives:	
3. Describe alternatives considered to avoid providing PHI, and why each alternative was rejected:	

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Part III — Attestation of Safeguards to Protect Beneficiary Information in the Offshore Subcontract	
Attestation	**Response**
A. Offshore subcontracting arrangement has policies and procedures in place to ensure that Medicare beneficiary protected health information (PHI) and other personal information remains secure.	☐ Yes ☐ No*
B. Offshore subcontracting arrangement prohibits subcontractor's access to Medicare data not associated with CalOptima's contract with the offshore subcontractor.	☐ Yes ☐ No*
C. Offshore subcontracting arrangement has policies and procedures in place that allow for immediate termination of the subcontract upon discovery of a significant security breach.	☐ Yes ☐ No*
D. Offshore subcontracting arrangement includes all required Medicare Part C and D language (e.g., record retention requirements, compliance with all Medicare Part C and D requirements, etc.)	☐ Yes ☐ No*

Part IV — Attestation of Audit Requirements to Ensure Protection of PHI	
Attestation	**Response**
A. Our Organization will conduct an annual audit of the offshore subcontractor/employee.	☐ Yes ☐ No*
B. Audit results will be used by our Organization to evaluate the continuation of its relationship with the offshore subcontractor/employee.	☐ Yes ☐ No*
C. Our Organization agrees to share offshore subcontractor's/employee's audit results with CalOptima or CMS upon request.	☐ Yes ☐ No*

***Explanation required for all "no" responses to Part III and Part IV above:**

Part V — Organization Information	
By signing below, I hereby attest that the information contained herein is true, correct and complete.	
Printed name of authorized person:	Title:
Email:	Phone #:
Signature:	Date:

Note: CalOptima's policies and procedures, CMS training module instructions for FWA, General Compliance, General HIPAA, CalOptima's Code of Conduct, CalOptima's Compliance Plan can be accessed at https://www.caloptima.org/en/About/GeneralCompliance.aspx

EXHIBIT H
Business Associate Contract

[insert CalOptima vendor BAA if applicable]

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken at August 4, 2022
Regular Meeting of the CalOptima Board of Directors

Report Item
23. Approve Actions Related to the Procurement of a Customer Relationship Management System

Contacts
Wael Younan, Chief Information Officer / Chief Information Security Officer, (657) 900-1154
Nora Onishi, Director, Information Technology Services, (714) 246-8630

Recommended Actions
1. Approve the scope of work (SOW) for the Customer Relationship Management (CRM) system.
2. Authorize the Chief Executive Officer to release the CRM request for proposal (RFP) with the approved SOW and to negotiate and contract with the selected vendor.

Background
As part of CalOptima's Workplace Modernization and Digital Transformation Strategy, Information Technology Services will be evaluating and deploying multiple solutions. These solutions coincide with CalOptima's Cloud First strategy and take regulatory compliance and security measures into consideration. These initiatives will assist CalOptima in achieving its Vision Statement of removing barriers to achieve real-time claims payments and 24-hour treatment authorizations and doing annual assessments around social determinants of health by 2027. The projects and products that CalOptima implements will result in value-based care and improvements for member, provider, and employee experiences. These enhancements will provide CalOptima with the ability to be robust, agile, and to scale as a future-focused healthcare organization.

Discussion
The CRM system will provide a solution that connects data from multiple systems to enrich CalOptima's call center staff engagement with members and providers. The CRM capabilities will support and enhance efficiency to enable CalOptima's Customer Service teams to provide positive outcomes for and experiences with members and providers. This system will allow for a more personalized experience by greeting customers by name and having their information populated into the system for an overall better customer service experience.

The attached SOW will support the request for approval to release the RFP, which will support CalOptima's business requirement to enhance healthcare delivery and customer experience. If approved, the RFP will be issued consistent with CalOptima's procurement process. Review of bids by a committee with a representation of stakeholders from multiple departments will take place to ensure collaboration and selection integrity by CalOptima staff. Based on the scoring from the bid review, CalOptima will ask vendors to provide a demonstration for evaluation and functionality scoring to select a vendor.

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Fiscal Impact
The recommended action is a budgeted item. An estimated cost of $925,000 for the capital project, "Customer Relationship Management System" under the "Applications Management" category was included in the Fiscal Year 2022-23 Digital Transformation Year One Capital Budget approved by the Board on June 2, 2022.

Rationale for Recommendation
CalOptima recognizes the value of its customers, especially the member population that is hard to reach. With an opportunity to engage with its customers, CalOptima wants to enable its call center staff to have all the relevant information available, in real-time, to make the most of the interaction with the customer. Every customer engagement is an opportunity for CalOptima to provide optimized customer support. CalOptima needs to make the best use of that moment to enable its team to help members and providers and provide a personal experience to each customer staff interfaces with.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Proposed CRM Scope of Work

/s/ Michael Hunn *07/28/2022*
Authorized Signature **Date**

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Customer Relationship Management System (CRM) Scope of Work

OBJECTIVE

The purpose of this RFP is to solicit proposals from qualified Customer Relationship Management (CRM) technology/platform vendors, interested in contracting with CalOptima to provide a solution that connects data from multiple systems, enhance / improve efficiency across the organization. The solution will deliver a positive customer experience that helps resolve customer inquiries, challenges, and to support staff performance efficiency with quality service delivery across all customer interactions.

CalOptima has the option to award contracts to a single or multiple supplier(s) as needed to ensure the required coverage for its customers. CalOptima has the option to retain any partial services in-house.

A. **CRM System Requirements**

1. CRM System Functionality

A. Customer Engagement Service Center:

1. Real-time integration with multiple systems to retrieve key data elements to support customer engagement. Connections of software through Application Programming Interface (API) or other methods of integration.

2. Customer level detail information for verification / validation of caller – tracked confirmation on validation elements – retain tracking for audit and recall for next engagement recognition. Continuous improvement to personalize customer experience.

a. Identify Customer to be Member or Provider, based on verification to drive rules and system allowed functions, templated and queue distribution.

b. Adaptive business rules, alerts, notifications, knowledge base from multiple source systems.

c. Outstanding prompts identified from Core System(s), triggers to direct customer engagement to specific queue or to prompt specific questions for the customer service team to resolve.

d. Ability to identify customer information based on automated voice interactions or advanced phone/system prompting features prior to being connected with a CalOptima staff.

e. Ability to capture customer preferences and continue to prompt preferences to Chatbot or Customer Staff to improve customer engagement - (member preferred name, etc.).

B. WebChat / Chatbot Engagement (Member):

1. Chatbot functionality- ability to set engagement based on member's preferred written language validation to enable chat in CalOptima threshold languages:

    a. Advanced chatbots or Artificial Intelligence (AI) webchats with predictive customer support capabilities to assist customers without CalOptima staff intervention.

    b. Chatbot ability to capture and complete customer request for configured parameters (ID Card request, phone number change, address updates, Primary Care Provider (PCP) and Independent Physician Association (IPA) plan changes, claims and authorization status, etc.).

    c. Support for text/SMS-based customer engagement using chatbot and / or live-agent interactions when we have member approval to allow text messaging.

    d. Chatbot ability to relay status of other department values (i.e., claims requests, authorization status).

    e. Escalation to CalOptima staff for additional assistance where Chatbot is not able to fully respond either by design, no information found, or unable to understand the request.

    f. Ability to triage the intake to direct the escalation of CalOptima staff to the right resource, queue, and prompt to place into the priority of the queue.

    g. Ability to track and document all chat activity.

    h. Ability to set up export results and requests into core system to support update and triggers required by core system.

C. Customer Service / Member facing staff Engagement:

1. Enable CalOptima staff to consistently respond to incoming calls, emails, and web requests from members, providers, and other interested parties in an efficient and accurate manner.

    a. Intake engagement with data capture and decision tree documentation

    b. Intuitive and real-time customer management decisioning tools towards problem resolution actions.

    c. Ability to support automated callback request.

    d. Ability to house knowledge/resources to assist CalOptima staff in defining workflows during time of call with or without the assistance of artificial intelligence (AI).

    e. Ability to present customer information or reason for engagement to CalOptima staff to preview prior to live interactions with the customer.

f. Ability to standardize and customize call documentation tools for staff to utilize during customer interactions with the use of predictive customer support or real-time decisioning tools.

g. Advanced knowledge management features that enable CalOptima staff to leverage relevant information towards a faster resolution.

h. Enable CalOptima staff to easily view, filter, categorize, and access historical and recent call interactions based on sophisticated system classification of various. call situations (i.e., general inquiry, dissatisfaction, education of healthcare benefits) based on evolving business and/or regulatory rules.

i. Ability to complete requests and functions of the customer requests; enable the data update to upload into the Core system(s) to support update and triggers required by core system.

D. Customer Service / Clinical Case Management Engagement

1. Automated call distribution to Clinical Care staff when prompted by decision tree indication or chatbot responses.

a. Clinical and customer detail core system information prompts allow immediate insight to customer's existing case details, outstanding information, goals, etc.

b. Intake engagement with AI functionalities, data capture and decision tree documentation.

c. Clinical documentation ability to trigger (privacy limitation) to hold from display unless security of user is allowed.

d. Ability to toggle to clinical system to maintain clinical data in core system

e. Ability to capture closure of contact or route to another CalOptima staff as needed.

E. Provider Engagement:

1. WebChat / Chatbot Engagement:

a. Chatbot functionality to support membership eligibility inquiry replacing IVR phoneline inquiry.

b. Enable data demographic updates, provider data attestation.

c. Advanced chatbots or AI webchats with predictive provider support capabilities to assist customers without CalOptima staff intervention.

d. Chatbot ability to capture and complete provider inquiry / request for configured parameters (i.e., claims request, authorization status).

e. Ability to support automated callback request.

f. Escalation to CalOptima staff for additional assistance where Chatbot is not able to fully respond either by design, no information found, or unable to understand the request.

g. Ability to triage the intake to direct the escalation of CalOptima staff to the right resource, queue, and prompt to place into the priority of the queue.

h. Ability to track and document all chat activity

i. Ability to set up export results and requests into core system to support update and triggers required by core system.

2. Provider Call Center Engagement

a. Queue intake – prompt with provider information pre-verified and triaged to personalize Customer staff engagement with the caller.

b. Intake engagement with data capture and decision tree documentation.

c. Intuitive and real-time customer management decisioning tools towards problem resolution actions.

d. Ability to house knowledge/resources to assist CalOptima staff in defined workflows during time of call with or without the assistance of artificial intelligence (AI).

e. Ability to present staff information or reason for engagement to CalOptima staff to preview prior to live interactions with the provider.

f. Ability to complete requests and functions of the provider requests; enable the data update to upload into the Core system(s) to support update and triggers required by core system.

F. Contact Center Workforce Engagement Management

1. Workforce Management distribution of workload – track wait times, call times, resolution vs route next, track engagement to support ongoing improvement and needs.

a. Track interaction recording for training and audit purposes.

b. Agent evaluation to support performance feedback and training.

c. Performance Management.

d. Interaction Analytics

i. Ability to alert and notify other CalOptima staff advising that their involvement is required to provide further assistance to the customer.

e. Coaching / E-learning

i. Advanced knowledge management features to enable CalOptima staff to leverage relevant information towards a faster resolution.

ii. Continuous development and update of the knowledge library.

f. Post – WebChat / Chatbot and Call Surveying

g. Complaints Management

h. Total Contact Center Performance Management

i. Ability to evaluate key metrics, including, the average speed of answer, answer number of calls per hour, average transfer rate, average call handling time, average daily call volume.

ii. Ability to determine peak call times and real-time monitoring of current wait times.

i. Customer Personality Analysis

j. Emotion Detection / Recognition

i. Ability to emotion detect, recognize, and identify customer sentiment (i.e., customer dissatisfaction, evaluating soft skills improvement opportunities, reducing call average handle time) with or without the assistance of AI.

k. Interaction Analytics

i. Ability to transcribe in real-time verbal interactions amongst CalOptima staff and customer while housing and procuring interaction analytics (i.e., soft skills, staff coaching/performance feedback, adhering to business rules).

l. Predictive Customer Support

i. Ability to alert and notify other CalOptima staff advising that their involvement is required to provide further assistance to the customer.

m. Real-time decisioning statistics to enable continuous improvement.

G. System Function Configuration / Administration:

1. Ability for CalOptima to leverage out of the box functionality and apply custom configuration to support our needs.

a. Configuration settings, triggers, dropdown menus, decision tree prompts to support consistent workflows.

b. Documentation templates (standardized and customizable) to capture intake, required elements to support reporting regulatory requirements.

i. Example of data elements/fields but not limited to:

1. Call date and time for each unique staff to customer/caller interaction

2. Classification of the call (i.e., inquiry, dissatisfaction)

3. Elements of the Caller (i.e., caller information, reason for call, actions taken to assist caller)

c. Ability to leverage out of the box Dashboards and customize Dashboards.

d. Ability to trigger real-time alerts to management team – enable real-time interactions with CalOptima staff.

H. Reporting and auditing functionality

1. All data stored and captured from Customer intake are discrete and reportable.

2. Define the list of standard (out of the box) reports that are delivered with the system.

3. Ability to create standard CalOptima reports and frequency of updates.

4. Ability to run adhoc reports and / or leverage existing reports with variation of criteria and elements.

5. Ability to report everything for audit purposes with tracked audit capture of adds/changes/deletes within the record.

I. System User Security Functionality and Maintenance

1. Ability to set internal users with SSO to Active Directory.

2. Ability to set Role base type security.

3. Ability to set up internal CalOptima users vs external users – which will have different methods for multi-factor authentication (MFA).

4. Ability to set up permanent user roles based on department security with an ability to add temporary additional privileges when authorized by management.

5. Ability to monitor and automate trigger for inactivity – auto inactivate.

6. Ability for external users to self-reset password, retrieve user ID or reset to active status based on required elements of user verification and authentication.

2. Customer / Broker Sales Management Service (Preferred not required capability)

A. Ability to create a broker portal that provides our sales agents and brokers access to data on our members that are eligible for our Line of Business and Plan.

1. Data will be obtained from multiple core systems and include member details, plan and coverage information, quotes, claims history to help with provider (PCP and Health Plan) selection.

    a. Ability to develop template to store marketing materials and product information on the Sales plan(s).

    b. Ability to capture detail on User accessing member information with date and time of inquiry for audit and oversight functionality.

    c. Ability to provide user with set of standard data elements to support marketing and sales activity.

    d. Lead Management: Ability to build distribution of sales leads; based on territory, language thresholds and capabilities, member preferences if captured.

    e. Sales Enablement: Ability to set Sales productivity goals, incentives.

    f. Sales Performance: Ability to monitor sales agent results, allow for coaching, training to support improvement of tactics and performance outcomes.

    g. Ability to set template of data capture for intake form of required field and elements to support an application submission from member.

    h. Ability to leverage electronic signature of member and agent.

    i. Ability to upload hard copy form and leverage IDP technology to drop data elements from the form to complete digital form for data capture.

    j. Ability to submit data elements – into CalOptima's various systems to complete submission of application for enrollment to CMS.

    k. Ability to retrieve closure and results of the applications – to support case closure to the broker or CalOptima agent.

    l. Ability to leverage broker data to drive billing and payment for contracted broker service.

    m. Ability to trigger payment data requirements to CalOptima's financial system to issue payment to broker/ agent.

    n. Ability to create Dashboard – alerts and monitoring of Broker sales status.

    o. Define standard broker reports available.

    p. Ability to create custom reports or modify standard reports to customize parameters for CalOptima.

q. Sales Analytics: Ability to create custom reports and leverage existing reports with modifications.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 4, 2022
Regular Meeting of the CalOptima Board of Directors

Report Item

24. Approve Actions Related to the Procurement of a Web Traffic Analytics Solution.

Contacts

Wael Younan, Chief Information Officer / Chief Information Security Officer, (657) 900-1154
Rick Cabral, Associate Director, Information Technology Services, (714) 347-5788

Recommended Actions

1. Approve the scope of work (SOW) for the Web Traffic Analytics Solution.
2. Authorize the CEO to release the request for proposal (RFP), select a vendor, and negotiate and execute a contract with the selected vendor.

Background

As part of CalOptima's Workplace Modernization and Digital Transformation Strategy, Information Technology Services (ITS) will be evaluating and deploying multiple solutions. These solutions coincide with CalOptima's Cloud First strategy and take regulatory compliance and security measures into consideration. These initiatives will assist CalOptima in achieving its Vision Statement of removing barriers to achieve real-time claims payments and 24-hour treatment authorizations and doing annual assessments around social determinants of health by 2027. The projects and products that CalOptima implements will result in value-based care and improvements for member, provider, and employee experiences. These enhancements will provide CalOptima with the ability to be robust and agile, and to scale as a future-focused healthcare organization.

Discussion

CalOptima ITS and Communications staff are seeking approval for the SOW for a Web Traffic Analytics Solution and request for the approval to release the RFP to select and contract with a vendor to provide the solution. The Web Traffic Analytics Solution will facilitate collection and interpretation of visitor usage data for the CalOptima.org website and community portals. This tracking and analytics capability will assist CalOptima staff to better understand who is using CalOptima's sites, how long they stay on the sites, what they are doing on the site, and why they are leaving the sites. By having access to this website traffic analytical tool, CalOptima staff will be able to understand use patterns for its sites with the goal of informing ongoing content development decisions. This will lead to better website design and improved utilization of CalOptima's websites and portals, making information about CalOptima programs and services easier for members to access and utilize.

The ITS and Communications teams will work in conjunction with Vendor Management to review the proposals received to determine the vendor that best meets the needs of the organization. Once the vendor is selected, CalOptima will negotiate and execute a contract with the vendor for implementation. The initial contract term will be for three years with two one-year options to extend at an estimated annual cost of no more than $150,000.

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Fiscal Impact

The recommended action is a budgeted item. An estimated cost of $150,000 for the capital project, "Analytics for Member and Provider Use of Web Tools" under the "Applications Development" category, was included in the Fiscal Year 2022-23 Digital Transformation Year One Capital Budget approved by the Board on June 2, 2022.

Rationale for Recommendation

CalOptima recognizes the importance of providing constituents access to accurate and timely information and services. With an opportunity to review and analyze website utilization data, CalOptima staff will be able to continuously refine and improve its website design and improve visitor experience. By providing members and the community at large with better access to information about CalOptima programs and services, CalOptima will contribute to improved public health outcomes for the entire Orange County community.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Scope of Work for the Web Traffic Analytics Solution.

/s/ Michael Hunn *07/28/2022*
Authorized Signature **Date**

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Web Analytics – Scope of Work

A. OBJECTIVE

CalOptima is seeking to purchase a web traffic analytics tool with the capability to track, measure, and report on usage of CalOptima's public facing websites including CalOptima.org and the community (Member and Provider) portals.

B. FUNCTIONAL REQUIREMENTS

The analytics tool must provide the following capabilities:

1. Data collection, processing, and storage
    a. Track and monitor user identities, usage, and associated browser related user profile data across all CalOptima's websites/applications.
    b. Track the number of active users on the website across specific timeframes (Daily, weekly, custom time frame).
    c. Track the behavior across multiple sites for a user during the entire lifecycle of a user's session.
    d. Define custom fields/tags for tracking and reporting.
    e. Export data into standardized formats for consumption by other 3rd party vendors or products within the same ecosystem.
2. Data Visualization
    a. Allow users to see real-time information in a graphical and easy-to-digest format.
    b. Provide dashboards for real-time and historical usage information.
3. Visitor Attributes and Segmentation.
    a. Use advanced analytics and Artificial Intelligence (AI) capabilities to discover visitor segmentation though usage patterns and anomalies.
4. Integration
    a. Must integrate with other technologies in our technology stack including but not limited to Sitecore, .Net, Angular.
    b. Must not negatively impact native system performance.
    c. Tool must provide capability to interact with all analytic features via service API calls.
5. Reporting
    a. Real-Time and historical data for standard and customized periods.
    b. Standardized and Custom dimensions and metrics.
    c. Easy-to-use built-in Reports – Reports must be able to identify user actions, screen usage, and system log/events.
    d. Embeddable results for real-time analytics and reporting.
    e. Ability to customize built-in reports as well as build new user defined reports.
    f. Ability to analyze keywords.

6. Scalable and future-proof
    a. Tool will provide capability to interact with different types of analytic tools.
    b. Provides capability of consuming large datasets in production without significant impact to computing resources (hardware or cloud services).

C. NON-FUNCTIONAL REQUIREMENTS

1. The tool must be web-based, Software as a Service (SaaS) architecture
    a. Describe recommended network architecture including network topology, protocols, operating systems, database architecture, and network hardware.
    b. Identify all components that contribute to redundancy and fault tolerance.
2. CalOptima prefers applications supported on the Chrome browser. CMS regulatory requirements of a Health Plan is to stay within one version of the latest release from the Browser vendors.
    a. Describe your process to keep the application up to date and the process to maintain and validate application functionality on every browser update.
    b. If Chrome is not your supported browser, describe your browser requirement(s) and ongoing version support.
3. The user interface must be a responsive design that conforms to devices and monitors of varying shapes and sizes.
    a. Describe how your application automatically adapts to various client equipment types including tablet and mobile devices.
4. The vendor must provide multiple application environments with the purpose of supporting multiple needs of the customer. Environments expected to be provided are listed but may not be limited to:
    a. Production
    b. QA/UAT
    c. Development
5. The application must support application program interfaces (APIs) for both inbound and outbound data exchange. Vendor must provide documentation and technical support for all APIs.
    a. Provide a list of all current APIs and identify most commonly used APIs.
    b. Provide a list of all future APIs planned.

D. TECHNICAL SUPPORT REQUIREMENTS

1. Vendor - Training
    a. Vendor must provide online classes for users, developers as well as the administrators prior to the implementation and on-going through the period services agreement.
2. Vendor – Support and Documentation
    a. Vendor must provide at least Mon-Fri, 8am-6pm (PST) live phone or chat technical support.
    b. Vendor must provide access to professional services, user communities, knowledge base documents and other online recorded tutorials/help.

c. CalOptima shall include the following performance standards in the final support agreement.

Provide and define your company's position on each of the following:

Standard	Measure	Remedy	YOUR RESPONSE	
Response Time			**Measure**	**Remedy**
Application performance	85% of all transactions: 1 second - field to field 1 second - screen to screen 1 second - screen/database updates 1 second - inquiry	Time frame identified for correction and restoration to an acceptable level within 24 hours. Escape clause for consistent patterns of poor response.		
Adequate Growth/Capacity	Specific growth/capacity plan	No cost to CalOptima for unanticipated system upgrades.		
Support available: direct calls	7am - 7pm normal business days, pacific time	Escape clause for consistent patterns of poor response.		
Support available: after hours	24 x 7, 365 days per year			
Support available: e-mail/ web services	7am-7pm normal business days, pacific time			

Standard	Measure	Remedy	Your Response	
Response Time			**Measure**	**Remedy**
Support Levels			**Measure**	**Remedy**
	L1: system down/dead callback 1 hour fix or work-around 4 hours fix within 2 days	Escape clause for consistent patterns of poor response.		
	L2: critical, no work-around callback 1 hour fix or work-around 1 day fix within 3 days	Escape clause for consistent patterns of poor response.		
	L3: non-critical callback 4 hours fix or work-around 2 days fix within 5 days			
	L4: cosmetic callback 5 days fix by next upgrade			
	L5: modification request callback within 1 day to get high level requirements and assess feasibility			

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 4, 2022
Regular Meeting of the CalOptima Board of Directors

Report Item

25. Approve Amending the Applied Behavioral Analysis Provider Contracts to Increase Rates for Medi-Cal, and Use of Reserve Funds to Support the Increase

Contacts

Carmen Katsarov, LPCC, CCM, Executive Director, Behavioral Health Integration (714)-796-6168
Michael Gomez, Executive Director, Network Operations (714) 347-3292

Recommended Actions

1. Authorize amending the current Medi-Cal Fee-for-Service Applied Behavioral Analysis provider contracts to reflect increases to reimbursement rates effective October 1, 2022; and
2. Authorize unbudgeted expenditures in an amount up to $14.9 million from existing reserves to fund the increase to reimbursement rates for Medi-Cal for Applied Behavioral Analysis contracts.

Background

CalOptima's contracted network of Applied Behavioral Analysis (ABA) providers plays a vital role in providing services to members up to 21 years of age requiring care for autism and other developmental conditions. CalOptima is required by the Department of Health Care Services (DHCS) to provide services that include ABA under all plan letter (APL) 19-010, Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit that is further defined in APL19-014 Responsibilities for Behavioral Health Treatment (BHT) coverage for members under the age of 21. *See* Attachments 2 and 3. Managed Care Plans must also provide BHT services in accordance with timely access standards, pursuant to Welfare and Institutions Code section 14197 and the MCP contracts with DHCS.

On January 1, 2018, CalOptima assumed responsibility for behavioral health services from its external vendor and established its network of contracted ABA providers. Currently, there are more than 4,000 CalOptima members receiving ABA services.

The availability of ABA providers allows members to access services in a timely manner. ABA services include, but are not limited to, direct one-on-one, in-home or office sessions with a trained ABA professional, group social skills, and family training. As part of its mission to provide members with access to covered medically necessary healthcare services, CalOptima continues efforts to work with ABA providers to ensure a robust network of providers.

In order to maintain a comprehensive network to provide required BHT services, staff recommends increases in the Medi-Cal ABA reimbursement rates.

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Discussion

CalOptima is committed to ensuring equitable and quality care for its members. The COVID-19 pandemic has been especially difficult for children with autism or other developmental delays. In-person ABA services were stopped during periods of full lockdown. ABA providers and CalOptima quickly shifted to provide support through telehealth services to maintain some form of treatment but could not replace the benefits of in-person ABA care. This was further complicated by limited or no in-person school and limited social interaction. Because of the reduction in-person ABA services and in-person social interactions that children requiring ABA services received during the COVID-19 pandemic, with the re-opening of in-person services CalOptima anticipates a future increase in the need for ABA services. The pandemic also affected ABA providers in a reduction of their workforce and increased overhead costs. CalOptima's intent is to be proactive and address this issue thoughtfully and comprehensively.

CalOptima values a collaborative partnership with its providers. CalOptima regularly met with providers, and various contracted ABA providers expressed ongoing barriers and struggles they face due to inflation and the rising cost of living, the increase of the minimum wage, and increased overhead costs that have resulted in continued difficulties with recruiting and maintaining quality staff. These issues have only increased during the pandemic. Many providers confirmed they work with commercial plans and have had to make difficult business decisions to accept fewer Medi-Cal members so they can continue to maintain their business.

CalOptima also assessed market equivalency with the Regional Center of Orange County and commercial and sister Medi Cal organizations and payers, and CalOptima has determined that an increase in reimbursement rates is needed for CalOptima to compete in the market and to ensure CalOptima's vulnerable members have continued quality care. CalOptima is committed to ensuring that children in Orange County that have Medi-Cal continue to have equitable access to the same quality providers and services that other children that have commercial plans have to continue to reduce health care disparities.

The proposed amendment will increase rates for Medi-Cal fee for service (FFS) ABA services by an average of 21.3% effective October 1, 2022. Rates increases will vary by service and provider type, ranging from 0% to 31.9% increase above current rates. This action will support continued quality care for CalOptima's members. Therefore, staff recommends approving amendments to the Medi-Cal FFS ABA provider contracts authorizing an increase in reimbursement rates effective October 1, 2022.

Fiscal Impact

The recommended action to amend the current Medi-Cal FFS ABA contracts to increase reimbursement rates effective October 1, 2022, is an unbudgeted item. The estimated annual fiscal impact is $19.9 million. The additional fiscal impact for the nine-month period in Fiscal Year 2022-23 is $14.9 million or a 21.3% increase from current rates. An allocation of this amount from existing reserves will fund this

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action through June 30, 2023. Management will include medical expenses related to the rate increase in future operating budgets.

Rationale for Recommendation

CalOptima has had the same pricing since taking BHT, including ABA services, in-house in January 2018. The rate increase to the Medi-Cal FFS ABA provider contracts will help support current and future equitable quality network and quality care.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Proposed ABA provider Contract Amendment
2. APL19-010 Early and Periodic Screening, Diagnostic and Treatment (EPSDT)
3. APL 19-014- Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21

/s/ Michael Hunn *07/28/2022*
Authorized Signature **Date**

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AMENDMENT @@Amendment Number@@ TO
PROFESSIONAL SERVICES CONTRACT

THIS AMENDMENT @@Amendment Number@@ TO THE PROFESSIONAL SERVICES CONTRACT ("Amendment @@Amendment Number@@") shall be effective on the first day of the first month following execution of this Amendment @@Amendment Number@@, by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and **@@Provider Name@@** ("Professional"), with respect to the following facts:

RECITALS

A. CalOptima and Professional entered into a Professional Services Contract, by which Professional has agreed to provide or arrange for the provision of Covered Services to Members.

B. CalOptima and Professional desire to amend this Contract on the terms and conditions set forth herein.

NOW, THEREFORE, the parties agree as follows:

1. Attachment B, Confidential Compensation Terms, shall be deleted in its entirety and replaced with Attachment B – Amendment @@Amendment Number@@, Confidential Compensation Terms.

2. Attachment B, Compensation shall be deleted in its entirety and replaced with the new Attachment B, Compensation attached herein.

3. CONTRACT REMAINS IN FULL FORCE AND EFFECT – Except as specifically amended by this Amendment @@Amendment Number@@, all other conditions contained in the Contract as previously amended shall continue in full force and effect.

IN WITNESS WHEREOF, CalOptima and Professional have executed this Amendment @@Amendment Number@@.

FOR PROFESSIONAL:	FOR CALOPTIMA:
_____	_____
Signature	Signature
_____	Yunkyung Kim
Print Name	Print Name
_____	Chief Operating Officer
Title	Title
_____	_____
Date	Date

ATTACHMENT B

CONFIDENTIAL COMPENSATION TERMS

I. MEDI-CAL PROGRAM

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 billed charges or the following amounts:

CalOptima ABA Fee Schedule Autism Related Services

HCPCS Code	Procedure Description	Paraprofessional or Registered Behavior Technician		Associate Behavioral Analyst (BCaBA), or Behavior Management Assistant		Board Certified Behavior Analyst (BCBA), or Behavior Management Consultant/ Licensed Health Professional		Board Certified Behavior Analyst (BCBA)	
		Modifier	Rates	Modifier	Rates	Modifier	Rates	Modifier	Rates
H0031	Functional Behavioral Assessment by BCBA, per 15 min	N/A		N/A		N/A		HO	[redacted]
H0032	Case oversight and management of treatment team, per 15 min	N/A		HN	[redacted]	HO	[redacted]	HO	[redacted]
H2019	Direct Applied Behavior Analysis (ABA) services by a paraprofessional or Board-Certified Behavior Analyst (BCBA) provider, per 15	HM	[redacted]	HN	[redacted]	HO	[redacted]	HO	[redacted]
S5110	Home care training, family, per 15 min	HM	[redacted]	HN	[redacted]	HO	[redacted]	HO	[redacted]
H2014	Social Skills group, per 15 min	HQ	[redacted]	HQ	[redacted]	HQ	[redacted]	HQ	[redacted]
H2014	Skills training and development, per 15 min	HM	[redacted]	HN	[redacted]	HO	[redacted]	HO	[redacted]
S5108	Home care training to home care, client, per 15 min	HM	[redacted]	HN	[redacted]	HO	[redacted]	HO	[redacted]

Modifier	Description
HO	Board Certified Behavior Analyst (BCBA or BCBA-D) or Licensed Health Professional, which is a psychologist, Clinical Social Worker, Marriage and Family Therapist, or other licensed professional whose California licensure permits the design and/or implementation of behavior modification intervention services. Additionally, must have 12 twelve semester units in ABA, and 2 years experience designing and implementing behavior modification intervention services.
HN	Associate Behavioral Analyst (BCaBA), or Behavior Management Assistant
HM	Paraprofessional or Registered Behavior Technician
HQ	Group Setting

NOTES:

1. 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.
2. Rates include reimbursement for travel time and expense.
3. CPT or HCPCS codes not contained in the above fee schedule are not reimbursable.
4. Professional shall not be reimbursed for services provided to Member if there was no prior authorization received from CalOptima in accordance with Cal Optima Policies and Procedures.
5. The coding definitions (e.g., CPT/HCPCS Codes) assigned in this Agreement 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. DHCS, AMA, 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, it is understood that services will automatically revert to the new code(s) that best apply to the service.

II. PACE PROGRAM

Not Applicable to this Contract

III. ONE CARE AND ONECARE CONNECT PROGRAM

Not Applicable to this Contract

IV. PAYMENT PROCEDURES

1. CalOptima agrees to grant Professional access to Member management information systems. Professional agrees to verify each Member's eligibility to receive Covered Services on the date of service.

2. Billing and Claims Submission. Professional shall submit Claims for Covered Services in accordance with CalOptima Policies applicable to the Claims submission process.

3. Prompt Payment. CalOptima shall make payments to Professional in the time and manner set forth in CalOptima Policies and Procedures.

4. Claim Completion and Accuracy. Professional shall be responsible for the completion and accuracy of all Claims submitted, whether on paper forms or electronically, including claims submitted for the Professional by other parties. Use of a billing agent does not abrogate Professional's responsibility for the truth and accuracy of the submitted information. A Claim may not be submitted before the delivery of service. Professional acknowledges that Professional remains responsible for all Claims and that anyone who misrepresents, falsifies, or causes to be misrepresented or falsified, any records or other information relating to that Claim may be subject to legal action.

5. Claims Deficiencies. Any Claim that fails to meet CalOptima requirements for claims processing shall be denied and Professional notified of denial pursuant to CalOptima Policies and applicable Federal and/or State laws and regulations.

6. Coordination of Benefits (COB). Professional shall coordinate benefits with other programs or entitlements recognizing where Other Health Coverage (OHC) is primary coverage in accordance with CalOptima Program requirements. Professional acknowledges that Medi-Cal is the payor of last resort.

7. Crossover Claims – Dual Eligible Members. "Crossover Claims are claims for Dual Eligible Members where Medi-Cal is the secondary payer and Medicare or other health care coverage (OHC) is the Primary payor for dates of service during which the Dual Eligible Member was not assigned to one of CalOptima's Programs. California law limits Medi-Cal's reimbursement for a crossover claim to an amount that, when combined with the Medicare payment, should not exceed Medi-Cal's maximum allowed for similar services (Refer to Welfare and Institutions Code, Section 14109.5.)

   "Dual Eligible Members" are members who are eligible for both Medicare or other health care coverage (OHC) and Medi-Cal benefits.

   The Medi-Cal reimbursement rates in this contract will not apply to Crossover Claims for Dual Eligible Members. For Crossover Claims payment CalOptima will reimburse in accordance with CalOptima Policies, and state and federal regulations.

8. Member Financial Protections. Professional shall comply with Member financial protections as follows:

   8.1 Professional agrees to indemnify and hold Members harmless from all efforts to seek compensation and any claims for compensation from Members for Covered Services under this Contract. In no event shall a Member be liable to Professional for any amounts which are owed by, or are the obligation of, CalOptima.

   8.2 Professional agrees to hold Member harmless and not liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts. Professional may not impose cost-sharing that exceeds the amount of cost-sharing

that would be permitted with respect to the individual under Title XIX if the individual were not enrolled in such a plan. Professional will:

1) accept the plan payment as payment in full, or

2) bill the appropriate State source.

8.3 In no event, including, but not limited to, non-payment by CalOptima, CalOptima's or the Professional's insolvency, or breach of this contract by CalOptima, shall the Professional, or any of its Practitioners, bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against the State of California or any Member or person acting on behalf of a Member for Covered Services pursuant to this Contract. Notwithstanding the foregoing, Professional may collect SOC, co-payments, and deductibles if, and to the extent, required under a specific CalOptima Program and applicable law.

8.4 This provision does not prohibit Professional from billing and collecting payment for non- Covered Services if the CalOptima Member agrees to the payment in writing prior to the actual delivery of non-Covered Services and a copy of such agreement is given to the Member and placed in the Member's medical record prior to rendering such services.

8.5 Upon receiving notice of Professional invoicing or balance billing a Member for the difference between the Professional's billed charges and the reimbursement paid by CalOptima for any Covered Services, CalOptima may sanction the Professional or take other action as provided in this Contract.

This Section shall survive the termination of this Contract for Covered Services furnished to CalOptima Members prior to the termination of this Contract, regardless of the cause giving rise to termination, and shall be construed to be for the benefit of Members. This Section shall supersede any oral or written contrary agreement now existing or hereafter entered into between Professional and its Practitioners. Language to ensure the foregoing shall be included in all of Professional's Subcontracts.

State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: August 14, 2019

ALL PLAN LETTER 19-010
SUPERSEDES ALL PLAN LETTER 18-007 and 07-008

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: REQUIREMENTS FOR COVERAGE OF EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT SERVICES FOR MEDI-CAL MEMBERS UNDER THE AGE OF 21

PURPOSE:
This All Plan Letter (APL) clarifies the responsibilities of Medi-Cal managed care health plans (MCPs) to provide Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services to eligible members under the age of 21. This policy applies to all members under the age of 21 enrolled in MCPs. This guidance is intended to reinforce existing state and federal laws and regulations regarding the provision of Medi-Cal services, including EPSDT, and does not represent any change in policy.

BACKGROUND:
In 1967, Congress expanded the Medicaid benefit for children with the creation of the EPSDT benefit. The EPSDT benefit is set forth in the Social Security Act (SSA) Section 1905(r) and Title 42 of the United States Code (USC) Section 1396d.[1, 2] The EPSDT benefit provides a comprehensive array of prevention, diagnostic, and treatment services for individuals under the age of 21 who are enrolled in Medi-Cal. According to guidance from the Centers for Medicare and Medicaid Services (CMS), titled *EPSDT — A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents* (June 2014) on page 1, "The EPSDT benefit is more robust than the Medicaid benefit for adults and is designed to assure that children receive early detection and care, so that health problems are averted or diagnosed and treated as early as possible. The goal of EPSDT is to assure that individual children get the health care they need when they need it—the right care to the right child at the right time in the right setting."[3]

Under the EPSDT benefit, states are required to provide any Medicaid-covered service listed within the categories of mandatory and optional services in the SSA Section

[1] SSA Section 1905 is available at: https://www.ssa.gov/OP_Home/ssact/title19/1905.htm
[2] 42 USC Section 1396d is available at: http://uscode.house.gov/view.xhtml?req=(title:42%20section:1396d%20edition:prelim
[3] *EPSDT — A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents* is available at: https://www.medicaid.gov/medicaid/benefits/downloads/epsdt_coverage_guide.pdf

1905(a), regardless of whether such services are covered under California's Medicaid State Plan, for members who are eligible for EPSDT services when the services are determined to be medically necessary to correct or ameliorate defects and physical and mental illnesses or conditions.

The SSA Section 1905(r) and Title 42 of the USC Section 1396d(r) defines EPSDT services as follows:

> (r) Early and periodic screening, diagnostic, and treatment services
> The term "early and periodic screening, diagnostic, and treatment services" means the following items and services:
>
> (1) Screening services—
>
> (A) which are provided—
>
> (i) at intervals which meet reasonable standards of medical and dental practice, as determined by the state after consultation with recognized medical and dental organizations involved in child health care and, with respect to immunizations under subparagraph (B)(iii), in accordance with the schedule referred to in section 1396s(c)(2)(B)(i) of this title for pediatric vaccines, and
>
> (ii) at such other intervals, indicated as medically necessary, to determine the existence of certain physical or mental illnesses or conditions; and
>
> (B) which shall at a minimum include—
>
> (i) a comprehensive health and developmental history (including assessment of both physical and mental health development),
>
> (ii) a comprehensive unclothed physical exam,
>
> (iii) appropriate immunizations (according to the schedule referred to in section 1396s(c)(2)(B)(i) of this title for pediatric vaccines) according to age and health history,
>
> (iv) laboratory tests (including lead blood level assessment appropriate for age and risk factors), and
>
> (v) health education (including anticipatory guidance).
>
> (2) Vision services—
>
> (A) which are provided—
>
> (i) at intervals which meet reasonable standards of medical practice, as determined by the state after consultation with recognized medical organizations involved in child health care, and

(ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and

(B) which shall at a minimum include diagnosis and treatment for defects in vision, including eyeglasses.

(3) Dental services—

(A) which are provided—

(i) at intervals which meet reasonable standards of dental practice, as determined by the state after consultation with recognized dental organizations involved in child health care, and

(ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and

(B) which shall at a minimum include relief of pain and infections, restoration of teeth, and maintenance of dental health.

(4) Hearing services—

(A) which are provided—

(i) at intervals which meet reasonable standards of medical practice, as determined by the state after consultation with recognized medical organizations involved in child health care, and

(ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and

(B) which shall at a minimum include diagnosis and treatment for defects in hearing, including hearing aids.

(5) Such other necessary health care, diagnostic services, treatment, and other measures described in subsection (a) of this section to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the state plan.

Bright Futures Periodicity Schedule and Guidelines for Pediatric Preventive Care

The Patient Protection and Affordable Care Act (ACA) specified that coverage of preventive care and screenings must be conducted with evidence-informed, comprehensive guidelines supported by the Health Resources and Services Administration (HRSA), which is an agency of the United States Department of Health

and Human Services.[4] HRSA participated in the development of, and provides ongoing support to, the national health promotion and prevention initiative known as Bright Futures, which is led by the American Academy of Pediatrics (AAP). The AAP develops theory-based and evidence-based guidance and recommendations for preventive care screenings and well-child visits for children and regularly publishes updated tools and resources for use by clinicians and state agencies. These tools include the "Bright Futures Guidelines" and the "Recommendations for Preventive Pediatric Health Care," which is also known as the "periodicity schedule." The periodicity schedule indicates specific preventive screenings and procedures that are to be provided to children at age-specific periodic intervals specific ages from birth through age 21.[5]

EPSDT in California

For members under age 21, MCPs must provide a more robust range of medically necessary services than they do for adults that include standards set forth in federal and state law. This includes the contractual obligation to provide the EPSDT benefit in accordance with the AAP/Bright Futures periodicity schedule.[6]

The EPSDT benefit in California is established in the Medi-Cal Schedule of Benefits set forth in Welfare and Institutions Code (WIC) Section 14132(v), which states that, "Early and periodic screening, diagnosis, and treatment for any individual under 21 years of age is covered, consistent with the requirements of Subchapter XIX (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code."[7]

[4] See Title 1 of the ACA, Part A, Subpart II—Improving Coverage, SEC.2713. Coverage of Preventive Health Services. The ACA is available at: https://www.govinfo.gov/content/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf

[5] For more information about the AAP/Bright Futures initiative, and to view the most recent periodicity schedule and guidelines, go to https://brightfutures.aap.org/Pages/default.aspx. Additional information on the periodicity schedule is available at: https://www.aap.org/en-us/professional-resources/practice-transformation/managing-patients/Pages/Periodicity-Schedule.aspx

[6] MCP Contracts, Exhibit A, Attachment 10, Services for Members under Twenty-One (21) Years of Age. Current MCP contracts are available at: https://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx. The forthcoming 2017 Final Rule contract amendment (identified as Package 42, an updated version of which was shared with MCPs in January 2018) clarifies that the AAP guidelines and periodicity schedule specifically means Bright Futures guidelines and recommendations. To date the amendment is pending approval by CMS.

[7] WIC Section 14132 is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14132.

WIC Section 14059.5 was amended, effective January 1, 2019, to define medical necessity for EPSDT services and included the following requirements:[8]

> (a) For individuals 21 years of age or older, a service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.
>
> (b)(1) For individuals under 21 years of age, a service is "medically necessary" or a "medical necessity" if the service meets the standards set forth in Section 1396d(r)(5) of Title 42 of the United States Code.
>
> (2) The department and its contractors shall update any model evidence of coverage documents, beneficiary handbooks, and related material to ensure the medical necessity standard for coverage for individuals under 21 years of age is accurately reflected in all materials.

REQUIREMENTS:
The EPSDT benefit includes the specific services listed above in Title 42 of the USC Section 1396d(r). For members under the age of 21, MCPs are required to provide and cover all medically necessary EPSDT services, defined as any service that meets the standards set forth in Title 42 of the USC Section 1396d(r)(5), unless otherwise carved out of the MCP's contract, regardless of whether such services are covered under California's Medicaid State Plan for adults, when the services are determined to be medically necessary to correct or ameliorate defects and physical and mental illnesses or conditions.

A service need not cure a condition in order to be covered under EPSDT. Services that maintain or improve the child's current health condition are also covered under EPSDT because they "ameliorate" a condition. Maintenance services are defined as services that sustain or support rather than those that cure or improve health problems. Services are covered when they prevent a condition from worsening or prevent development of additional health problems. The common definition of "ameliorate" is to "make more tolerable." Additional services must be provided if determined to be medically necessary for an individual child.[9]

Medical necessity decisions are individualized. Flat limits or hard limits based on a monetary cap or budgetary constraints are not consistent with EPSDT requirements.

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[8] WIC Section 14059.5 is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14059.5.
[9] *EPSDT — A Guide for State: Coverage in the Medicaid Benefit for Children and Adolescents*, pages 23 and 24.

Therefore, MCPs are prohibited from imposing service limitations on any EPSDT benefit other than medical necessity. The determination of whether a service is medically necessary or a medical necessity for an individual child must be made on a case-by-case basis, taking into account the particular needs of the child.

Pursuant to WIC Section 14059.5(b)(1), for individuals under 21 years of age, a service is considered "medically necessary" or a "medical necessity" if the service meets the standards set forth in federal Medicaid law for EPSDT (Title 42 of the USC Section 1396d(r)(5)). Therefore, an EPSDT service is considered medically necessary or a medical necessity when it is necessary to correct or ameliorate defects and physical and mental illnesses and conditions that are discovered by screening services. MCPs must apply this definition when determining if a service is medically necessary or a medical necessity for an EPSDT eligible member.

MCPs must use the current AAP/Bright Futures periodicity schedule and guidelines when delivering the EPSDT benefit, including but not limited to screening services, vision services, and hearing services. MCPs must provide all age-specific assessments and services required by the MCP contract and the AAP/Bright Futures periodicity schedule. However, this does not alleviate MCPs of their responsibility to provide any medically necessary EPSDT services that exceed those recommended by AAP/Bright Futures.

All members under the age of 21 must receive EPSDT preventive services, including screenings, designed to identify health and developmental issues as early as possible. MCPs must provide members with appropriate referrals for diagnosis and treatment without delay. MCPs are also responsible for ensuring EPSDT members have timely access to all medically necessary EPSDT services and that appropriate diagnostic and treatment services are initiated as soon as possible, but no later than 60 calendar days following either a preventive screening or other visit that identifies a need for follow-up.

In addition, MCPs must comply with the Americans with Disabilities Act mandate to provide services in the most integrated setting appropriate to members and in compliance with anti-discrimination laws.[10, 11]

[10] *Olmstead v. L.C.* (1999) 527 U.S. 581. Decisions from the Supreme Court of the United States are available at: https://www.supremecourt.gov/
[11] California Government Code (GOV) Section 11135. GOV Section 11135 is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=11135.&lawCode=GOV

Behavioral Health Treatment

MCPs are responsible for providing medically necessary Behavioral Health Treatment (BHT) services, consistent with the requirements in this APL, for eligible members under the age of 21.[12]

Member Information, Case Management/Care Coordination, and Transportation

Consistent with the MCP contract, MCPs must ensure the provision of Comprehensive Medical Case Management services, including coordination of care for all medically necessary EPSDT services delivered both within and outside the MCP's provider network. MCPs are also responsible for the coordination of carved-out and linked services and referral to appropriate community resources and other agencies, regardless of whether the MCP is responsible for paying for the service.[13]

MCPs must also ensure the coverage of Targeted Case Management (TCM) services.[14] MCPs are responsible for determining whether an EPSDT member requires TCM services and must refer members who are eligible for TCM services to a Regional Center (RC) or local governmental health program, as appropriate for the provision of TCM services. If the ESPDT member is receiving TCM services, the MCP is responsible for coordinating the member's health care with the TCM provider and for determining the medical necessity of diagnostic and treatment services that are covered under the MCP's contract that are recommended by the TCM provider. If the MCP determines that an EPSDT member is not accepted for TCM services, the MCP must ensure that the member's access to services are comparable to EPSDT TCM services.

MCPs are also required to provide appointment scheduling assistance and necessary transportation, including non-emergency medical transportation and non-medical transportation (NMT) to and from medical appointments for the medically necessary EPSDT services they are responsible for providing pursuant to their contracts with DHCS.[15] Consistent with the requirements in APL 17-010, MCPs must provide NMT for all medically necessary EPSDT services, including those services that are carved-out of the MCP's contract. MCPs are also required to establish procedures for members to obtain necessary transportation services.

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[12] For more information on BHT, see APL 18-006, Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21, or any future iterations of this APL. APLs are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

[13] MCP contracts, Exhibit A, Attachment 11, Comprehensive Case Management Including Coordination of Care Services.

[14] MCP contracts, Exhibit A, Attachment 11, Targeted Case Management Services

[15] For more information on transportation, see APL 17-010, Non-Emergency Medical and Non-Medical Transportation Services, or any future iterations of this APL.

MCPs must effectively inform EPSDT members or their families/primary caregivers about EPSDT, including the benefits of preventive care, the services available under EPSDT, where and how to obtain these services, and that necessary transportation and scheduling assistance is available. In addition to existing requirements for the provision of the Evidence of Coverage to members, this information must be provided annually to EPSDT members or their families/primary caregivers who have not accessed EPSDT services.[16] MCPs have a responsibility to provide health education, including anticipatory guidance, to members under age 21 and to their parents or guardians in order to effectively use those resources, including screenings and treatment.[17, 18] This information must be provided in the member's primary language at a sixth grade reading level as required in the MCP contract and APL 17-011, Standards for Determining Threshold Languages and Requirements for Section 1557 of the Affordable Care Act, and APL 18-016, Readability and Suitability of Health Education Materials, including future iterations of these APLs.

Certain Carved-Out Services

For members under the age of 21, MCPs are required to provide and cover all medically necessary EPSDT services except those services that are specifically carved out of the MCP's contract and not included in the MCP's capitated rate. Carved-out services vary and can include, but are not limited to, California Children's Services (CCS), dental services, Specialty Mental Health Services, and Substance Use Disorder Services. This portion of the APL is not intended to address all carved-out services; however, DHCS is providing necessary clarification to MCPs below specific to CCS and dental services for when these services are carved-out of the MCP's contract.

California Children's Services

Most MCP contracts carve-out coverage for CCS-covered conditions. If an EPSDT eligible child is a member of an MCP, and the MCP's contract carves out coverage for CCS-eligible conditions, then the child may obtain treatment related to the CCS-eligible condition from CCS if the child enrolls in CCS.

Once the MCP has adequate diagnostic evidence that a member has a CCS-eligible condition, the MCP must refer the member to the local county CCS office for determination of eligibility. Until the member's CCS eligibility is confirmed by the local CCS program, and the medically necessary services are being provided under the CCS program, the MCP remains responsible for the provision of all medically necessary

[16] Title 42 of the Code of Federal Regulations (CFR) Section 441.56. 42 CFR Part 441 is available at: https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=d52504d844298122c9f25162843f660d&mc=true&n=pt42.4.441&r=PART&ty=HTML
[17] 42 USC Section 1396d(r)(1)(B)(v)
[18] *EPSDT — A Guide for State: Coverage in the Medicaid Benefit for Children and Adolescents*, page 4.

EPSDT services. It is part of the MCP's case management obligation to communicate with the county CCS program to ensure that the member's care needs are continuously met and to arrange for the member's EPSDT services when the county CCS program is not doing so.

Dental Services
Although dental services are carved-out of MCP contracts, the contract requires MCPs to cover and ensure that dental screenings/oral health assessments for all members are included as a part of the initial health assessment. For members under the age of 21, a dental screening/oral health assessment must be performed as part of every periodic assessment, with annual dental referrals made no later than 12 months of age or when referral is indicated based on assessment. Fluoride varnish and oral fluoride supplementation assessment and provision must be consistent with the AAP/Bright Futures periodicity schedule and anticipatory guidance. MCPs must also ensure that members are referred to appropriate Medi-Cal dental providers.

Additionally, MCPs must cover and ensure the provision of covered medical services related to dental services that are not provided by dentists or dental anesthetists, but may require prior authorization for medical services required in support of dental procedures.[19]

<u>Coordinating with Other Outside Entities Responsible for Providing EPSDT Services</u>
Where another entity, such as a Local Education Agency (LEA), RC, or local governmental health program, has overlapping responsibility for providing services to a member under the age of 21, MCPs must do the following:

- Assess what level of EPSDT medically necessary services the member requires,
- Determine what level of service (if any) is being provided by other entities, and
- Coordinate the provision of services with the other entities to ensure that MCPs and the other entities are not providing duplicative services, and that the child is receiving all medically necessary EPSDT services in a timely manner.

MCPs have the primary responsibility to provide all medically necessary EPSDT services, including services which exceed the amount provided by LEAs, RCs, or local governmental health programs. However, these other entities must continue to meet their own requirements regarding provision of services. MCPs should not rely on LEA programs, RCs, CCS, the Child Health and Disability Prevention Program, local governmental health programs, or other entities as the primary provider of medically necessary EPSDT services.

[19] For more information, see APL 15-012, Dental Services – Intravenous Sedation and General Anesthesia Coverage, or any future iterations of this APL.

The MCP is the primary provider of such medical services except for those services that have been expressly carved-out. MCPs are required to provide case management and coordination of care to ensure that EPSDT members can access medically necessary EPSDT services as determined by the MCP provider. For example, when school is not in session, MCPs must cover medically necessary ESPDT services that were being provided by the LEA program when school was in session.

MCPs are responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters. MCPs must communicate these EPSDT requirements to all delegated entities and subcontractors. MCPs must ensure that all of their own policies and procedures, as well as the policies, procedures, and practices of any delegates, subplans, contracted providers, or subcontracted Independent Physician Associations or medical groups, comply with these EPSDT requirements and this APL.

If the requirements contained in this APL, including any updates or revisions to this APL, necessitate a change in an MCP's policies and procedures, the MCP must submit its updated policies and procedures to its Managed Care Operations Division (MCOD) contract manager within 30 days of the release of this APL. If an MCP determines that no changes to its policies and procedures are necessary, the MCP must submit an email confirmation to its MCOD contract manager within 30 days of the release of this APL, stating that the MCP's policies and procedures have been reviewed and no changes are necessary. The email confirmation must include the title of this APL as well as the applicable APL release date in the subject line.

DHCS, in concert with the Department of Managed Health Care, will monitor MCPs for compliance with these requirements. Failure to comply with the requirements contained in this APL may result in a corrective action plan, and/or administrative and financial sanctions,[20] as provided for under the terms of the MCP contracts and any applicable APL and state or federal statutes and regulations, including but not limited to Title 22 of the California Code of Regulations Sections 53350, 53352, and 53860.

[20] For more information, see APL 18-003, titled Administrative and Financial Sanctions, or any future iterations of this APL.

If you have any questions regarding the requirements of this APL, please contact your Managed Care Operations Division contract manager.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

State of California—Health and Human Services Agency
Department of Health Care Services

RICHARD FIGUEROA
ACTING DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: November 12, 2019

All Plan Letter 19-014
Supersedes All Plan Letter 18-006

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: RESPONSIBILITIES FOR BEHAVIORAL HEALTH TREATMENT COVERAGE FOR MEMBERS UNDER THE AGE OF 21

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide guidance to Medi-Cal managed care health plans (MCPs) about the provision of medically necessary Behavioral Health Treatment (BHT) services for members under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit and in accordance with mental health parity requirements.

BACKGROUND:
On July 7, 2014, the Centers for Medicare and Medicaid Services (CMS) released guidance on coverage of BHT services pursuant to federal law.[1] Federal law requires the EPSDT benefit to include a comprehensive array of preventive, diagnostic and treatment services for low-income individuals under 21 years of age, which encompasses BHT services.[2, 3] In accordance with federal EPSDT requirements, Medi-Cal provides coverage for all medically necessary BHT services for eligible beneficiaries under 21 years of age. This applies to any health condition, including children diagnosed with autism spectrum disorder (ASD)[4] and children for whom a licensed

[1] The CMS Informational Bulletin dated July 7, 2014, is available at: http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-07-07-14.pdf
[2] Title 42 of the United States Code (USC), Section 1396d(r). The USC is searchable at: https://uscode.house.gov/.
[3] Title 42 of the Code of Federal Regulations (CFR), Section 440.130(c). The CFR is searchable at: https://www.ecfr.gov/cgi-bin/ECFR?page=browse.
[4] ASD is a developmental disability that can cause significant social, communication, and behavioral challenges. A diagnosis of ASD now includes several conditions that previously were diagnosed separately: autistic disorder, pervasive developmental disorder not otherwise specified and Asperger syndrome. These conditions are now all called ASD in the Diagnostic and Statistical Manual V.

physician, surgeon, or psychologist determines that BHT services are medically necessary.[5]

On March 30, 2016, CMS issued a final rule (CMS-2333-F) that applied certain requirements from the Mental Health Parity and Addiction Equity Act of 2008 (Pub. L. 110-343, enacted on October 3, 2008) to services covered by MCPs. The general parity requirement contained in Title 42 of the Code of Federal Regulations section 438.910(b) prohibits treatment limitations for mental health benefits from being more restrictive than the predominant treatment limitations applied to medical or surgical benefits.[6] In accordance with federal law, mental health parity also applies to BHT services.

BHT services include applied behavioral analysis and a variety of other behavioral interventions that have been identified as evidence-based approaches that prevent or minimize the adverse effects of behaviors that interfere with learning and social interaction. The goal is to promote, to the maximum extent practicable, the functioning of a beneficiary, including those with or without ASD. Examples of BHT services include behavioral interventions, cognitive behavioral intervention, comprehensive behavioral treatment, language training, modeling, natural teaching strategies, parent/guardian training, peer training, pivotal response training, schedules, scripting, self-management, social skills package, and story-based interventions.

POLICY:
For members under the age of 21, MCPs are required to provide and cover, or arrange, as appropriate, all medically necessary EPSDT services, including BHT services, when they are covered under Medicaid, regardless of whether California's Medicaid State Plan covers such services for adults. Additionally, MCPs must comply with mental health parity requirements when providing BHT services.

For the EPSDT population, state and federal law define a service as "medically necessary" if the service is necessary to correct or ameliorate defects and physical and/or mental illnesses and conditions.[7] A BHT service need not cure a condition in order to be covered. Services that maintain or improve the child's current health

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[5] For additional information on EPSDT requirements, including the definition of "medically necessary," see APL 19-010: *Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21*, or any future version of this APL. APLs are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx.
[6] For additional information on mental health parity, see APL 17-018: *Medi-Cal Managed Care Health Plan Responsibilities for Outpatient Mental Health Services*, or any future version of this APL.
[7] 42 USC 1396d(r); Welfare and Institutions Code section 14059.5(b)(1). See also: EPSDT – A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents, JUNE 2014 at pp. 23-24, available at: https://www.medicaid.gov/medicaid/benefits/downloads/epsdt_coverage_guide.pdf

condition are considered a clinical benefit and must be covered to "correct or ameliorate" a member's condition. Maintenance services are defined as services that sustain or support rather than those that cure or improve health problems. MCPs must cover all services that prevent a child's condition from worsening or that prevent the development of additional health problems. The common definition of "ameliorate" is to "make more tolerable." Therefore, MCPs must cover BHT services regardless of whether California's Medicaid State Plan covers such services for adults, when the BHT services have an ameliorative, maintenance purpose.

Medical necessity decisions are individualized. Therefore, MCPs are prohibited from imposing service limitations on any EPSDT benefit other than medical necessity. The determination of whether a service is medically necessary for an individual child must be made on a case-by-case basis, taking into account the particular needs of the child.

MCPs must comply with mental health parity requirements when providing BHT services. Treatment limitations for BHT services may not be more restrictive than the predominant treatment limitations applied to medical or surgical benefits. Additionally, mental health parity requirements stipulate that MCPs must disclose utilization management criteria.

CRITERIA FOR BHT SERVICES FOR MEMBERS UNDER THE AGE OF 21

A member must:

1) Have a recommendation from a licensed physician, surgeon or psychologist that evidence-based BHT services are medically necessary;
2) Be medically stable; and
3) Not have a need for 24-hour medical/nursing monitoring or procedures provided in a hospital or intermediate care facility for persons with intellectual disabilities.

MCPs are responsible for coordinating the provision of services with other entities, including but not limited to Regional Centers and County Mental Health plans, to ensure that MCPs and other entities are not providing duplicative services.

COVERED SERVICES

BHT services for ASD, or where there is suspicion of ASD that is not yet diagnosed, must be:

1) Medically necessary, as defined for the EPSDT population;
2) Provided and supervised in accordance with an MCP-approved behavioral treatment plan that is developed by a BHT service provider who meets the requirements in California's Medicaid State Plan; and,

3) Provided by a qualified autism provider who meets the requirements contained in California's Medicaid State Plan or licensed provider acting within the scope of their licensure.[8]

BHT services for members without an ASD diagnosis must be:
1) Medically necessary, as defined for the EPSDT population;
2) Provided in accordance with an MCP-approved behavioral treatment plan; and,
3) Provided by a licensed provider acting within the scope of their licensure.

Medi-Cal does not cover the following as BHT services under the EPSDT benefit:
1) Services rendered when continued clinical benefit is not expected, unless the services are determined to be medically necessary.
2) Provision or coordination of respite, day care, or educational services, or reimbursement of a parent, legal guardian, or legally responsible person for costs associated with participation under the behavioral treatment plan.
3) Treatment where the sole purpose is vocationally- or recreationally-based.
4) Custodial care. For purposes of BHT services, custodial care:
    a. Is provided primarily to maintain the member's or anyone else's safety; and,
    b. Could be provided by persons without professional skills or training.
5) Services, supplies, or procedures performed in a non-conventional setting, including, but not limited to, resorts, spas, and camps.
6) Services rendered by a parent, legal guardian, or legally responsible person.
7) Services that are not evidence-based behavioral intervention practices.

BEHAVIORAL TREATMENT PLAN

BHT services must be provided, observed, and directed under an MCP-approved behavioral treatment plan. The behavioral treatment plan must be person-centered and based on individualized, measurable goals and objectives over a specific timeline for the specific member being treated. The behavioral treatment plan must be reviewed, revised, and/or modified no less than once every six months by the provider of BHT services. The 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.[9] Decreasing the amount and duration of services is prohibited if the therapies are medically necessary.

[8] See California's Medicaid State Plan, Limitations on Attachment 3.1-A, 13c – Preventive Services, BHT, and Attachment 3.1-A, Supplement 6. California's Medicaid State Plan is available at: https://www.dhcs.ca.gov/formsandpubs/laws/Pages/CaliforniStatePlan.aspx
[9] See footnote 7, *supra.*

The approved behavioral treatment plan must also meet the following criteria:

1) Include a description of patient information, reason for referral, brief background information (e.g., demographics, living situation, or home/school/work information), clinical interview, review of recent assessments/reports, assessment procedures and results, and evidence-based BHT services.
2) Delineate both the frequency of baseline behaviors and the treatment planned to address the behaviors.
3) Identify measurable long-, intermediate-, and short-term goals and objectives that are specific, behaviorally defined, developmentally appropriate, socially significant, and based upon clinical observation.
4) Include outcome measurement assessment criteria that will be used to measure achievement of behavior objectives.
5) Include the member's current level of need (baseline, behavior parent/guardian is expected to demonstrate, including condition under which it must be demonstrated and mastery criteria [the objective goal]), date of introduction, estimated date of mastery, specify plan for generalization and report goal as met, not met, modified (include explanation).
6) Utilize evidence-based BHT services with demonstrated clinical efficacy tailored to the member.
7) Clearly identify the service type, number of hours of direct service(s), observation and direction, parent/guardian training, support and participation needed to achieve the goals and objectives, the frequency at which the member's progress is measured and reported, transition plan, crisis plan, and each individual provider who is responsible for delivering services.
8) Include care coordination that involves the parents or caregiver(s), school, state disability programs, and other programs and institutions, as applicable.
9) Consider the member's age, school attendance requirements, and other daily activities when determining the number of hours of medically necessary direct service and supervision.
10) Deliver BHT services in a home or community-based setting, including clinics. Any portion of medically necessary BHT services that are provided in school must be clinically indicated as well as proportioned to the total BHT services received at home and in the community.
11) Include an exit plan/criteria. However, only a determination that services are no longer medically necessary under the EPSDT standard can be used to reduce or eliminate services.[10]

[10] See footnote 7, *supra.*

CONTINUITY OF CARE

MCPs must offer members continued access to out-of-network providers of BHT services (continuity of care) for up to 12 months, in accordance with existing contract requirements and APL 18-008: *Continuity of Care for Medi-Cal Members Who Transition into Medi-Cal Managed Care*, or any future version of this APL.

TIMELY ACCESS STANDARDS

MCPs must provide BHT services in accordance with timely access standards, pursuant to Welfare and Institutions Code section 14197 and the MCP contracts.

MCPs are responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including applicable APLs and Policy Letters. These requirements must be communicated by each MCP to all delegated entities and subcontractors.

For questions regarding this APL, contact your Managed Care Operations Division contract manager.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 4, 2022
Regular Meeting of the CalOptima Board of Directors

Report Item

26. Authorize Amendments to CalOptima's OneCare and OneCare Connect Health Network Contracts, Except ARTA Western California Inc., Monarch Healthcare, A Medical Group Inc., Talbert Medical Group P.C., and Fee-for-Service OneCare, OneCare Connect, and PACE Contracts Except UCI Health, to Include Language for Sequestration and Recoupment

Contacts

Yunkyung Kim, Chief Operating Officer, (714) 246-8408
Michael Gomez, Executive Director, Network Operations, (714) 347-3292

Recommended Actions

1. Amend OneCare Shared-Risk Group (SRG) and OneCare Connect SRG, Health Maintenance Organization (HMO) Physician Hospital Consortia-Physician, Physician Hospital Consortia-Hospital health network contracts except ARTA Western California Inc., Monarch Healthcare, A Medical Group Inc., and Talbert Medical Group P.C., to reflect language for sequestration and recoupment, effective September 1, 2022;
2. Amend the OneCare, OneCare Connect, and PACE Fee-for-Service (FFS) Professional Services contracts, except UCI Health, to reflect language for updated sequestration practices, effective September 1, 2022;
3. Amend the OneCare, OneCare Connect, and PACE Fee-for-Service (FFS) Ancillary Services contracts, to reflect language for updated sequestration practices, effective September 1, 2022; and
4. Approve the OneCare, OneCare Connect, and PACE Amended and Restated FFS Hospital Services contracts, except UCI Health, to include language reflecting updated sequestration practices, effective September 1, 2022.

Background and Discussion

Staff requests that the CalOptima Board of Directors (Board) approve amendments to the above health network and FFS contracts, as well as the amended and restated contracts, all reflecting added language addressing CMS sequestration rates and recoupment of overpayment from providers, effective September 1, 2022.

Sequestration

Congress has enacted various sequestrations (i.e., an automatic reduction of certain federal spending usually by a uniform percentage) on Medicare programs, some of which were subsequently suspended while others were implemented. Most recently, the Centers for Medicare & Medicaid Services (CMS) implemented a 1% mandatory sequestration authorized by the Budget Control Act of 2011 from April 1, 2022, through June 30, 2022. This sequestration increased to 2% effective July 1, 2022. The above contract amendments stipulate that in the event a CMS-implemented sequestration(s) exceeds 2% in the aggregate at any point in the term of the contract, the amount in excess of two percent (2%) reduction will be passed on to the provider at the same percentage that CMS has reduced payment to CalOptima. Staff will return to the Board with additional recommendations in the event the 2% sequestration threshold is no longer financially sustainable for CalOptima.

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Recoupment

The recoupment clause in the above health network contracts references procedures for recouping payments made to providers in the following circumstances:

- **Overpayment to Physician Groups:** Physician Groups will have the opportunity to return any funds overpaid, paid in duplicate, or not due to the provider. If not resolved as such, those funds will be recovered by recoupment or offset from other payments due to the provider by CalOptima.
- **Health Network Termination:** Upon termination or transition of a health network to a different delegation model, CalOptima has the right to offset any unpaid claims that are the responsibility of the health network against payments owed to the provider. These include capitation payments, financial security withholds, pay-for-performance amounts, quality incentives, and shared-risk pool surpluses.
- **Shared-Risk Pool Payments:** This clause provides that upon contract termination or expiration, any deficit under the physician half of an SRG contract may be recouped by CalOptima by offsetting deficit amounts against capitation payments, financial security withholds, pay-for-performance amounts, quality incentives, and shared-risk pool surpluses.
- **Regulator Recoupment Upon Termination:** This clause provides that following contract termination or expiration, monies to any provider who has not complied with regulatory requirements governing physician incentive plans can be recouped. This includes, through notification to the provider, offset by any future amount owed by CalOptima to the provider under contract including capitation payments, financial security withholds, pay-for-performance amounts, quality incentives, and shared-risk pool surpluses.

To ensure avoidance of any overpayment to providers and adherence to the updated sequestration practices, staff requests approval of the above amendments and amended and restated contracts, effective September 1, 2022.

Fiscal Impact

The recommended action is not expected to have an additional fiscal impact on CalOptima's Fiscal Year 2022-23 Operating Budget.

Rationale for Recommendation

Approving the above amendments and amended and restated contracts will provide guidelines and align with current operations for addressing cases of overpayment or sequestration amounts in excess of 2%.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

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Attachments

1. Entities Covered by this Recommended Action
2. Proposed amendment template: OneCare (Medicare Advantage) Shared-Risk Group Health Network
3. Proposed amendment template: OneCare Connect (Cal Medi-Connect) Shared-Risk Group Health Network
4. Proposed amendment template: OneCare Connect, Physician Hospital Consortia, and HMO (RKK) Health Network
5. Proposed amendment template: OneCare, OneCare Connect, and PACE Professional Services Contract
6. Proposed amended and restated template: OneCare, OneCare Connect, and PACE Hospital Services Contract
7. Proposed amendment template: OneCare, OneCare Connect, and PACE Ancillary Services Contract

/s/ Michael Hunn *07/28/2022*
Authorized Signature **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

OneCare Health Networks				
Name	**Address**	**City**	**State**	**Zip Code**
AltaMed Health Services Corporation	2040 Camfield Ave.	Los Angeles	CA	90040
AMVI/Prospect Medical Group	600 City Parkway West, #800	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming St. Ste. 202	Westminster	CA	92683
Noble Community Medical Associates, Inc. of Mid-Orange County	5785 Corporate Ave.	Cypress	CA	90630
United Care Medical Group, Inc.	600 City Parkway West	Orange	CA	92868
OneCare Health Connect Networks				
Name	**Address**	**City**	**State**	**Zip Code**
AltaMed Health Services Corporation	2040 Camfield Ave.	Los Angeles	CA	90040
AMVI Care Health Network	600 City Parkway West Ste. 800	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming St. Ste. 202	Westminster	CA	92683
Fountain Valley Regional Hospital and Medical Center	17100 Euclid St.	Fountain Valley	CA	92708
Heritage Provider Network, Inc.	8510 Balboa Blvd. Ste. 285	Northridge	CA	91325
Noble Community Medical Associates, Inc. of Mid-Orange County	5785 Corporate Ave.	Cypress	CA	90630
Prospect Medical Group, Inc.	600 City Parkway West Ste. 800	Orange	CA	92868
United Care Medical Group, Inc.	600 City Parkway West	Orange	CA	92868

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AMENDMENT [xxx] TO
MEDICARE ADVANTAGE PHYSICIAN GROUP SERVICE AGREEMENT

THIS AMENDMENT [____] TO THE MEDICARE ADVANTAGE PHYSICIAN GROUP SERVICE AGREEMENT ("Amendment [___]") is effective as of [_____], by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and [_____] ("[_____]"), with respect to the following facts:

RECITALS

A. CalOptima and Physician Group have entered into a Medicare Advantage Physician Group Service Agreement (Contract), whereby Physician Group provides items and services to certain Medicare beneficiaries enrolled in the MA Program operated by CalOptima.

B. CalOptima and Physician Group desire to amend this Contract on the terms and conditions set forth herein.

NOW, THEREFORE, the parties agree as follows:

1. Section 6.5, "CalOptima Right to Recover" of Article 6, COMPENSATION shall be added to the Contract as follows:

"6.5 **CalOptima Right to Recover.**

6.5.1 Overpayments. Physician Group acknowledges and agrees that, in the event that CalOptima determines that an amount has been overpaid or paid in duplicate, or that funds were paid which were not due under this Contract to Physician Group, CalOptima shall have the right to recover such amounts from Physician Group by recoupment or offset from current or future amounts due from CalOptima to Physician Group under this Contract or any other agreement between the parties, after giving Physician Group notice and an opportunity to return/pay such amounts.

6.5.2 Health Network Termination. In the event of termination of the Health Network or the transition of the Health Network to a different delegation model, CalOptima shall have the right to offset any unpaid claims that are the financial responsibility of Physician Group paid by CalOptima against any funds owed to Physician Group by CalOptima, including capitation payments, financial security withholds, pay-for-performance amounts, quality incentives, and shared risk pool surpluses.

6.5.3 Shared Risk Pool Payments Upon Termination. If this Contract terminates or expires for any reason and Physician Group is responsible for a deficit under any shared risk program under this Contract based on the final shared risk pool report results ("Deficit"), such Deficit shall be due to CalOptima as follows, as allowed by Laws: CalOptima may elect to recoup such Deficit by either (1) offsetting such Deficit amounts, upon notice to Physician Group, from any current or future amounts owed by CalOptima to Physician Group under the Contract or any other agreement between the Parties, including capitation payments, financial security withholds, pay-for-performance amounts, quality incentives, and shared risk pool surpluses; or (2) sending an invoice to Physician Group that payment

for such Deficits are due to CalOptima within thirty (30) days of Physician Group's receipt of the CalOptima invoice.

6.5.4 Regulator Recoupment Upon Termination. If following the termination or expiration of this Contract, CalOptima's Regulators find that Physician Group (or its Downstream Entities) has failed to comply with the requirements governing physician incentive plans and CalOptima's Regulators offset, recoup and/or otherwise seek recovery of FFP, as described in Section 1.33, CalOptima may elect to recoup such FFP amounts, as allowed by Laws, by either: (1) offsetting such FFP amounts, upon notice to Physician Group, from any current or future amounts owed by CalOptima to Physician Group under the Contract or any other agreement between the Parties, including capitation payments, financial security withholds, pay-for-performance amounts, quality incentives, or shared risk pool surpluses; or (2) sending an invoice to Physician Group that payment for such FFP amounts are due to CalOptima within thirty (30) days of Physician Group's receipt of the CalOptima invoice.

6.5.5 Dispute Resolution. Physician Group may use CalOptima's provider dispute resolution procedure, as described under CalOptima's Policies, and/or the dispute resolution procedures under this Contract to resolve any disputes related to the calculation or payment of such Deficits or FFP amounts.

6.5.6 Survival. This Section 6.7 shall survive the termination or expiration of the Contract."

2. ATTACHEMENT C, Section 5, "Sequestration" shall be added to the Contract as follows:

"5. Sequestration. If CMS reduces payment to CalOptima under the CMS Contract by more than two percent (2%) at any time during the Term, CalOptima may, upon written notice to Physician Group, reduce payment to Physician Group under this Attachment C by the same percentage that CMS reduced payment to CalOptima. This provision applies each time CMS reduces payment to CalOptima by more than two percent (2%) during the Term."

3. CONTRACT REMAINS IN FULL FORCE AND EFFECT – Except as specifically amended by this Amendment, all other conditions contained in the Contract shall continue in full force and effect. After the Amendment Effective Date, any reference to the Contract shall mean the Contract as amended and supplemented by this Amendment. Notwithstanding anything to the contrary in the Contract, in the event of a conflict between the terms and conditions of this Amendment and those contained within the Contract, the terms and conditions of this Amendment shall prevail. Capitalized terms not otherwise defined in this Amendment shall have the meanings ascribed to them in the Contract. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

IN WITNESS WHEREOF, CalOptima and [_____] have executed this Amendment.

FOR PHYSICIAN GROUP:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	Yunkyung Kim _____
PRINT NAME	PRINT NAME
_____	Chief Operating Officer __
TITLE	TITLE
_____	_____
DATE	DATE

AMENDMENT {XXXXXX} TO

CAL MEDICONNECT PHYSICIAN GROUP SERVICES CONTRACT

This Amendment [XXXXX] to the Cal MediConnect Physician Group Services Contract ("Amendment") is effective as of [_____], by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and, [_____] ("Physician Group"), with respect to the following facts:

RECITALS

A. Physician Group and CalOptima have entered into a Cal MediConnect Physician Group Services Contract ("Contract") for the provision of specified covered services to CalOptima members in identified CalOptima Programs.

B. CalOptima and Physician Group desire to amend the Contract to extend the term of the Contract and revise the Corrective Action Plan time frame.

NOW, THEREFORE, the parties agree as follows:

1. Section 6.7, "CalOptima Right to Recover" of Article 6, COMPENSATION shall be added to the Contract as follows:

"6.7 **CalOptima Right to Recover.**

6.7.1 Overpayments. Physician Group acknowledges and agrees that, in the event that CalOptima determines that an amount has been overpaid or paid in duplicate, or that funds were paid which were not due under this Contract to Physician Group, CalOptima shall have the right to recover such amounts from Physician Group by recoupment or offset from current or future amounts due from CalOptima to Physician Group under this Contract or any other agreement between the parties, after giving Physician Group notice and an opportunity to return/pay such amounts.

6.7.2 Health Network Termination. In the event of termination of the Health Network or the transition of the Health Network to a different delegation model, CalOptima shall have the right to offset any unpaid claims that are the financial responsibility of Physician Group paid by CalOptima against any funds owed to Physician Group by CalOptima, including capitation payments, financial security withholds, pay-for-performance amounts, quality incentives, and shared risk pool surpluses.

6.7.3 Shared Risk Pool Payments Upon Termination. If this Contract terminates or expires for any reason and Physician Group is responsible for a deficit under any shared risk program under this Contract based on the final shared risk pool report results ("Deficit"), such Deficit shall be due to CalOptima as follows, as allowed by Laws: CalOptima may elect to recoup such Deficit by either (1) offsetting such Deficit amounts, upon notice to Physician Group, from any current or future amounts owed by CalOptima

to Physician Group under the Contract or any other agreement between the Parties, including capitation payments, financial security withholds, pay-for-performance amounts, quality incentives, and shared risk pool surpluses; or (2) sending an invoice to Physician Group that payment for such Deficits are due to CalOptima within thirty (30) days of Physician Group's receipt of the CalOptima invoice.

6.7.4 Regulator Recoupment Upon Termination. If following the termination or expiration of this Contract, CalOptima's Regulators find that Physician Group (or its Downstream Entities) has failed to comply with the requirements governing physician incentive plans and CalOptima's Regulators offset, recoup and/or otherwise seek recovery of FFP, as described in Section 1.33, CalOptima may elect to recoup such FFP amounts, as allowed by Laws, by either: (1) offsetting such FFP amounts, upon notice to Physician Group, from any current or future amounts owed by CalOptima to Physician Group under the Contract or any other agreement between the Parties, including capitation payments, financial security withholds, pay-for-performance amounts, quality incentives, or shared risk pool surpluses; or (2) sending an invoice to Physician Group that payment for such FFP amounts are due to CalOptima within thirty (30) days of Physician Group's receipt of the CalOptima invoice.

6.7.5 Dispute Resolution. Physician Group may use CalOptima's provider dispute resolution procedure, as described under CalOptima's Policies, and/or the dispute resolution procedures under this Contract to resolve any disputes related to the calculation or payment of such Deficits or FFP amounts.

6.7.6 Survival. This Section 6.7 shall survive the termination or expiration of the Contract."

2. ATTACHEMENT D, Section 1.7, "Sequestration" shall be added to the Contract as follows:

"1.7 **Sequestration**. If CMS reduces payment to CalOptima under the CMS Contract by more than two percent (2%) at any time during the Term, CalOptima may, upon written notice to Physician Group, reduce payment to Physician Group under this Attachment C by the same percentage that CMS reduced payment to CalOptima. This provision applies each time CMS reduces payment to CalOptima by more than two percent (2%) during the Term."

3. CONTRACT REMAINS IN FULL FORCE AND EFFECT – Except as specifically amended by this Amendment, all other conditions contained in the Contract shall continue in full force and effect. After the Amendment Effective Date, any reference to the Contract shall mean the Contract as amended and supplemented by this Amendment. Notwithstanding anything to the contrary in the Contract, in the event of a conflict between the terms and conditions of this Amendment and those contained within the Contract, the terms and conditions of this Amendment shall prevail. Capitalized terms not otherwise defined in this Amendment shall have the meanings ascribed to them in the Contract. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

IN WITNESS THEREOF, CalOptima and {Insert HN Name Here} have executed this Amendment {Insert Amendment # Here}:

FOR PHYSICIAN GROUP:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	_____
PRINT NAME	PRINT NAME
_____	_____
TITLE	TITLE
_____	_____
DATE	DATE

AMENDMENT {XXXXXX} TO

CAL MEDICONNECT [_____] SERVICES CONTRACT

This Amendment [XXXXX] to the Cal MediConnect [_____] Services Contract ("Amendment") is effective as of [_____], by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and, [_____] ("[_____]"), with respect to the following facts:

RECITALS

A. [_____] and CalOptima have entered into a Cal MediConnect ___[_____] Services Contract ("Contract") for the provision of specified covered services to CalOptima members in identified CalOptima Programs.

B. CalOptima and [_____] desire to amend the Contract to extend the term of the Contract and revise the Corrective Action Plan time frame.

NOW, THEREFORE, the parties agree as follows:

1. Section 6.7, "**CalOptima Right to Recover**" of Article 6, COMPENSATION shall be added to the Contract as follows:

"6.7 **CalOptima Right to Recover**.

6.7.1 Overpayments. [_____] acknowledges and agrees that, in the event that CalOptima determines that an amount has been overpaid or paid in duplicate, or that funds were paid which were not due under this Contract to [_____], CalOptima shall have the right to recover such amounts from [_____] by recoupment or offset from current or future amounts due from CalOptima to [_____] under this Contract or any other agreement between the parties, after giving [_____] notice and an opportunity to return/pay such amounts.

6.7.2 Health Network Termination. In the event of termination of the Health Network or the transition of the Health Network to a different delegation model, CalOptima shall have the right to offset any unpaid claims that are the financial responsibility of [_____] paid by CalOptima against any funds owed to [_____] by CalOptima, including capitation payments, financial security withholds, pay-for-performance amounts, quality incentives, and shared risk pool surpluses.
Shared Risk Pool Payments Upon Termination. If this Contract terminates or expires for any reason and Physician Group is responsible for a deficit under any shared risk program under this Contract based on the final shared risk pool report results ("Deficit"), such Deficit shall be due to CalOptima as follows, as allowed by Laws: CalOptima may elect to recoup such Deficit by either (1) offsetting such Deficit amounts, upon notice to Physician Group, from any current or future amounts owed by CalOptima to Physician Group under the Contract or any other agreement between the Parties, including capitation payments, financial security withholds, pay-for-performance amounts, quality incentives, and shared risk pool surpluses; or (2) sending an

invoice to Physician Group that payment for such Deficits are due to CalOptima within thirty (30) days of Physician Group's receipt of the CalOptima invoice.

6.7.3 Regulator Recoupment Upon Termination. If following the termination or expiration of this Contract, CalOptima's Regulators find that [_____] (or its Downstream Entities) has failed to comply with the requirements governing physician incentive plans and CalOptima's Regulators offset, recoup and/or otherwise seek recovery of FFP, as described in Section 1.33, CalOptima may elect to recoup such FFP amounts, as allowed by Laws, by either: (1) offsetting such FFP amounts, upon notice to [_____], from any current or future amounts owed by CalOptima to [_____] under the Contract or any other agreement between the Parties, including capitation payments, financial security withholds, pay-for-performance amounts, quality incentives, or shared risk pool surpluses; or (2) sending an invoice to [_____] that payment for such FFP amounts are due to CalOptima within thirty (30) days of [_____]'s receipt of the CalOptima invoice.

6.7.4 Dispute Resolution. [_____] may use CalOptima's provider dispute resolution procedure, as described under CalOptima's Policies, and/or the dispute resolution procedures under this Contract to resolve any disputes related to the calculation or payment of such Deficits or FFP amounts.

6.7.5 Survival. This Section 6.7 shall survive the termination or expiration of the Contract."

2.

ATTACHEMENT D, Section 1.7, "Sequestration" shall be added to the Contract as follows:

"1.7 **Sequestration**. If CMS reduces payment to CalOptima under the CMS Contract by more than two percent (2%) at any time during the Term, CalOptima may, upon written notice to Physician Group[_____], reduce payment to Physician Group[_____] under this Attachment D 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."

3. CONTRACT REMAINS IN FULL FORCE AND EFFECT – Except as specifically amended by this Amendment, all other conditions contained in the Contract shall continue in full force and effect. After the Amendment Effective Date, any reference to the Contract shall mean the Contract as amended and supplemented by this Amendment. Notwithstanding anything to the contrary in the Contract, in the event of a conflict between the terms and conditions of this Amendment and those contained within the Contract, the terms and conditions of this Amendment shall prevail. Capitalized terms not otherwise defined in this Amendment shall have the meanings ascribed to them in the Contract. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

[SIGNATURE ON NEXT PAGE]

IN WITNESS THEREOF, CalOptima and {Insert HN Name Here} have executed this Amendment {Insert Amendment # Here}:

FOR [_____]:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	Yunkyung Kim
PRINT NAME	PRINT NAME
_____	_____
TITLE	TITLE
_____	_____
DATE	DATE

AMENDMENT No. X TO
PROFESSIONAL SERVICES CONTRACT

This Amendment No. X to the Professional Services Contract ("**Amendment**") is effective as of [insert date] ("**Effective Date**")**,** by and between Orange County Health Authority, a Public Agency, dba CalOptima ("**CalOptima**"), and [insert provider name] ("**Professional**"), with respect to the following:

RECITALS

A. CalOptima and Professional entered into a Professional Services Contract ("**Contract**") under which Professional has agreed to furnish certain items and services to CalOptima Members.

B. CalOptima and Professional desire to amend certain terms of the Contract.

NOW, THEREFORE, the parties agree as follows:

1. Add the following new section 10 to Article IV. PAYMENT PROCEDURES of Attachment B of the Contract.

"10. Sequestration. If CMS reduces payment to CalOptima under the CMS Contract by more than two percent (2%) at any time during the Term, CalOptima may, upon written notice to Professional, reduce payment to Professional under this Attachment B – PACE, CALMEDICONNECT and MEDICARE ADVANTAGE, 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."

2. **CONTRACT REMAINS IN FULL FORCE AND EFFECT**. Except as specifically amended by this Amendment, all other conditions contained in the Contract shall continue in full force and effect. After the Amendment Effective Date, any reference to the Contract shall mean the Contract as amended and supplemented by this Amendment. Notwithstanding anything to the contrary in the Contract, in the event of a conflict between the terms and conditions of this Amendment and those contained within the Contract, the terms and conditions of this Amendment shall prevail. Capitalized terms not otherwise defined in this Amendment shall have the meanings ascribed to them in the Contract. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

IN WITNESS WHEREOF, CalOptima and Professional have executed this Amendment:

FOR PROFESSIONAL:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	Yunkyung Kim
PRINT NAME	PRINT NAME
_____	Chief Operating Officer
TITLE	TITLE
_____	_____
DATE	DATE

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AMENDMENT No. X TO
AMENDED AND RESTATED HOSPITAL SERVICES CONTRACT

This Amendment No. X to the Amended and Restated Hospital Services Contract ("**Amendment**") is effective as of {Effective Date here} ("**Effective Date**"), by and between Orange County Health Authority, a Public Agency, dba CalOptima ("**CalOptima**"), and [insert hospital name] ("**Hospital**"), with respect to the following:

RECITALS

A. CalOptima and Hospital entered into an Amended and Restated Hospital Services Contract ("**Contract**") under which Hospital has agreed to furnish certain items and services to CalOptima Members.

B. CalOptima and Hospital desire to amend certain terms of the Contract.

NOW, THEREFORE, the parties agree as follows:

1. Add the following new section 5 to Attachment B, Compensation, II. Medicare Advantage Program (OneCare) Reimbursement of the Contract:

   "5. Sequestration. If CMS reduces payment to CalOptima under the CMS Contract by more than two percent (2%) at any time during the Term, CalOptima may, upon written notice to Hospital, reduce payment to Hospital under this Attachment 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."

2. Add the following new section 5 to Attachment B, Compensation, III. Cal MediConnect Program (OneCare Connect) Reimbursement of the Contract:

   "5. Sequestration. If CMS reduces payment to CalOptima under the CMS Contract by more than two percent (2%) at any time during the Term, CalOptima may, upon written notice to Hospital, reduce payment to Hospital under this Attachment 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."

3. Add the following new section 5 to Attachment B, Compensation, IV. PACE Program Reimbursement of the Contract:

   "5. Sequestration. If CMS reduces payment to CalOptima under the CMS Contract by more than two percent (2%) at any time during the Term, CalOptima may, upon written notice to Hospital, reduce payment to Hospital under this Attachment 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."

4. **CONTRACT REMAINS IN FULL FORCE AND EFFECT**. Except as specifically amended by this Amendment, all other conditions contained in the Contract shall continue in full force and effect. After the Amendment Effective Date, any reference to the Contract shall mean the Contract as amended and supplemented by this Amendment. Notwithstanding anything to the contrary in the Contract, in the event of a conflict between the terms and conditions of this Amendment and those contained within the Contract, the terms and conditions of this Amendment shall prevail. Capitalized terms not otherwise defined in this Amendment shall have the meanings ascribed to them in the Contract. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

IN WITNESS WHEREOF, CalOptima and Hospital have executed this Amendment:

FOR HOSPIAL:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	Yunkyung Kim
PRINT NAME	PRINT NAME
_____	Chief Operating Officer
TITLE	TITLE
_____	_____
DATE	DATE

AMENDMENT No. X TO
ANCILLARY SERVICES CONTRACT

This Amendment No. X to the Ancillary Services Contract ("**Amendment**") is effective as of [insert date] ("**Effective Date**"), by and between Orange County Health Authority, a Public Agency, dba CalOptima ("**CalOptima**"), and [insert provider name] ("**Provider**"), with respect to the following:

RECITALS

A. CalOptima and Provider entered into an Ancillary Services Contract ("**Contract**") under which Provider has agreed to furnish certain items and services to CalOptima Members.

B. CalOptima and Provider desire to amend certain terms of the Contract.

NOW, THEREFORE, the parties agree as follows:

1. Add the following new section 3 to Attachment C, Compensation, II. Medicare Advantage Program (OneCare) Reimbursement of the Contract:

   "3. Sequestration. If CMS reduces payment to CalOptima under the CMS Contract by more than two percent (2%) at any time during the Term, CalOptima may, upon written notice to Hospital, reduce payment to Hospital under this Attachment C by the same percentage that CMS reduced payment to CalOptima. This provision applies each time CMS reduces payment to CalOptima by more than two percent (2%) during the Term."

2. Add the following new section 3 to Attachment C, Compensation, III. PACE Program Reimbursement of the Contract:

   "3. Sequestration. If CMS reduces payment to CalOptima under the CMS Contract by more than two percent (2%) at any time during the Term, CalOptima may, upon written notice to Hospital, reduce payment to Hospital under this Attachment C by the same percentage that CMS reduced payment to CalOptima. This provision applies each time CMS reduces payment to CalOptima by more than two percent (2%) during the Term."

3. Add the following new section 3to Attachment C, Compensation IV Cal MediConnect (OneCare Connect) Program Reimbursement of the Contract:

   "3. Sequestration. If CMS reduces payment to CalOptima under the CMS Contract by more than two percent (2%) at any time during the Term, CalOptima may, upon written notice to Hospital, reduce payment to Hospital under this Attachment C by the same percentage that CMS reduced payment to CalOptima. This provision applies each time CMS reduces payment to CalOptima by more than two percent (2%) during the Term."

4. **CONTRACT REMAINS IN FULL FORCE AND EFFECT**. Except as specifically amended by this Amendment, all other conditions contained in the Contract shall continue in full force and effect. After the Amendment Effective Date, any reference to the Contract shall mean the Contract as amended and supplemented by this Amendment. Notwithstanding anything to the contrary in the Contract, in the event of a conflict between the terms and conditions of this Amendment and those contained within the Contract, the terms and conditions of this Amendment shall prevail.

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Capitalized terms not otherwise defined in this Amendment shall have the meanings ascribed to them in the Contract. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

IN WITNESS WHEREOF, CalOptima and Provider have executed this Amendment:

FOR PROVIDER:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	Yunkyung Kim
PRINT NAME	PRINT NAME
_____	Chief Operating Officer
TITLE	TITLE
_____	_____
DATE	DATE

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 4, 2022
Regular Meeting of the CalOptima Board of Directors

Report Item

27. Authorize Amendments to CalOptima's OneCare and OneCare Connect Health Network Contracts for ARTA Western California Inc., Monarch Healthcare, A Medical Group Inc., and Talbert Medical Group P.C., Only to Include Language for Sequestration and Recoupment

Contacts

Yunkyung Kim, Chief Operating Officer 714-246-8408
Michael Gomez, Executive Director, Network Operations 714-347-3292

Recommended Actions

Amend OneCare and OneCare Connect Shared-Risk Group (SRG) and Health Maintenance Organization (HMO) health network contracts for ARTA Western California Inc., Monarch Healthcare, A Medical Group Inc., and Talbert Medical Group P.C. only, to reflect language for sequestration and recoupment, effective September 1, 2022

Background and Discussion

Staff requests that the CalOptima Board of Directors (Board) approve amendments to the above health network contracts to reflect language addressing CMS sequestration rates and recoupment of overpayment from providers, effective September 1, 2022.

Sequestration

Congress has enacted various sequestrations (i.e., an automatic reduction of certain federal spending usually by a uniform percentage) on Medicare programs, some of which were subsequently suspended while others were implemented. Most recently, the Centers for Medicare & Medicaid Services (CMS) implemented a 1% mandatory sequestration authorized by the Budget Control Act of 2011 from April 1, 2022, through June 30, 2022. This sequestration increased to 2% effective July 1, 2022. The above contract amendments stipulate that in the event a CMS-implemented sequestration(s) exceeds 2% in the aggregate at any point in the term of the contract, the amount in excess of two percent (2%) reduction will be passed on to the provider at the same percentage that CMS has reduced payment to CalOptima.

Staff will return to the Board with additional recommendations in the event the 2% sequestration threshold is no longer financially sustainable for CalOptima.

Recoupment

The recoupment clause in the above health network contracts references procedures for recouping payments made to providers in the following circumstances:

- **Overpayment to Physician Groups:** Physician Groups will have the opportunity to return any funds overpaid, paid in duplicate, or not due to the provider. If not resolved as such, those funds will be recovered by recoupment or offset from other payments due to the provider by CalOptima.

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- **Health Network Termination:** Upon termination or transition of a health network to a different delegation model, CalOptima has the right to offset any unpaid claims that are the responsibility of the health network against payments owed to the provider. These include capitation payments, financial security withholds, pay-for-performance amounts, quality incentives, and shared-risk pool surpluses.
- **Shared-Risk Pool Payments:** This clause provides that upon contract termination or expiration, any deficit under the physician half of an SRG contract may be recouped by CalOptima by offsetting deficit amounts against capitation payments, financial security withholds, pay-for-performance amounts, quality incentives, and shared-risk pool surpluses.
- **Regulator Recoupment Upon Termination:** This clause provides that following contract termination or expiration, monies to any provider who has not complied with regulatory requirements governing physician incentive plans can be recouped. This includes, through notification to the provider, offset by any future amount owed by CalOptima to the provider under contract including capitation payments, financial security withholds, pay-for-performance amounts, quality incentives, and shared-risk pool surpluses.

To ensure avoidance of any overpayment to providers and adherence to the updated sequestration practices, staff requests approval of the above amendments, effective September 1, 2022.

Fiscal Impact

The recommended action is not expected to have an additional fiscal impact on CalOptima's Fiscal Year 2022-23 Operating Budget

Rationale for Recommendation

Approving the above amendments will provide guidelines and align with current operations for addressing cases of overpayment or sequestration amounts in excess of 2%

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Entities Covered by this Recommended Action
2. Proposed amendment template: OneCare Shared-Risk Group Health Network
3. Proposed amendment template: OneCare Connect Shared-Risk Group Health Network

/s/ Michael Hunn — *07/28/2022*

Authorized Signature — **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

OneCare Health Networks				
Name	**Address**	**City**	**State**	**Zip Code**
ARTA Western California, Inc.	2175 Park Place	El Segundo	CA	90245
Monarch Healthcare, A Medical Group, Inc.	11 Technology Dr.	Irvine	CA	92618
Talbert Medical Group, P.C.	2175 Park Place	El Segundo	CA	90245
OneCare Health Connect Networks				
Name	**Address**	**City**	**State**	**Zip Code**
ARTA Western California, Inc.	2175 Park Place	El Segundo	CA	90245
Monarch Health Plan, Inc.	11 Technology Dr.	Irvine	CA	92618
Talbert Medical Group, P.C.	2175 Park Place	El Segundo	CA	90245

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AMENDMENT [xxx] TO
MEDICARE ADVANTAGE PHYSICIAN GROUP SERVICE AGREEMENT

THIS AMENDMENT [____] TO THE MEDICARE ADVANTAGE PHYSICIAN GROUP SERVICE AGREEMENT ("Amendment [___]") is effective as of [_____], by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and [_____] ("[_____]"), with respect to the following facts:

RECITALS

A. CalOptima and Physician Group have entered into a Medicare Advantage Physician Group Service Agreement (Contract), whereby Physician Group provides items and services to certain Medicare beneficiaries enrolled in the MA Program operated by CalOptima.

B. CalOptima and Physician Group desire to amend this Contract on the terms and conditions set forth herein.

NOW, THEREFORE, the parties agree as follows:

1. Section 6.5, "CalOptima Right to Recover" of Article 6, COMPENSATION shall be added to the Contract as follows:

"6.5 **CalOptima Right to Recover.**

6.5.1 Overpayments. Physician Group acknowledges and agrees that, in the event that CalOptima determines that an amount has been overpaid or paid in duplicate, or that funds were paid which were not due under this Contract to Physician Group, CalOptima shall have the right to recover such amounts from Physician Group by recoupment or offset from current or future amounts due from CalOptima to Physician Group under this Contract or any other agreement between the parties, after giving Physician Group notice and an opportunity to return/pay such amounts.

6.5.2 Health Network Termination. In the event of termination of the Health Network or the transition of the Health Network to a different delegation model, CalOptima shall have the right to offset any unpaid claims that are the financial responsibility of Physician Group paid by CalOptima against any funds owed to Physician Group by CalOptima, including capitation payments, financial security withholds, pay-for-performance amounts, quality incentives, and shared risk pool surpluses.

6.5.3 Shared Risk Pool Payments Upon Termination. If this Contract terminates or expires for any reason and Physician Group is responsible for a deficit under any shared risk program under this Contract based on the final shared risk pool report results ("Deficit"), such Deficit shall be due to CalOptima as follows, as allowed by Laws: CalOptima may elect to recoup such Deficit by either (1) offsetting such Deficit amounts, upon notice to Physician Group, from any current or future amounts owed by CalOptima to Physician Group under the Contract or any other agreement between the Parties, including capitation payments, financial security withholds, pay-for-performance amounts, quality incentives, and shared risk pool surpluses; or (2) sending an invoice to Physician Group that payment

for such Deficits are due to CalOptima within thirty (30) days of Physician Group's receipt of the CalOptima invoice.

6.5.4 Regulator Recoupment Upon Termination. If following the termination or expiration of this Contract, CalOptima's Regulators find that Physician Group (or its Downstream Entities) has failed to comply with the requirements governing physician incentive plans and CalOptima's Regulators offset, recoup and/or otherwise seek recovery of FFP, as described in Section 1.33, CalOptima may elect to recoup such FFP amounts, as allowed by Laws, by either: (1) offsetting such FFP amounts, upon notice to Physician Group, from any current or future amounts owed by CalOptima to Physician Group under the Contract or any other agreement between the Parties, including capitation payments, financial security withholds, pay-for-performance amounts, quality incentives, or shared risk pool surpluses; or (2) sending an invoice to Physician Group that payment for such FFP amounts are due to CalOptima within thirty (30) days of Physician Group's receipt of the CalOptima invoice.

6.5.5 Dispute Resolution. Physician Group may use CalOptima's provider dispute resolution procedure, as described under CalOptima's Policies, and/or the dispute resolution procedures under this Contract to resolve any disputes related to the calculation or payment of such Deficits or FFP amounts.

6.5.6 Survival. This Section 6.7 shall survive the termination or expiration of the Contract."

2. ATTACHEMENT C, Section 5, "Sequestration" shall be added to the Contract as follows:

"5. Sequestration. If CMS reduces payment to CalOptima under the CMS Contract by more than two percent (2%) at any time during the Term, CalOptima may, upon written notice to Physician Group, reduce payment to Physician Group under this Attachment C by the same percentage that CMS reduced payment to CalOptima. This provision applies each time CMS reduces payment to CalOptima by more than two percent (2%) during the Term."

3. CONTRACT REMAINS IN FULL FORCE AND EFFECT – Except as specifically amended by this Amendment, all other conditions contained in the Contract shall continue in full force and effect. After the Amendment Effective Date, any reference to the Contract shall mean the Contract as amended and supplemented by this Amendment. Notwithstanding anything to the contrary in the Contract, in the event of a conflict between the terms and conditions of this Amendment and those contained within the Contract, the terms and conditions of this Amendment shall prevail. Capitalized terms not otherwise defined in this Amendment shall have the meanings ascribed to them in the Contract. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

IN WITNESS WHEREOF, CalOptima and [_____] have executed this Amendment.

FOR PHYSICIAN GROUP:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	Yunkyung Kim _____
PRINT NAME	PRINT NAME
_____	Chief Operating Officer __
TITLE	TITLE
_____	_____
DATE	DATE

AMENDMENT {XXXXXX} TO

CAL MEDICONNECT PHYSICIAN GROUP SERVICES CONTRACT

This Amendment [XXXXX] to the Cal MediConnect Physician Group Services Contract ("Amendment") is effective as of [_____], by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and, [_____] ("Physician Group"), with respect to the following facts:

RECITALS

A. Physician Group and CalOptima have entered into a Cal MediConnect Physician Group Services Contract ("Contract") for the provision of specified covered services to CalOptima members in identified CalOptima Programs.

B. CalOptima and Physician Group desire to amend the Contract to extend the term of the Contract and revise the Corrective Action Plan time frame.

NOW, THEREFORE, the parties agree as follows:

1. Section 6.7, "CalOptima Right to Recover" of Article 6, COMPENSATION shall be added to the Contract as follows:

"6.7 **CalOptima Right to Recover.**

6.7.1 Overpayments. Physician Group acknowledges and agrees that, in the event that CalOptima determines that an amount has been overpaid or paid in duplicate, or that funds were paid which were not due under this Contract to Physician Group, CalOptima shall have the right to recover such amounts from Physician Group by recoupment or offset from current or future amounts due from CalOptima to Physician Group under this Contract or any other agreement between the parties, after giving Physician Group notice and an opportunity to return/pay such amounts.

6.7.2 Health Network Termination. In the event of termination of the Health Network or the transition of the Health Network to a different delegation model, CalOptima shall have the right to offset any unpaid claims that are the financial responsibility of Physician Group paid by CalOptima against any funds owed to Physician Group by CalOptima, including capitation payments, financial security withholds, pay-for-performance amounts, quality incentives, and shared risk pool surpluses.

6.7.3 Shared Risk Pool Payments Upon Termination. If this Contract terminates or expires for any reason and Physician Group is responsible for a deficit under any shared risk program under this Contract based on the final shared risk pool report results ("Deficit"), such Deficit shall be due to CalOptima as follows, as allowed by Laws: CalOptima may elect to recoup such Deficit by either (1) offsetting such Deficit amounts, upon notice to Physician Group, from any current or future amounts owed by CalOptima

to Physician Group under the Contract or any other agreement between the Parties, including capitation payments, financial security withholds, pay-for-performance amounts, quality incentives, and shared risk pool surpluses; or (2) sending an invoice to Physician Group that payment for such Deficits are due to CalOptima within thirty (30) days of Physician Group's receipt of the CalOptima invoice.

6.7.4 Regulator Recoupment Upon Termination. If following the termination or expiration of this Contract, CalOptima's Regulators find that Physician Group (or its Downstream Entities) has failed to comply with the requirements governing physician incentive plans and CalOptima's Regulators offset, recoup and/or otherwise seek recovery of FFP, as described in Section 1.33, CalOptima may elect to recoup such FFP amounts, as allowed by Laws, by either: (1) offsetting such FFP amounts, upon notice to Physician Group, from any current or future amounts owed by CalOptima to Physician Group under the Contract or any other agreement between the Parties, including capitation payments, financial security withholds, pay-for-performance amounts, quality incentives, or shared risk pool surpluses; or (2) sending an invoice to Physician Group that payment for such FFP amounts are due to CalOptima within thirty (30) days of Physician Group's receipt of the CalOptima invoice.

6.7.5 Dispute Resolution. Physician Group may use CalOptima's provider dispute resolution procedure, as described under CalOptima's Policies, and/or the dispute resolution procedures under this Contract to resolve any disputes related to the calculation or payment of such Deficits or FFP amounts.

6.7.6 Survival. This Section 6.7 shall survive the termination or expiration of the Contract."

2. ATTACHEMENT D, Section 1.7, "Sequestration" shall be added to the Contract as follows:

"1.7 **Sequestration**. If CMS reduces payment to CalOptima under the CMS Contract by more than two percent (2%) at any time during the Term, CalOptima may, upon written notice to Physician Group, reduce payment to Physician Group under this Attachment C by the same percentage that CMS reduced payment to CalOptima. This provision applies each time CMS reduces payment to CalOptima by more than two percent (2%) during the Term."

3. CONTRACT REMAINS IN FULL FORCE AND EFFECT – Except as specifically amended by this Amendment, all other conditions contained in the Contract shall continue in full force and effect. After the Amendment Effective Date, any reference to the Contract shall mean the Contract as amended and supplemented by this Amendment. Notwithstanding anything to the contrary in the Contract, in the event of a conflict between the terms and conditions of this Amendment and those contained within the Contract, the terms and conditions of this Amendment shall prevail. Capitalized terms not otherwise defined in this Amendment shall have the meanings ascribed to them in the Contract. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

IN WITNESS THEREOF, CalOptima and {Insert HN Name Here} have executed this Amendment {Insert Amendment # Here}:

FOR PHYSICIAN GROUP:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	_____
PRINT NAME	PRINT NAME
_____	_____
TITLE	TITLE
_____	_____
DATE	DATE

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 4, 2022
Regular Meeting of the CalOptima Board of Directors

Report Item

28. Authorize Amendments to CalOptima's OneCare, OneCare Connect, and PACE Fee-for-Service Contracts for UCI Health Only to Include Language for Sequestration

Contacts

Yunkyung Kim, Chief Operating Officer, (714) 246-8408
Michael Gomez, Executive Director, Network Operations, (714) 347-3292

Recommended Actions

Amend OneCare, OneCare Connect, and PACE Fee-for-Service (FFS) Professional and Hospital Services contracts for UC Irvine Health only, to add language for sequestration, effective September 1, 2022

Background and Discussion

Staff requests that the CalOptima Board of Directors (Board) approve amendments to the above Professional Services contracts to reflect language addressing CMS sequestration rates and recoupment of overpayment from providers, effective September 1, 2022.

Sequestration

Congress has enacted various sequestrations (i.e., an automatic reduction of certain federal spending usually by a uniform percentage) on Medicare programs, some of which were subsequently suspended while others were implemented. Most recently, the Centers for Medicare & Medicaid Services (CMS) implemented a 1% mandatory sequestration authorized by the Budget Control Act of 2011 from April 1, 2022, through June 30, 2022. This sequestration increased to 2% effective July 1, 2022. The above contract amendments stipulate that in the event a CMS-implemented sequestration(s) exceeds 2% in the aggregate at any point in the term of the contract, the amount in excess of two percent (2%) reduction will be passed on to the provider at the same percentage that CMS has reduced payment to CalOptima.

Staff will return to the Board with additional recommendations in the event the 2% sequestration threshold is no longer financially sustainable for CalOptima.

To ensure adherence to the updated sequestration practices, staff requests approval of the above amendments, effective September 1, 2022.

Fiscal Impact

The recommended action is not expected to have an additional fiscal impact on CalOptima's Fiscal Year 2022-23 Operating Budget

Rationale for Recommendation

Approving the above amendments will provide guidelines and align with current operations for addressing cases of overpayment or sequestration amounts in excess of 2%

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Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Entities Covered by this Recommended Board Action
2. Proposed amendment template: FFS Professional Services Contract
3. Proposed amendment template: FFS Hospital Services Contract

/s/ Michael Hunn *07/28/2022*
Authorized Signature **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Regents of the University of California	1111 Franklin St. 12th Floor	Oakland	CA	94607

AMENDMENT No. X TO
PROFESSIONAL SERVICES CONTRACT

This Amendment No. X to the Professional Services Contract ("**Amendment**") is effective as of [insert date] ("**Effective Date**")**,** by and between Orange County Health Authority, a Public Agency, dba CalOptima ("**CalOptima**"), and [insert provider name] ("**Professional**"), with respect to the following:

RECITALS

A. CalOptima and Professional entered into a Professional Services Contract ("**Contract**") under which Professional has agreed to furnish certain items and services to CalOptima Members.

B. CalOptima and Professional desire to amend certain terms of the Contract.

NOW, THEREFORE, the parties agree as follows:

1. Add the following new section 10 to Article IV. PAYMENT PROCEDURES of Attachment B of the Contract.

"10. Sequestration. If CMS reduces payment to CalOptima under the CMS Contract by more than two percent (2%) at any time during the Term, CalOptima may, upon written notice to Professional, reduce payment to Professional under this Attachment B – PACE, CALMEDICONNECT and MEDICARE ADVANTAGE, 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."

2. **CONTRACT REMAINS IN FULL FORCE AND EFFECT**. Except as specifically amended by this Amendment, all other conditions contained in the Contract shall continue in full force and effect. After the Amendment Effective Date, any reference to the Contract shall mean the Contract as amended and supplemented by this Amendment. Notwithstanding anything to the contrary in the Contract, in the event of a conflict between the terms and conditions of this Amendment and those contained within the Contract, the terms and conditions of this Amendment shall prevail. Capitalized terms not otherwise defined in this Amendment shall have the meanings ascribed to them in the Contract. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

IN WITNESS WHEREOF, CalOptima and Professional have executed this Amendment:

FOR PROFESSIONAL:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	Yunkyung Kim
PRINT NAME	PRINT NAME
_____	Chief Operating Officer
TITLE	TITLE
_____	_____
DATE	DATE

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AMENDMENT No. X TO
AMENDED AND RESTATED HOSPITAL SERVICES CONTRACT

This Amendment No. X to the Amended and Restated Hospital Services Contract ("**Amendment**") is effective as of {Effective Date here} ("**Effective Date**"), by and between Orange County Health Authority, a Public Agency, dba CalOptima ("**CalOptima**"), and [insert hospital name] ("**Hospital**"), with respect to the following:

RECITALS

A. CalOptima and Hospital entered into an Amended and Restated Hospital Services Contract ("**Contract**") under which Hospital has agreed to furnish certain items and services to CalOptima Members.

B. CalOptima and Hospital desire to amend certain terms of the Contract.

NOW, THEREFORE, the parties agree as follows:

1. Add the following new section 5 to Attachment B, Compensation, II. Medicare Advantage Program (OneCare) Reimbursement of the Contract:

   "5. Sequestration. If CMS reduces payment to CalOptima under the CMS Contract by more than two percent (2%) at any time during the Term, CalOptima may, upon written notice to Hospital, reduce payment to Hospital under this Attachment 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."

2. Add the following new section 5 to Attachment B, Compensation, III. Cal MediConnect Program (OneCare Connect) Reimbursement of the Contract:

   "5. Sequestration. If CMS reduces payment to CalOptima under the CMS Contract by more than two percent (2%) at any time during the Term, CalOptima may, upon written notice to Hospital, reduce payment to Hospital under this Attachment 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."

3. Add the following new section 5 to Attachment B, Compensation, IV. PACE Program Reimbursement of the Contract:

   "5. Sequestration. If CMS reduces payment to CalOptima under the CMS Contract by more than two percent (2%) at any time during the Term, CalOptima may, upon written notice to Hospital, reduce payment to Hospital under this Attachment 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."

4. **CONTRACT REMAINS IN FULL FORCE AND EFFECT**. Except as specifically amended by this Amendment, all other conditions contained in the Contract shall continue in full force and effect. After the Amendment Effective Date, any reference to the Contract shall mean the Contract as amended and supplemented by this Amendment. Notwithstanding anything to the contrary in the Contract, in the event of a conflict between the terms and conditions of this Amendment and those contained within the Contract, the terms and conditions of this Amendment shall prevail. Capitalized terms not otherwise defined in this Amendment shall have the meanings ascribed to them in the Contract. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

IN WITNESS WHEREOF, CalOptima and Hospital have executed this Amendment:

FOR HOSPIAL:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	Yunkyung Kim
PRINT NAME	PRINT NAME
_____	Chief Operating Officer
TITLE	TITLE
_____	_____
DATE	DATE

Board of Directors Meeting
August 4, 2022

Special Joint Meeting of the Member Advisory Committee, OneCare Connect Member Advisory Committee, Provider Advisory Committee and Whole-Child Model Family Advisory Committee Report to the Board

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On June 9, 2021, the Member Advisory Committee (MAC), OneCare Connect Member Advisory Committee (OCC MAC), Provider Advisory Committee (PAC) and the Whole-Child Model Family Advisory Committee (WCM FAC) held a special joint meeting to discuss topics of mutual interest.

Michael Hunn, Chief Executive Officer, thanked all the committee members for their service to CalOptima and notified the committees that the CalOptima Board has approved the FY 2023 budget and noted that CalOptima received approval from the Board to move forward for the next three years with tactical priorities. Mr. Hunn also discussed the creation of a new strategic plan and that he would seek feedback from the committees as staff moved forward in the process.

Richard Pitts, D.O., Chief Medical Officer, provided a COVID-19 update and noted that COVID was surging again with new variants and that hospitalizations had been increasing in Orange County. Dr. Pitts also discussed how there has been an increase in Syphilis cases in Orange County that caused the death of several infants. Dr. Pitts noted that it was still easily treated with Penicillin. Dr. Pitts also shared an article with the committees on this topic.

Katie Balderas, Interim Director, Population Health Management, provided two different presentations to the committees. The first presentation covered the Homeless Health Initiative and she followed up with the presentation on Population Health Needs Assessment.

Kelly Bruno-Nelson, Executive Director, Program Implementation, and Michael Herman, Sr. Director, Operations, presented on CalAIM and reviewed the upcoming July 1, 2022 addition to the CalAIM program which adds Community Supports services. Community Supports includes short-term post-hospitalization housing and day habilitation programs, personal care and homemaker services which includes meals/medically tailored meals and sobering centers.

Kris Gericke, Director, Pharmacy Operations, provided the committee members with a Medi-Cal Rx update.

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

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